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Medicare For All Master File

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Background

Medicare for All is Broader than Medicare

Medicare for All provides comprehensive coverage (unlike existing Medicare)

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

Financed with a mixture of payroll taxes, premiums, and extensive cost-sharing, Medicare provides a narrow range of health benefits, requiring seniors to rely on wraparound insurance plans or Medicaid to cover the rest.¹⁰ By contrast, both Medicare for All proposals are comprehensive, including pharmaceutical, dental, vision, and long-term care. Without cost-sharing, co-pays, deductibles, and without limits on benefits, they would largely negate any need for private insurance.¹¹

“Medicare for All” doesn’t just extend existing Medicare to the entire population

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In short, Medicare for All proposals do not extend Medicare to all Americans, they create a new program, more comprehensive, but like Medicare in one crucial way: benefits are paid by the federal government. Medicare for All proposals are also distinguished from those designed to build on the current insurance system by improving existing Medicare or opening it to the general public.¹² While the latter programs would increase the share of the public with health insurance, by preserving the current for-profit private insurance system they would maintain many of the restrictions on access that killed Alec Smith and Shane Boyle. Furthermore, by maintaining the fragmented insurance system, they would limit the types of financial savings possible only with the single-payer system.

Medicare for America is Not Medicare for All

Medicare for America is different

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

Unlike Medicare for All, Medicare for America includes some cost-sharing, with deductibles of \$350 for individuals and \$500 for families, as well as annual out-of-pocket maximums of \$3,500 and \$5,000.

Medicare for America would also leave Medicare Advantage untouched and allow businesses to provide benefits for workers. “There are 160 million people who get their insurance through their employer,” DeLauro told the Huffington Post. “You cannot tell them overnight that it is gone.”⁵⁸ Not overnight, perhaps. But under Medicare for America, those employer plans wouldn’t last long. That’s because Medicare for America would require employers to offer gold-plated insurance equivalent to the revamped Medicare.⁵⁹ That mandate would prove prohibitively costly for scores of employers. Medicare for America anticipates as much—and so allows employers to pay an 8 percent payroll tax to move their workers onto the new government-run plan.⁶⁰ For many employers, an 8 percent payroll tax would be preferable to the headache of managing a benefits program. The private employer-sponsored insurance market would gradually wither away.

Underinsured

High Number Uninsured

9% of the population is uninsured, 26% uninsured

Pollin, 2018, Robert Pollin is Distinguished University Professor of Economics and Co-Director of the Political Economy Research Institute (PERI) at the University of Massachusetts Amherst. He is also the founder and President of PEAR (Pollin Energy and Retrofits), an Amherst, MA-based green energy company operating throughout the United States, Economic Analysis of Medicare for All, [file:///Users/stefanbauschard/Downloads/Medicare_For_All_12.5.18%20\(1\).pdf](file:///Users/stefanbauschard/Downloads/Medicare_For_All_12.5.18%20(1).pdf)

At present, roughly 9 percent of U.S. residents are uninsured and 26 percent are underinsured—i.e. they are unable to adequately access needed health care because of prohibitively high costs. The demand for health care services by these population cohorts will rise significantly under Medicare for All. Medicare for All will also provide stable access to decent coverage for those currently receiving adequate insurance coverage but who may face difficulties at later points. As a high-end estimate, we conclude that overall demand for health care services in the U.S. will rise by about 12 percent through Medicare for All.

Woolhandler, MD, MPH and Himmelstein, MD, professors CUNY School of Public Health, 2017 [Steffie Woolhandler, MD, MPH, and David U. Himmelstein, MD, both at CUNY School of Public Health, “The Obama Years: Tepid Palliation for America’s Health Scourges”, American Journal of Public Health 107, no. 1 (January 1, 2017): pp. 22-24. DOI: 10.2105/AJPH.2016.303531 accessed 7/22/17 TOG, * WAVE ONE*]

Access to care has improved, but remains abysmal, in part because many who gained coverage cannot afford to use it. In 2014, 66 million working-age adults skipped doctor visits, tests, or prescriptions because of costs—down from 80 million in 2012—while collection agencies dunned 37 million for medical debts, a reduction of 4 million.³ Post-ACA, the Consumer Financial Protection Bureau reported that medical debts still account for 52% of all bills sent to collection agencies. It is disturbing that the ACA has abetted corporate dominance in health care. The law funneled most of its trillion dollars in new federal spending through private insurers as payments for exchange coverage and Medicaid managed care plans, fortifying insurers' bottom line and political clout. Meanwhile, insurers have skirted the law's caps on overhead; Aetna's overhead actually rose from an average of 17.0% in 2008 to 2010, to 19.5% in early 2016. Taken together, insurers' added overhead and that of the new exchanges will consume 22.5% of the new federal spending.⁴ The ACA's promise to cut overpayments to Medicare Advantage plans (estimated at \$1000 or more per enrollee) was also undermined, as the Centers for Medicare and Medicaid Services handed out “quality bonuses” to almost all of these private plans. In both the Medicare Advantage program and the exchanges, insurers are abandoning unprofitable local markets while continuing to reap large profits from federal payments in others, essentially cherry-picking by county. The insurance giants, awash in cash, have gone on a shopping and merger spree that will shrink the number of major insurers from five to three, unless two pending mergers are blocked on antitrust grounds. The ACA's mandate that Medicare pay for “value not volume” through health maintenance organization-like entities called accountable care organizations has driven a wave of corporate takeovers. The move from fee-for-service to quasi-capitation has not garnered the promised savings⁵ (and its health impacts remain unknown) but is driving small-scale providers from the market. They lack the

financial reserves to bear risk for high-cost patients or to invest in the information technology and administrative systems needed to manage that risk or game the complex new payment incentives, as well as the market clout to bargain with suppliers and private payers. **Giant systems have been snapping up practices and hospitals, despite compelling evidence that such**

takeovers raise costs (particularly when they create regionally dominant systems) and scant evidence that they improve care. The Medicare Access and CHIP Reauthorization Act of 2015 physician payment reform, which disproportionately penalizes small practices, promises to accelerate this trend. Although some credit the ACA with slowing health care cost growth, the slowdown began in 2005, well before the law was passed, and ended in 2014 when it was fully implemented. It is disturbing that the slowdown was only seen among low- and middle-income Americans; health spending for the wealthiest 20% soared.⁶² **In 2015, there was an almost unprecedented increase in overall US death rates, while the poorest 20% of Americans**

have suffered rising mortality over the longer term. Some of this deterioration represents increasing rates of self-harm and fatal substance use, complex problems that cannot be blamed entirely on politicians. But politicians bear responsibility for the underfunding of mental health and addictions care, and for shrinking public health resources. **Congress and the president have also failed to pull policy levers—regulation, taxation, and social spending—that could ameliorate the market forces deepening the income divide and working-class despair.** Between 2009 and 2015, the wealthiest 1% of Americans captured 52% of total income growth—continuing a decades-long trend—pushing the Gini index of income inequality up by 2.4%. Although median family income rose sharply in 2015 (with the poor enjoying the largest percentage gains), it remains 1.6% below the 2007 level.

Even if Obamacare survives, massive problems

Gaffney, MD et. al. 2016 [Adam Gaffney MD et. al., Steffie WoolhandlerMD, MPH, Marcia AngellMD, and David U. HimmelsteinMD, 2016, “Moving Forward From the Affordable Care Act to a Single-Payer System”, American Journal of Public Health 106(6) pp.987-988 available online at <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2015.303157> accessed 7/2/17 TOG * WAVE ONE*]

But was that the message? There's reason for skepticism. **A decade from now**, according to the Congressional Budget Office, **27 million Americans will remain uninsured despite full implementation** of the law. **Many more are underinsured or constrained by “narrow networks” of providers that limit choice and rupture longstanding therapeutic relationships. Doctors and nurses contend with growing requirements for mind-numbing electronic documentation^{1b} in a health care marketplace increasingly tilted toward giant insurers and hospital conglomerates that amass power through consolidation.** Finally, the system's administrative complexity, which robs patients and providers of time, money, and morale, was further fueled by the ACA.

Affordable Care Act (ACA) Inadequate

Affordable Care Act is inadequate

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

Most on the left, and virtually all Democrats, defend the ACA for these accomplishments. Yet few have been enthusiastic.⁴⁴ Tens of millions are still without insurance, and the coverage provided has been disappointing. The ACA pegs subsidies to the cost of so-called “silver” insurance plans, whose actuarial value—the share of medical expenses covered—is only 70%. By limiting the cost to the insurance company, a low actuarial value limits the cost of government subsidies, at the expense of subscribers who, on average, face deductibles of over \$4000.⁴⁵ Worse, the rising cost of healthcare is driving up these deductibles and the price of other forms of cost-sharing in both ACA plans and all other forms of private health insurance. Despite a plethora of measures intended to control costs by tweaking payment methods and coverage provisions, the ACA has largely failed to control rising costs beyond the continuing efforts of insurers to lower them by discouraging utilization through rising cost-sharing. The Centers for Medicare and Medicaid Services (CMS) now projects that health-care spending will rise by over 5% a year for the next decade—significantly faster than income.⁴⁶ As critics predicted at the time, the ACA has failed to maintain affordability because it did not address the real cost drivers pushing up US healthcare spending: the drive for profits, and the inefficiency this produces in our fragmented private healthcare system. Rather than build a popular movement to force Congressional action, the law’s architects secured its passage by trading away measures that threatened major stakeholders, drug companies, insurers, and hospitals. The ACA experience demonstrates, however, that the only way to control healthcare costs and allow real universal access is by addressing precisely these stakeholders, their inefficiency, and their profits.⁴⁷

General Health Insurance/Death Contention

S. health care is in shambles – 28 million are without insurance, millions are underinsured, and premiums will skyrocket – the wasteful bureaucracy of private insurers makes meaningful improvements impossible

Geyman 17 [John Geyman, M.D. is professor emeritus of family medicine at the University of Washington School of Medicine, a family physician with 21 years in academic medicine, Professor Emeritus of Family Medicine at the University of Washington School of Medicine, former editor of The Journal of the American Board of Family Medicine, member of the Institute of Medicine, now the National Academy of Medicine former president of Physicians for a National Health Program International Journal of Health Services, 5-26, <http://pnhp.org/blog/2017/05/26/crossroads-in-u-s-health-care-which-of-three-financing-alternatives/>]

Almost **two million Americans go through bankruptcy every year because of medical bills and illness, despite most having had insurance**, owning their own homes, having attended college, and having held responsible jobs.

Under the ACA, insurers have consolidated and narrowed networks, resulting in restricted access to care.

There are still about 28 million Americans without any health insurance.

Many physicians refuse to see uninsured patients, even those with Medicaid coverage, and waiting times can be lengthy if they are to be seen.

There are still widespread disparities of care, including by race/ethnicity, socioeconomic status, age, gender, location, and disability status, that lead many people to forgo necessary care and suffer worse outcomes.

Studies by the Commonwealth Fund find that the U. S. ranks #11 among 11 advanced countries in overall ranking, cost-restricted access, efficiency, equity, and healthy lives (2).

Under our multi-payer system with some 1,300 private insurers seeking to enroll healthier patients and avoid sicker patients, the health care bureaucracy is massive and expensive—the overhead of the private health insurance industry is \$792 per capita, more than five times that of Canada with its single-payer public financing system.

Facing uncertainty over the future of government funding for cost-sharing payments under the ACA, the extent of deregulation that will come out of the current political debate, and the future of Medicaid, **insurers are planning sharp premium increases in 2018 and threatening to exit even more markets than they have left already.** People living in rural areas are especially vulnerable to these changes.

The new Trump budget proposal would cut federal spending by \$3.6 trillion over ten years, with deep cuts to Medicaid and other safety net programs.

Comparison of Three Financing Alternatives

1. Continuing the ACA (ObamaCare)

The ACA brought important improvements in access to care, providing new coverage for 24 million Americans, especially through expansion of Medicaid in 31 states. It established ten categories of essential health benefits, and also required insurers to stop denying coverage for pre-existing conditions and allow children to stay on their parents' coverage until age 26. Cost-sharing reduction (CSR) payments were made to help 7 million people afford coverage through the exchanges, about 60 percent of all new enrollees.

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Despite these improvements, the ACA falls far short of our needs on many counts. Costs and prices of health care services have continued to soar, forcing many people to forgo necessary care and incur worse outcomes. Although the ACA expanded funding for community health centers, we still have a porous safety net that will become even more so under the proposed Trump budget proposal. Most Democrats are strongly defending the ACA against Republican attacks, calling for continuation of CSR payments and reconsideration of the public option, which was dropped in 2009 due to strong opposition from the insurance industry. That opposition remains today, and if put in place, the public option would attract more expensive, high-needs patients, relieving private insurers of the costs of covering them.

2. Repeal and replace the ACA with the AHCA (TrumpCare)

This has been the consistent goal of the GOP since the passage of the ACA in

2010, but repeal has failed on some 60 occasions in Congress. Since the 2016 elections, despite having control of both chambers of Congress and the White House, Republicans have had great difficulty in coming up with a replacement plan. The provision of subsidies or tax credits, definition of essential health benefits, and cutbacks to Medicaid have been especially controversial.

After the first GOP plan for the AHCA was pulled from the floor without enough votes, House Republicans hastily drafted a revised bill, hoping to appease the hard right Freedom Caucus while gaining enough support from more moderate Republicans. That bill barely passed by a vote of 217 to 213, with these provisions:

Eliminates the individual mandate and requirement that larger employers offer employer-sponsored coverage.

Allows states to limit essential health benefits through waivers (such as hospital care or maternity care).

Reduces funding for Medicaid by \$839 billion.

Allows insurers to charge seniors up to five times the rates for younger patients.

Defunds Planned Parenthood.

Replaces the ACA's subsidies with less generous tax credits.

Allows insurers to raise premiums on patients with pre-existing conditions, while providing (inadequate) funds for high-risk pools.

Repeals taxes on pharmaceutical and medical device industries.

Provides wealthy taxpayers \$882 billion in tax breaks.

That bill has gone on to the Senate, where it is receiving little support. A 13-man (no women) working group is charged with writing a new bill. The CBO has recently scored the House bill, noting that 23 million people will lose coverage by 2026, including 14 million who would otherwise have had it through Medicaid. That 23 million, plus today's 28 million uninsured under the ACA, totals 51 million uninsured (even more than when the ACA was passed!), plus tens of millions more underinsured as insurers reduce benefits. The CBO projects a 20 percent increase in insurance premiums in 2018, and that sicker patients can expect huge increases in costs. It also recognizes that costs for skimpier coverage may be unaffordable for many in states that get waivers to back away from some essential health benefits and/or cut CSR payments. If ever a final GOP bill is passed by both chambers of Congress, its main elements will likely include such already discredited approaches as further deregulation of the insurance industry, increased cost sharing with patients, health savings accounts, high-risk pools, selling insurance across state lines, and more privatization of Medicare and Medicaid.

3. Single-payer national health insurance (NHI), or Medicare for All

It has become clear that neither the ACA nor the AHCA can ever make health care accessible and affordable for all as long as they rely on a multi-payer, profiteering market-based system, and that either approach will leave out increasing numbers of Americans. We can expect the AHCA or whatever version might eventually clear both chambers of Congress will be even worse than the ACA, while giving huge tax breaks for the wealthy.

Single-payer NHI (H.R. 676 in the House, with 112 co-sponsors) is the only financing alternative to effectively reform U.S. health care. It is a common sense approach to long overdue fundamental system reform. When enacted, all Americans will gain universal access to affordable, comprehensive health care regardless of their health status or income, with full choice of physician and hospital anywhere in the country. They will be part of a single risk pool of 320 million Americans that accommodates the needs of the sickest patients while saving enough money to provide health care to our entire population. Benefits will include physician and hospital care, outpatient care, dental and vision services, rehabilitation, long-term care, mental health care, and prescription drugs. Today's huge bureaucracy and wasteful overhead of a failing private insurance industry will be a thing of the past.

According to the latest projections, NHI will save \$616 billion a year (\$503 billion by eliminating administrative overhead and \$113 billion on outpatient prescription drugs through negotiated drug prices). (3) It will be funded by a progressive funding plan whereby 95 percent of Americans will pay less than they do now for insurance and care. As an example, those with annual incomes of \$50,000 will pay \$1,500 in taxes.

Tens of thousands of preventable deaths year after year results in millions of deaths – insurance access is vital

Hahn 15 [Matthew Hahn, M.D. *Internally cites Robert Zarr, board-certified pediatrician at Unity Health Care, medical degree from Baylor College of Medicine and completed his pediatric residency at Texas Children's Hospital in Houston. He also has a master's degree in public health, specializing in international health, from the University of Texas School of Public Health, 11-16-2015, <https://www.singlepayeraction.org/2015/09/16/more-americans-have-health-coverage-but-many-cant-afford-to-use-it/>]

The Census Bureau says number of uninsured has dropped to 33 million in wake of Affordable Care Act.

But the Census Bureau is silent on problems of rising deductibles, copays, coinsurance and narrow networks that deter people from seeking care.

"The Census Bureau's official estimate that 33 million Americans lacked health insurance in 2014 reflects a significant and welcome drop from the 42 million it reported as uninsured in 2013," said Dr. Robert Zarr, president of Physicians for a National Health Program, today. "But the number of people who remain without coverage is still intolerably high. And the Census Bureau report leaves entirely unmentioned the millions of people who have health insurance but who can't afford to use it because of high deductibles and copays."

"Having health insurance is better than not having coverage, as several research studies have shown," Zarr, a Washington, D.C.-based pediatrician, said. "For example, the 33 million people the Census Bureau says were uninsured in 2014 means that approximately 33,000 people died needlessly last year because they couldn't get access to timely and appropriate care." He cited a landmark study in the American Journal of Public Health showing that for every 1 million persons who are uninsured in a given year, there are about 1,000 deaths linked chiefly to that factor.

"That's an unnecessary death every 16 minutes," Zarr said. "That's completely unacceptable. Moreover, the Congressional Budget Office predicts at least 27 million people will be uninsured every year for the next 10 years – so that's tens of thousands of preventable deaths, year in and year out."

"And keep in mind that even if all the states had accepted the Medicaid expansion, about 24 million people would still be uninsured under the Affordable Care Act," he said. "We simply can't go on like this."

Single payer reprioritizes health over profits by controlling costs and increasing negotiating power – solves tens of thousands of deaths annually

Woolhandler 17 [Steffie Woolhandler, practicing primary care physician, distinguished professor of public health and health policy in the CUNY School of Public Health at Hunter College, adjunct clinical professor at Albert Einstein College of Medicine, and lecturer in medicine at Harvard Medical School, where she co-directed the general internal medicine fellowship program and practiced primary care

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internal medicine at Cambridge Hospital. Dr. Woolhandler earned her bachelor's degree from Stanford University; her medical degree from Louisiana State University; and her master's degree from the University of California. She worked in 1990-1991 as a Robert Wood Johnson Foundation health policy fellow at the Institute of Medicine and the U.S. Congress. David U. Himmelstein, distinguished professor of public health and health policy in the CUNY School of Public Health at Hunter College, adjunct clinical professor at Albert Einstein College of Medicine, and lecturer in medicine at Harvard Medical School. He has served as chief of the division of social and community medicine at Cambridge Hospital. Dr. Himmelstein received his medical degree from Columbia University and completed internal medicine training at Highland Hospital/University of California San Francisco and a fellowship in general internal medicine at Harvard. "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs", Annals of Internal Medicine, 4-18, <http://annals.org/aim/article/2605414/single-payer-reform-only-way-fulfill-president-s-pledge-more>]

President Donald Trump and congressional Republicans have vowed to repeal and replace the Patient Protection and Affordable Care Act (ACA). Repealing it is relatively easy. Replacing it with "something great" is much trickier. The president has promised universal coverage and reduced deductibles and copayments, all within tight budgetary constraints. That is a tall order and unlikely to be filled by proposals that Republicans have offered thus far.

Speaker of the House Paul Ryan's blueprint (1) would rebrand the ACA's premium subsidies as "tax credits" (technically, the subsidies are already tax credits) and offer them to anyone lacking job-based coverage—even the wealthy—reducing the funds available to subsidize premiums for lower-income persons in the United States. He would allow "mini-med" plans offering minuscule coverage and interstate sales of insurance, circumventing state-based consumer protections. And he would augment tax breaks for health savings accounts, a boon for persons in high tax brackets.

Speaker Ryan would also end the long-standing federal commitment to match states' Medicaid spending, substituting block grants that state governments could divert to nonmedical purposes. Moreover, decoupling federal contributions from actual medical expenditures amounts to a *sotto voce* cut. For Medicare, he would trim federal spending by delaying eligibility until age 67 years; replace seniors' guaranteed benefits with vouchers to purchase coverage; and tie the vouchers' value to overall inflation, which lags behind health care inflation.

In sum, Speaker Ryan's proposal, and a similar one from Secretary of Health and Human Services Tom Price, would shrink the coverage of poor and low-income persons in the United States while maintaining (or expanding) outlays for some higher-income groups. That approach might save federal dollars by shifting costs onto patients and state budgets. But containing overall health care costs requires denting the revenues (and profits) of corporate giants that increasingly dominate care—an unlikely outcome of policies that expand the role of private insurers and weaken public oversight.

Although Republicans' proposals seem unlikely to achieve President Trump's triple aim (more coverage, better benefits, and lower costs), single-payer reform could Such reform would replace the current welter of insurance plans with a single, public plan covering everyone for all medically necessary care—in essence, an expanded and upgraded version of the traditional Medicare program (that is, not Medicare Advantage).

The economic case for single-payer reform is compelling. Private insurers' overhead currently averages 12.4% versus 2.2% in traditional Medicare (2). Reducing overhead to Medicare's level would save approximately \$220 billion this year (Table) (3). Single-payer reform could also sharply reduce billing and paperwork costs for physicians, hospitals, and other providers. For example, by paying hospitals lump-sum operating budgets rather than forcing them to bill per patient, Scotland and Canada have held hospital administrative costs to approximately 12% of their revenue versus 25.3% in the United States (4). Simplified, uniform billing procedures could reduce the money and time that physicians spend on billing-related documentation.

All told, we estimate that single-payer reform could save approximately \$504 billion annually on bureaucracy (Table). Any such estimate is imprecise; however, this figure is in line with Pozen and Cutler's estimate (\$383 billion, updated to reflect health care inflation) (5), which excludes potential savings for providers other than

physicians and hospitals Additional savings could come from adopting the negotiating strategies that most nations with national health insurance use, which pay approximately one half what we do for prescription drugs.

Of course, single-payer reform would bring added costs as well as savings. Full coverage would (and should) boost use for the 26 million persons in the United States who remain uninsured despite the ACA. And plugging the gaps in existing coverage (abolishing copayments and deductibles, covering such services as dental and long-term care that many policies exclude, and bringing Medicaid fees up to par) would further increase clinical expenditures.

Studies provide imperfect guidance on the probable magnitude of changes in use under single-payer reform. Microlevel experiments indicate that when a few persons in a community gain full coverage their use surges (6). But when many persons gain coverage, the fixed supply of physicians and hospitals constrains community-wide increases in use. For example, when Canada rolled out its single-payer program, the total number of physician visits changed little; increased visits for poorer, sicker patients were offset by small declines in visits for healthier, more affluent persons (7). Despite dire predictions of patient pileups, Medicare and Medicaid's start-up in 1966 similarly shifted care toward the poor but caused no net increase in use (8).

Despite some uncertainties, analysts from government agencies and prominent consulting firms have concluded that administrative and drug savings would fully offset increased use, allowing universal, comprehensive coverage within the current health care budgetary envelope (9). International experience with single-payer reform provides further reassurance. It has been thoroughly vetted in Canada and other nations where access is better, costs are lower, and quality is similar to that in the United States.

The potential health benefits from single-payer reform are more important than the economic ones. Being uninsured has mortal consequences. Covering the 26 million persons in the United States who are currently uninsured would probably save tens of thousands of lives annually. And underinsurance now endangers many more by, for example, delaying persons from seeking care for myocardial infarction or causing patients to skimp on cardiac or asthma medications. Single-payer reform would also free patients from the confines of narrow provider networks and lift the financial threat of illness, a frequent contributor to bankruptcy and the most common cause of serious credit problems.

The ACA has helped millions. However, our health care system remains deeply flawed. Nine percent of persons in the United States are uninsured, deductibles are rising and networks narrowing, costs are again on the upswing, the pursuit of profit too often displaces medical goals, and physicians are increasingly demoralized.

Reforms that move forward from the ACA are urgently needed and widely supported. Even two fifths of Republicans (and 53% of those favoring repeal of the ACA) would opt for single-payer reform (10). Yet, the current Washington regime seems intent on moving backward, threatening to replace the ACA with something far worse.

Savings from administrative simplicity and global budgeting fully offset the costs of expanded coverage. Only single-source payment solves – even a move from one to two insurers fragments coverage and undermines health planning.

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Single-payer national health insurance could cover the uninsured and upgrade coverage for most Americans without increasing costs; savings on insurance overhead and other bureaucracy would fully offset the costs of improved care. In contrast, proposed incremental reforms are projected to cover a fraction of the uninsured, at great cost.

Moreover, even these projections are suspect; reforms of the past quarter century have not stemmed the erosion of coverage. Despite incrementalists' claims of pragmatism, they have proven unable to shepherd meaningful reform through the political system.

While national health insurance is often dismissed as ultra left by the policy community, it is dead center in public opinion. Polls have consistently shown that at least 40%, and perhaps 60%, of Americans favor such reform.

WE ADVOCATE **SINGLE-PAYER** national health insurance (NHI) (Table 1 ►) because it **would work and lesser reforms would not**. The policy establishment often portrays NHI as an impossible dream: an ultra-left, utopian vision. Yet, most other wealthy capitalist nations have implemented NHI, and it enjoys wide, even majority, public support in the United States.

Key Features of Single-Payer National Health Insurance

Most would agree that our health care system is deeply troubled. At least 41 million people residing in the United States have no health insurance, and millions more have inadequate coverage. Medical care costs are soaring, and job-based coverage is eroding. Public resources of enormous worth—hospitals, visiting nurse agencies, even hospices—built over decades by taxes, charity, and devoted volunteers, are being taken over by companies attentive to profits but indifferent to suffering.

Since the defeat of the Clintons' Rube Goldberg scheme for universal coverage, reform debate has been muted. But the fast developing medical care crisis—business grappling with soaring premiums, workers and unions fighting cutbacks in coverage, governments confronting deficits, and a sharp upturn in the number of individuals who are unemployed and uninsured—ensures a reopening of health policy debate.

THE LIMITS OF INCREMENTALISM

Since the passage of Medicare and Medicaid, a welter of incremental reforms have been attempted—and have failed. Health maintenance organizations (**HMOs**) and diagnosis-related groups promised to contain costs and free up funds to expand coverage. Billions have been allocated to expanding Medicaid, the **S**tate **C**hildren's **H**ealth **I**nsurance **P**rogram, and similar state-based insurance programs for poor and near-poor citizens. Medicare and Medicaid have pushed managed care. Oregon essayed rationing; Massachusetts and Hawaii passed laws requiring all employers to cover their workers; Tennessee promised nearly universal coverage; and several states implemented risk pools to insure high-cost individuals and insurance regulations to protect consumers.¹ Senators Kennedy and Kassebaum lent their names to insurance market reform legislation. And for-profit firms pledged that market discipline and businesslike efficiency would fix health care.

Fans of incrementalism dismiss NHI as a hopeless home run swing when a bunt—small steps toward universal coverage—would do. Despite incrementalists' claims of pragmatism, however, they have proven unable to shepherd meaningful reform through our political system. Over the past quarter century,

incrementalists have trumpeted victories such as those detailed above. Meanwhile, the number of uninsured individuals has increased by 18 million, health care's share of the gross domestic product has risen from 7.9% to 13.2%, and more and more seniors have been forced to choose between food and medicine. How many more strikes before incrementalism is out?

Incrementalism founders on a simple problem: expansion of coverage must increase costs unless resources are diverted from elsewhere in the system. US health costs are already nearly double those of any other nation and are rising rapidly.² The economic climate is cool. Yet, an incrementalist strategy implausibly posits massive infusions of new money, funds that would go mostly to the poor and near poor, who wield little political power. For instance, proposals to offer tax credits for the purchase of coverage would cost about \$3000 annually per newly insured person.³ Employer mandate proposals in California would boost public spending by between \$4000 and \$10 000 per newly insured person while also increasing employers' costs.⁴

Absent new money, patchwork reforms can expand coverage only by siphoning resources from existing clinical care. Advocates of managed care and market competition once argued that their strategy could accomplish this end by trimming clinical fat. Unfortunately, new layers of corporate bureaucrats have invariably overseen the managed care "diet" prescribed for clinicians and patients. Such cost management bureaucracies have devoured virtually all of the existing clinical savings and antagonized huge swaths of middle-class patients as well as the medical profession.

THE FISCAL CASE FOR NHI

The fiscal case for NHI arises from the observation that bureaucracy now consumes nearly 30% of our health care budget,^{5–7} as well as the fact that this enormous bureaucratic burden is a peculiarly American phenomenon. Our biggest HMOs keep 20%, even 25%, of premiums for their overhead and profits; Canada's NHI has 1% overhead,² and even us Medicare takes less than 4%.⁹ HMOs also inflict mountains of paperwork on clinicians and institutional providers. The average US hospital spends one quarter of its budget on billing and administration, nearly twice the average in Canada.⁷ American physicians spend far more time and money on paperwork and billing than their Canadian colleagues.⁵ Administration consumes 35% of home care agency budgets in the United States, as opposed to 15.8% in Ontario (S. Woolhandler, T. Campbell, D. U. Himmelstein, unpublished data, 1999–2000).

Reducing our bureaucratic spending to Canadian levels would save at least \$140 billion annually, enough to fully cover the uninsured and upgrade coverage among those now underinsured. Proponents of NHI,¹⁰ disinterested civil servants,^{11,12} and even skeptics¹³ all agree on this point. NHI would require new taxes, but these taxes would be fully offset by a fall in insurance premiums and out-of-pocket costs. Moreover, the additional tax burden would be smaller than is usually appreciated, because nearly 60% of health spending is already tax supported¹⁴ (vs roughly 70% in Canada).

Unfortunately, incremental tinkering cannot achieve significant bureaucratic savings. The key to administrative simplicity in Canada (and other nations) is single-source payment through a public insurer. Canadian hospitals have a global annual budget to cover all costs—much as a health department is funded in the United States—virtually eliminating billing. Physicians bill a single insurer using a simple form, and fee schedules are negotiated annually between provincial medical associations and governments. In contrast, US providers face a welter of plans—at least 755 in Seattle alone¹⁵—each with its own rules and paperwork.

Even a step from 1 to 2 insurers raises providers' administrative costs. **Fragmented coverage** necessitates eligibility determination and internal cost accounting to attribute costs to individual patients and insurers and **undermines global budgeting and health planning efforts**. Although many assumed that computerization of billing would cut administrative costs, savings have not materialized.¹⁶ While all nations with NHI have lower health administration costs than the United States, **multipayer systems sacrifice** part of **this advantage**. Thus, Germany's health care providers employ far more administrators and clerks than Canada's.¹⁷ In the United Kingdom, the implementation of "internal markets" (in effect, a multipayer structure superimposed on the National Health Service) doubled administrative costs.¹⁸

For insurers, a **multipayer** structure requires **duplication** of claims processing facilities and reduces the size of the group that is insured, which **increases overhead**^{19,20}; insurance overhead in the multipayer NHI systems of Germany and the Netherlands is at least **double** that in Canada.²¹ Any degree of participation by private **insurers** also **raises administrative costs**.²¹ Private insurers in Australia, Germany, and the Netherlands all have high overheads: 15.8%, 20.4%, and 10.4%, respectively.²² Functions essential to private insurance but absent in public programs (e.g., underwriting and marketing) account for about two thirds of private insurers' overhead.²²

THE POLITICAL CASE FOR NHI

The political case for **NHI** arises from the fact that it **would improve care for most Americans, not just the poor**: solidarity is stronger than charity, a formulation we first heard from Vicente Navarro. **NHI would not just expand current insurance arrangements; it would upgrade coverage** for many in the middle class, **assuage** clinicians' and communities' **concerns over the growing corporate dominance of care, and provide a framework for addressing the myriad problems exacerbated by our current irrational financing structure**. These problems **include the overuse of technology and neglect of caring, the extortionate profits of our drug industry, the imbalance between curative and preventive resources, the mismatch between health investments and need, and the multitude of quality problems that plague us** (why is it that virtually every hospital in the United States has a complex computer billing system yet almost none have computerized order-entry systems that would prevent millions of medication errors?).

Among those who already have coverage, **NHI** would eliminate the fear that today's coverage will subsequently become unaffordable or disappear as a result of a strike, layoff, disabling illness, or college graduation. It would afford them a free choice of providers, a top priority for many Americans according to polls (hence the right-wing appropriation of terms such as "consumer choice health reform") but rare in today's managed care environment. **It would encompass many services that are excluded from current coverage—notably long-term care, as well as prescription drugs for the elderly.**

Among health workers, **NHI can** reduce the aggravation of bureaucratic hassles, dampen market-induced gyrations in the financial health of institutions and practices, and refocus the attention of health leaders from profits to health improvement. NHI offers reassurance for health workers and communities now fearful that a distant corporate board may discontinue vital but unprofitable services.

In contrast, incremental reforms divide our potential supporters, proposing fixes for the problems of the uninsured, seniors, disgruntled HMO members, and unhappy physicians and nurses in **separate pieces of legislation** that **compete for resources**. And the fundamental problem of **corporate control** of our health care system remains **unaddressed**.

Escalating costs overwhelm the short-term benefits of incremental reforms. Only eliminating private insurance is sustainable.

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FACP Nahiris Bahamon, MD, Resident Representative Kathy Bottum, MD, PhD Duane Dowell, MD, Past Co-President Claudia Fegan, MD, CHCQM, FACP Peter Gann, MD, ScD Pamella Gronemeyer, MD, FCAP, Co-President for Southern Illinois Arielle Hirschfeld, MD, Resident Representative Carol Krohm, MD Alex Neuman, DO, Resident Representative Peter Orris, MD, MPH, FACP, FACOEM Simon Piller, MD William Reed, MD Anne Robin, MD Susan Rogers, MD, FACP, Past Co-President James Ronayne, MD Anne Scheetz, MD, FACP, Organizer Alap Shah, MD, Co-President for Northern Illinois Phil Verhoef, MD, PhD, Immediate Past Co-President Daniel Yohanna, MD, "Single-Payer and Incremental "Reform" Options", <http://www.pnhpillinois.org/incrementalism.pdf> [italics in original]

Why Support Single-Payer Over Other Reform Options?

Because we know that single-payer is the **only** reform which will result in universal coverage. A **vast amount of domestic and international experience** teaches us that single payer **isn't one way** to get to **universal health care: singlepayer is the only way to provide sustainable high-quality, comprehensive coverage for all.**

Reforms that retain the private health insurance industry have been **tried over and over again, and continue to fail**. In contrast, single-payer works because it does two things that reforms centered on the private insurance industry can't:

(1) *Single-Payer Provides Comprehensive, Universal Coverage:* Having private insurance is not the same as having access to health care. More than one-quarter of insured Americans go without needed care due to costs each year. In addition, of the one million Americans bankrupted by medical bills annually, more than 75 percent had insurance when they got sick. Expanding defective coverage which doesn't provide access to care or financial protection to more people is **not a solution** to the health care crisis.

(2) *Single-Payer Controls Costs So Benefits Are Sustainable:* Giving Americans subsidies to purchase insurance or ordering businesses to provide it is **useless** so long as health care costs continue to skyrocket. Any gains in coverage will be **quickly erased** unless benefits are reduced or huge new funding sources are found. Private insurers are profit focused, squandering \$350 billion per year on administrative waste. In contrast, single-payer reigns in costs by **eliminating wasteful duplication, refocusing priorities on primary and preventive care, and using market power to bargain** down costs so benefits can last for generations.

Single-payer isn't the best way to universal coverage. It's the **only way**.

But Countries Like France, Germany and Switzerland Have Private Insurance, Right?

Wrong. No country has achieved universal health care while retaining U.S.-style private insurance. Other industrialized countries have realized that U.S.-style **for profit insurers have no purpose other than to fight claims, issue denials, and screen out the sick**, wasting hundreds of billions in the process. **Universal coverage is impossible with profit-focused insurers** fighting over healthy patients and driving up costs. All have taken the steps necessary to regulate U.S.-style private insurance out of existence. **While it is true that some countries have "private insurers," these entities are so fundamentally different from U.S. for profit insurers that they may as well be from a different planet.** In Switzerland, for instance – arguably the most "private" system in Western Europe – the government requires insurers to be non-profit, determines their benefit packages, sets their premiums, and forces them to make risk adjustment payments to their competitors if they enroll a healthier population. Implementing such a system in the U.S. is no more "politically feasible" than implementing singlepayer. And **because administrative expenses increase with each additional insurer, single-payer beats these systems in costs.**

But Getting “Something” is Better than Getting “Nothing,” Isn’t It?

Not if that “something” makes it more difficult to reach a real solution and ensures temporary relief will be followed by prolonged suffering. Timid reforms which accommodate private insurers may allow some people to buy inadequate insurance products for a short time. But such a system will quickly be crushed by the weight of rising health care costs, as Medicaid, SCHIP and dozens of state initiatives have been. After that, the health system is back to square one.

In addition, expending political capital on reforms that we know won’t work makes the public cynical and gives ammunition to those who say that the government cannot create effective programs. Hence, any attempt at real reform is delayed, usually by decades. The minor temporal relief that reformers might get by acquiescing to insurance industry demands is simply not worth the continued suffering of the American people.

But Such a System Could be a “Step” Towards a Single-Payer System, Right?

No. Enacting phony “universal coverage” has not brought any state closer to a single-payer system. Since the early 1990s, Minnesota, Oregon, Maine, Florida, Utah, Washington, California, Vermont and Massachusetts have been among the states that have attempted to “patch-up” their fundamentally flawed systems while retaining a place for insurance companies. All have failed. Upon passage, incremental reforms in each of these states were hailed by politicians and the media as a “step toward universal coverage.” Yet despite all the claims of pragmatism, incremental reformers have been unable to shepherd through meaningful change in nearly four decades of trying. And while reformers in these states continue to wait for the next “step,” residents continue to suffer. (see chart below). The definition of insanity is to repeat an action expecting a different result. This is exactly what we have done in continuing to advocate incremental reforms as “steps” toward single-payer. What Americans need is not more proposals for patchwork reforms. We need leaders willing to stand up for the only solution that will work.

Only federal single payer has the resources and market power to ensure successful transition – establishes a glide path allowing cost-cutting to fill-in gradually

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<https://benjaminstudebaker.com/2017/06/02/why-single-payer-works-better-at-the-national-level-than-the-state-level/>

There’s a single payer plan advancing in the state of California, and many people are excited about it. And for good reason—a single payer system can potentially extend coverage while cutting costs. I’ve written about the virtues of single payer many times before, but there is a political danger in attempting to do single payer at the state level. Ironically and tragically, the very economic forces which make single payer such a good federal policy create powerful dangers for state systems.

The private system in the United States wastes huge amounts of money. To show just how bad it is, I like to use a figure I call the “healthcare efficiency rating” or “HER” for short. It’s relatively simple—we just divide a country’s life expectancy by its total healthcare spending as a percent of GDP. Among rich countries, the United States ranks dead last in HER, and it’s not close:

America is in red. The green countries use single-payer, and the blue countries use hybrid systems which contain large public components. Overall, the single payer systems are the most efficient:

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Because the American healthcare system is so inefficient, we spend a much larger percentage of our GDP on healthcare than countries with single payer do. Healthcare spending in the US is about 17% of GDP. In Britain it's 9%. Yet in the United States, average life expectancy is 79.3 while in the UK it's 81.2. The Brits aren't just getting more lifespan for their money—they're getting more lifespan, full stop.

Single payer cuts costs by giving the government a monopoly on demand. Because the state negotiates on behalf of all patients, it can more or less dictate prices to doctors, hospitals, and drug companies. Usually countries with single payer manage their costs by listening to patients—if patients feel that the quality of the service is poor, they can vote in parties that pledge to increase funding. If patients feel that the service is costing taxpayers too much money, they can vote in parties that pledge to force costs down. The left and the right in European countries often act as a yin-yang on healthcare—the left stops the right from destroying the service and the right stops the left from allowing the service to grow fat and inefficient. Single payer is so inexpensive because when the government decides to reduce the cost of the service, it changes compensation for everyone in the healthcare sector and leaves them with no where to go.

The American healthcare system is very fat and inefficient and there is much room for cost-cutting. For instance, because American drug companies receive entirely too much money, they have lots of extra cash to waste on advertising—far more than what they spend on medical research:

In theory, if the United States were to create a federal single payer system like Britain's and cut healthcare spending to 9% of GDP, it could save \$1.4 trillion every year. That's more than \$14 trillion in the first decade, without including inflation or economic growth, both of which would raise that figure. The thing is, these cost savings are so immense that if we did this all at once we'd create tremendous disruption in the healthcare sector. In addition to wiping out the \$800 billion health insurance industry and its 450,000+ jobs, we'd also cut some of the 12.4 million healthcare jobs and reduce compensation for the rest. So in practice, a federal system might instead reduce healthcare costs gradually. Instead of forcing compensation down to European levels immediately, we might hold down the rate at which healthcare costs grow below the rates of growth and inflation until at some point, some years down the line, we'd achieve a competitive spending percentage and HER. This means that a federal single payer system might initially cost a trillion dollars more than is really necessary, as we slowly transition the healthcare system to a lower compensation, higher efficiency model.

Fortunately, the federal government doesn't need to collect all that tax money. Because of its tremendous ability to borrow large sums of money, the feds can cover some of it with borrowing. The IMF calculates that the United States can safely borrow an additional 165% of GDP before it runs out of “fiscal space”. That's about \$30 trillion dollars.

If we aimed to reduce healthcare spending to 12% of GDP in the long-term, we could raise that 12% (\$2.1 trillion) in taxes while covering the remaining 5% (\$890 billion) with borrowing in the first year. Some of the taxes we'd need are already on the books—the government already raises revenue to fund spending equivalent to 8.3% of GDP, which goes mostly to Medicaid and Medicare. So with a 12% target, new taxes might only amount to about 3.7% of GDP, or \$660 billion. Each year, we could trim the fat a bit, gradually decreasing the sum we borrow until it reaches zero. We'd come nowhere close to reaching our fiscal limit. Along the way, American families and businesses would feel significant economic relief—most people's tax burdens would be significantly smaller than their current premiums. They'd have more to spend on other things, and other sectors of the economy would grow, generating new jobs.

It's a major undertaking, but it can work for two key reasons:

The federal government **has the spending capacity** to cover some of the cost with borrowing while we transition to a more efficient system, enabling American families and businesses to immediately get significant relief even while we help people in the healthcare and insurance sectors find new jobs or adjust to more reasonable compensation packages.

A federal single payer program covers the entire healthcare sector so it's a true monopoly.

What goes wrong when a single state tries to do single payer? Well, a single US state has problems in both these areas. Many individual US states have balanced budget amendments preventing them from borrowing large amounts of money to facilitate a gradual transition. Even the ones that don't have balanced budget amendments would struggle to get access to the kind of credit available to the federal government. And crucially, individual US states cannot exercise a true monopoly on demand. If one state tries to slash healthcare spending significantly, its best doctors can simply run to neighboring states, producing doctor shortages and reducing quality of care. This makes individual states afraid to use the cost-cutting leverage which single payer gives them. If they don't use the cost-cutting leverage and don't borrow money, they have to raise taxes high enough to cover healthcare spending which will support a national spending figure of 17% of GDP. This means that they end up raising much more tax revenue than the Europeans do to continue propping up a healthcare sector which is too big to fail. This prevents citizens from getting the healthcare relief we promise them—their premiums disappear, but their taxes rise too much for them to get the full benefits of single payer.

In the long-run, people are unlikely to continue to support that kind of system, and when they give up on it the right will attempt to use the failure as evidence in national debates about single payer, even though the policy is much more workable at the federal level. There is no other rich democracy American doctors can emigrate to which will pay them the extraordinarily bloated wages they receive in the United States. For the feds, it's simply a question of whether they prefer to borrow a lot of money facilitating a gradual transition or to profoundly disrupt the healthcare sector to save Americans huge amounts of money very quickly.

In sum, the hardest thing about single payer is the fact that it's replacing a system that has accustomed millions of people who work in the healthcare sector to unrealistic and unsustainable levels of compensation. If we cut their pay to reduce costs and give them somewhere to run, they'll run. If we cut their pay very quickly, we'll produce a significant increase in unemployment and disrupt many people's lives. If we cut their pay gradually, we need to be able to borrow money in the short-term to avoid raising taxes too much. The federal government has the resources and the potential market power to get these things done. The states don't. It's hard to wrap our heads around just how wasteful our healthcare system is. It's a problem that is far too big for any one state to handle. We need the feds—without them, we risk handing the right undeserved propaganda coups, enabling the private system to go on flushing our hard-earned money down the drain.

Lack of Health Care Kills

Lack of health care kills 18,000 per year

Ronald Pies, MD, is Professor of Psychiatry and Lecturer on Bioethics at SUNY Upstate Medical University, Syracuse, New York, and Clinical Professor of Psychiatry at Tufts University School of Medicine in Boston, Massachusetts, Universal Health Care: A Moral Obligation? <https://sites.sph.harvard.edu/hhropenforum/2012/02/15/universal-health-care-a-moral-obligation/>

As a psychiatric physician for nearly thirty years, I am always surprised when I hear politicians claim that the U.S. health care system is “the best in the world.” To be sure, we are among the most advanced nations when it comes to medical technology, and we are second to none when it comes to the dedication of our doctors, nurses, and allied professionals. But if we examine indices of public health such as infant mortality and preventable deaths, we are far from having the best health care “system.” For example, according to a [2002 study by the Institute of Medicine](#), 18,000 Americans die every year because they don’t have health insurance. And in a [2008 Commonwealth Fund-supported study](#) comparing “preventable deaths” in nineteen industrialized countries, the United States placed last.

Those without access to health care die, lack of *universal care* makes death and poor health more likely

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Empirical Evidence The empirical evidence for the minor premise is the substantial research on disparities in both health and health care, and the negative consequences experienced by uninsured and underinsured Americans. A few examples should suffice. Research evidence that the uninsured suffer ill health was presented by the American College of Physicians-American Society of Internal Medicine in their 2000 report entitled, “No health insurance? It’s enough to make you sick—Scientific research linking the lack of health coverage to poor health” (available at www.acponline.org/uninsured/.) Moreover, a May 2002 report by the non-partisan Kaiser Commission on Medicaid and Medicare documented that the uninsured have a 10 to 15 percent higher mortality rate and earn 10 to 30 percent less because of their poor health (Kaiser Family Foundation, 2002). In short, because they are uninsured, they are both sicker and poorer. In the same year, the Institute of Medicine (2002) issued a report estimating that more than 18,000 adults die each year in the United States because they “are uninsured. With the population increase since 2000, the Urban Institute’s estimate of deaths in 2008 due to lack of health insurance was 22,000 Americans (as cited in Reid, 2009, p. 208). A more recent estimate is an annual death rate of 45,000 (Wilper et al., 2009). A current review of research on health disparities is Anderson, Rice, and Kominski (2007).

The minor premise of the argument asserts universal health care, not simply health care. Compared to other countries in Europe and Scandinavia, the U.S. is the only industrialized country that lacks a national policy and system of universal health care. There is additional evidence that the health status of people living in countries with universal health care is equal to, and better than in the United States. On the sole outcome measure of health status, the World Health Organization (2000) ranked the U.S. 24th on the level of health and 32nd on the distribution of health throughout its population. In overall attainment of the three goals of health status, responsiveness, and fair financing, the U.S. health care system was ranked 15th by the World Health Organization. In overall health system performance of four universal functions (stewardship, creating resources, financing, and delivery of services), the U.S. was ranked 37th of the 191 member nations of the World Health Organization (WHO, 2000, Annex Table 1, p. 155). It is the distribution of health care that relates most directly to the issue of universal access, though the limited access to health care for 47 million uninsured Americans also contributes to a lower level of health of the population as a whole. The lack of universal access in the American healthcare system also makes it less responsive to the population's expectations and needs. Related to the criterion of responsiveness, McGlynn et al. (2003) estimated that Americans are receiving on average only 55 percent of the medical care they need. A beneficent health care delivery system provides medically necessary care for the entire population it is designed to serve. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 2781-2786). AuthorHouse. Kindle Edition.

Medicare for All Increases Health Care Access

Medicare for all increase health care access

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

In its most recent projection, the Centers for Medicare and Medicaid Services (CMS) estimated that total U.S. Health Consumption Expenditures for 2017 was \$3.33 trillion. This represents 17.2 percent of U.S. GDP for 2017 according to the CMS projection. As of 2016, the U.S. health care system includes 292.3 million people (91.2 percent) who have some form of health insurance coverage and 28.1 million (8.8 percent) who are uninsured.¹ But, roughly speaking, an additional 85 million people—26 percent of the population (and 29 percent of the insured population)—are underinsured. These are people who are unable to adequately access needed health care because of prohibitively high costs. The primary goal of Medicare for All is to provide high-quality health care to all U.S. residents. This includes full coverage for the 8.8 percent of the population that is presently uninsured and the 26 percent of the population that is underinsured. Medicare for All also aims to provide stable access to decent coverage to all U.S. residents, including those who currently receive adequate care but may face difficulties at later points. In reviewing the relevant research literature, we conclude that, as a high-end figure, overall demand for health care services (i.e. health care “utilization”) would rise by about 12 percent as a result of providing decent universal coverage under Medicare for All. This would translate into a 12 percent increase in Health Consumption Expenditures before we incorporate any of the cost saving measures that are achievable under Medicare for All. Thus, Health Consumption Expenditures (exclusive of public health activity) would rise from \$3.24 trillion to \$3.63 trillion as of 2017 before taking into account the cost savings measures that can result through Medicare for All.

Health Care Access Reduces Death

Health care access reduces mortality

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

It is also the case that, on balance, other countries that provide universal health care generate superior health outcomes relative to the U.S. Another 2017 study summarizes some key evidence as follows: "In other countries, a shift to universal health care has been associated with reduced mortality. Specifically, 34 countries score higher than the USA on the Health Access and Quality Index, a metric based on amenable mortality, or death that could be averted with medical care. All of these countries provide a form of universal care.

Medicare for All will save lives

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

The focus of this study is an economic analysis of the 2017 Medicare for All bill. As we will discuss, according to our review of the relevant research literature, under the Medicare for All framework, the U.S. economy can achieve decent health care coverage for all residents, even while lowering overall costs of the health care system by about 10 percent. As we demonstrate below, this results through the combination of overall costs rising by roughly 12 percent to provide all U.S. residents with decent coverage, while the Medicare for All system achieves close to 20 percent in savings in its operations relative to the existing system. As a result, on average, all households and businesses should be able to spend about 10 percent less than they are now for health care, while all U.S. residents will be provided with decent coverage. In Chapter 5, we review in detail the financial impacts of the transition into Medicare for All for households and businesses of various types. But, of course, Medicare for All cannot be simply evaluated on the basis of its financial impacts. The most fundamental goal is to improve health care outcomes, even if that is not the focus of this study. We nevertheless provide here a very brief overview of the substantial research literature examining how the provision of decent and affordable health care affects health outcomes. As one standard reference, the U.S. Institute of Medicine (IOM) produced a series of six reports between 2002 and 2004 that reviewed the evidence on the lack of health insurance coverage in the U.S. The IOM then updated these findings in 2009. Their basic conclusion was that people lacking in health insurance suffer from worse health and die sooner than those who do have decent insurance. We quote here in full from the IOM's own "Summary of the Evidence on the Health Effects of Uninsurance for Children and Adults1 : Children benefit considerably from health insurance, as demonstrated by recent evaluations of enrollment in Medicaid and the SCHIP program: ú When previously uninsured children acquire insurance, their access to health care services,

including ambulatory care, preventive health care (e.g., immunizations), prescription medications, and dental care improves. ú When previously uninsured children who are well or have special health needs acquire insurance, they are less likely to experience unmet health care needs. Uninsured children with special health care needs are much more likely to have an unmet health need than their counterparts with insurance. ú When previously uninsured children acquire insurance, they receive more timely diagnosis of serious health conditions, experience fewer avoidable hospitalizations, have improved asthma outcomes, and miss fewer days of school. Adults benefit substantially from health insurance for preventive care when they are well and for early diagnosis and treatment when they are sick or injured: ú Without health insurance, men and women are less likely to receive effective clinical preventive services. ECONOMIC ANALYSIS OF MEDICARE FOR ALL / PERI 2018 19 ú Without health insurance, chronically ill adults are much more likely to delay or forgo needed health care and medications. ú Without health insurance, adults with cardiovascular disease or cardiac risk factors are less likely to be aware of their conditions, their conditions are less likely to be well controlled, and they experience worse health outcomes. ú Without health insurance, adults are more likely to be diagnosed with later-stage breast, colorectal, or other cancers that are detectable by screening or symptom assessment by a clinician. As a consequence, when uninsured adults are diagnosed with such cancers, they are more likely to die or suffer poorer health outcomes. ú Without health insurance, adults with serious conditions, such as cardio-vascular disease or trauma, have higher mortality. ú The benefits of health insurance have been clearly demonstrated through recent studies of the experiences of previously uninsured adults after they acquire Medicare coverage at age 65. These studies demonstrate that when previously uninsured adults gain Medicare coverage: - Their access to physician services and hospital care, particularly for adults with cardiovascular disease or diabetes, improves. - Their use of effective clinical preventive services increases. - They experience substantially improved trends in health and functional status. - Their risk of death when hospitalized for serious conditions declines. A good example of the types of specific research results that the general IOM report summarized is the 2009 study by Wilper et al., "Health Insurance and Mortality in U.S. Adults."² The authors of this study analyzed data from the Third National Health and Nutrition Examination Survey. They found that uninsurance is positively associated with mortality. They write that "the strength of that association appears similar to that from a study that evaluated data from the mid-1980s, despite changes in medical therapeutics and the demography of the uninsured since that time," (2009, p. 2289). Specifically, they found that "lack of health insurance is associated with as many as 44,789 deaths per year in the United States, more than those caused by kidney disease," (2009, p. 2294)

Economy

Medicare for All Strengthens the Economy

Medicare for All means overall economic gain

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As of 2017, U.S. Health Consumption Expenditures are equal to 17.2 percent of GDP. The comparable ratio for eight other large industrial economies ranges between 8.9 percent of GDP for Italy and 11.3 percent of GDP for Germany. In addition, health care spending as a share of the U.S. economy has risen dramatically over time. In 1970, U.S. Health Consumption Expenditures equaled 6.2 percent of GDP. The Centers for Medicare and Medicaid Services (CMS) projects that the ratio will reach 18.8 percent by 2026. Following from our estimates, Health Consumption Expenditures would fall to 15.8 percent of GDP under Medicare for All, as of the 2017 economy. This would represent a dramatic decline in health care spending as a share of GDP for the U.S., but would still be substantially higher than the figures for all other large advanced economies. We conclude that further incremental improvements in service delivery under Medicare for All should enable U.S. health care costs to stabilize at around 15.8 percent of GDP, even after taking account of the rising cost pressures resulting from an aging population. Based on these results, we can then develop a 10-year forecast of Health Consumption Expenditures under Medicare for All, and compare this forecast with the projection by CMS of Health Consumption Expenditures assuming that the U.S. continues operating under its existing health care system. We find that, over the decade 2017 – 2026, the cumulative savings through operating under Medicare for All would be \$5.1 trillion, equal to 2.1 percent of cumulative GDP. There would also be broader macroeconomic benefits through operating the U.S. health care system under Medicare for All. Among these are that improved health outcomes will raise productivity; Medicare for All will support greater income equality; and that Medicare for All should support net job creation, especially through lowering operating costs for small- and mediumsized businesses.

Net reduction in business costs

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Business health care premiums cut by 8 percent relative to existing spending per worker. As of 2017, U.S. businesses paid about \$669 billion to provide health care coverage for their employees.¹¹⁶ As a transitional program for the first 2-3 years under which Medicare for All operates, we propose that all businesses that are now contributing to this overall \$669 billion level of funding be able to spend 8 percent less on premiums. Specifically, this would mean that health care premiums under Medicare for All will be defined as being 8 percent less than the spending levels by firms that are providing coverage for their employees. Through this simple framework, all businesses that now provide health care

coverage for their employees will be guaranteed to receive proportional benefits during Medicare for All's initial years of operation. Within this basic framework, we will need to address further detailed issues to make the proposal workable. These include: i How to treat existing firms that either had not been offering coverage at all to their employees or were only offering coverage to a subset of their workforce? ii How to treat newly created firms? iii What should be the revenue-generating framework for businesses into which Medicare for All converts beyond this 2 – 3 year transition arrangement? We address these detailed considerations below.

Medicare for All will increase job creation

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Medicare for All should support job creation. As a matter of accounting, job creation in any economy depends on 1) the level of production (GDP) in the economy; and 2) the proportion of overall production costs that are spent on hiring people into jobs. For a given level of production, employment will rise when the economy's productive activities are more labor-intensive—i.e. a higher share of overall production is devoted to hiring workers as opposed to spending relatively more on, among other things, purchasing machines, buildings, land, and energy supplies. Medicare for All will support relatively higher levels of spending on job creation. As we have seen, net health care costs will fall for small- and medium-sized businesses. The operations of these businesses tend to be more labor-intensive than those for larger-scale businesses. Medicare for All will therefore encourage small- and medium-sized businesses to expand their operations and increase hiring

Medicare for All will increase productivity

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Improved health outcomes will raise productivity. With the establishment of decent universal health care throughout the U.S., we can expect that, on average, health outcomes of the population will improve. This will be a major accomplishment in itself. But it should also produce the additional benefit of increasing productivity growth. This would be due to a significant share of workers missing less time from their jobs and being more effective while at work, because their health care circumstances will have improved.

Right to Health Care

Medicare for All protects A Right to Health Care

Medicare for All protects health care as a right

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Under Medicare for All, all residents of the United States will have the opportunity to receive decent health care as a basic right. This will result through establishing a health insurance system that covers all residents in a manner comparable to the coverage now provided for residents 65 years old and older under the existing Medicare program. All health care consumers will also have the right to receive care from the providers of their choice.

The Affordable Care Act has abetted corporate dominance in health care. Minimal regulation and high-deductible plans only accentuate deep racial and income-based disparities.

Himmelstein et al, 17 – *Distinguished professor of public health and health policy in the CUNY School of Public Health at Hunter College, adjunct clinical professor at Albert Einstein College of Medicine, lecturer in medicine at Harvard Medical School, M.D. from Columbia University, **Distinguished professor of public health and health policy in the CUNY School of Public Health at Hunter College, adjunct clinical professor at Albert Einstein College of Medicine, and lecturer in medicine at Harvard Medical School, M.D. from Louisiana State University, MPH from University of California, ***Resident Physician, University of California San Francisco School of Medicine, M.D. from Harvard Medical School (David, Steffie Woolhandler, Samuel L Dickman, Inequality and the health-care system in the USA, *The Lancet*, Volume 389, No. 10077, p1431–1441)

Widening economic inequality in the USA has been accompanied by increasing disparities in health outcomes. The life expectancy of the wealthiest Americans now exceeds that of the poorest by 10–15 years. This report, part of a Series on health and inequality in the USA, focuses on how the health-care system, which could reduce income-based disparities in health, instead often exacerbates them. Other articles in this Series address population health inequalities, and the health effects of racism, mass incarceration, and the Affordable Care Act (ACA). **Poor Americans have worse access to care than do wealthy Americans**, partly because many remain uninsured despite coverage expansions since 2010 due to the ACA. For individuals with private insurance, **rising premiums and cost sharing have undermined wage gains and driven many households into debt and even bankruptcy**. Meanwhile, the share of health-care resources devoted to care of the wealthy has risen. Additional reforms that move forward, rather than backward, **from the ACA are sorely needed to mitigate health and health-care inequalities and reduce the financial burdens of medical care borne by non-wealthy Americans.**

Introduction

As economic inequality in the USA has deepened, so too has inequality in health. Almost every chronic condition, from stroke to heart disease and arthritis, follows a predictable pattern of rising prevalence with declining income.¹ **The life expectancy**

gap between rich and poor Americans has been widening since the 1970s,² with the difference between the richest and poorest 1% now standing at 10·1 years for women and 14·6 years for men.³ The health of poor communities is often neglected: for example, in Flint (MI, USA), a de-industrialised, impoverished, and predominately African-American city, public officials dismissed evidence that children were being exposed to toxic levels of lead in the city's drinking water for several months.⁴

Attention to economic inequality intensified after the Occupy Wall Street movement decried the rising wealth and power of the richest 1%. This movement popularised research by the economists Piketty and Saez⁵ that revealed levels of income inequality unrivalled since the stock market bubble of the 1920s. The share of total income going to the top 1% of earners has more than doubled since 1970 (figure 1),⁶ while most workers in the USA have experienced slow income growth.⁷ As measured by the Gini coefficient, a standard metric of income inequality, the USA is now more unequal than all but three other countries (Chile, Mexico, and Turkey) in the Organization for Economic Co-operation and Development (OECD). The most equal countries are Denmark, Slovenia, Norway, and Slovakia.

The surge in top incomes has magnified inequality in wealth (ie, assets). Since 1986, the top 0·1% of households (those with assets exceeding US\$20 million) has accumulated nearly half of all new wealth, and now controls as much wealth as the bottom 90%, whose share has fallen steadily.⁸

Wealth inequality between racial and ethnic groups in the USA is especially striking, and is several times greater than income inequality. In 2013, median family wealth for the non-Hispanic white population was ten times that of Hispanics and more than 12 times that of African-Americans.⁹ The racial wealth gap results from historical factors dating back to slavery—many of which persist—including legalised racial segregation in the pre-civil rights era, pervasive job and housing discrimination, exclusionary city zoning laws, unequal education, and inheritance laws that perpetuate past inequalities.¹⁰

Although top incomes have risen, so has extreme poverty. More than 1·6 million households in the USA, including 3·5 million children, survive on incomes of less than \$2 per person per day—WHO's definition of extreme poverty; this number has more than doubled since the 1990s.¹¹

The health-care system could soften the effects of economic inequality by delivering high-quality care to all. Yet the institutions and financing patterns of the health-care system in the USA—by far the world's most expensive¹²—cause it to fall short of this ideal. Although inequalities exist to some extent in every health-care system, they are particularly stark in the USA. Unequal access to medical services is likely to contribute to disparities in health status, while **rising costs (for both the insured and uninsured) reduce disposable incomes, particularly burdening low-income households.**

Many patients cannot afford the care they need, and often forgo medical care altogether. For example, 19% of non-elderly adults in the USA who received prescriptions in 2014 (after full implementation of the Affordable Care Act [ACA]) could not afford to fill them.¹³ Millions of middle-class families have been bankrupted by illness and medical bills.¹⁴ Meanwhile, very wealthy Americans are turning to so-called concierge practices that offer lengthy office visits and unfettered access to specialists.

This Series paper examines how the health-care system in the USA contributes and responds to inequality. We focus our attention on the association between inequality and the medical care system.

We first review how social position influences Americans' access to medical services and the quality of those services. The uninsured face the greatest barriers to care, but many insured Americans are also unable to afford medical care because of cost sharing. Although race-based disparities in quality are well documented, the low quality scores of doctors and hospitals serving poor communities might reflect patients' deprived social circumstances rather than their providers' performance. We also review how the health-care costs borne by households—in the form of insurance premiums, taxes, and out-of-pocket payments—exacerbate income inequality, forcing many Americans to cut back on food and other necessities, and contributing to most personal bankruptcies. We conclude by discussing the historical context for today's health-care inequalities, and propose options for reform.

Inequality and access to care

Income-related disparities in access to care are far wider in the USA than in other wealthy countries.¹⁵ Before the 2010 passage of the ACA, which progressively expanded health insurance coverage, 39% of Americans with below-average income reported not seeing a doctor for a medical problem because of cost, compared with 7% of low-income Canadians and 1% of those in the UK.¹⁶ Inequality in access to care is particularly stark in Southern states. For example, in Texas, Mississippi, and Florida, adults on a low income are more than twice as likely to face cost-related barriers to care as their counterparts in Maine (a relatively poor New England state) and Massachusetts.¹⁷

Disparities in access are largely due to high rates of uninsurance or inadequate health insurance among low-income Americans, although Americans with above-average incomes probably also have worse access to care than do their peers in other countries.¹⁶ Today, despite gains due to the ACA,²⁷ **27 million Americans (down from 50 million before the passage of the ACA) remain uninsured.** Most of the uninsured have annual incomes near or below the official poverty line (\$11 770 for an individual in 2016).

The **uninsured are far more likely than the insured to forgo needed medical visits, tests, treatments, and medications because of cost.** Cost barriers are especially severe for the millions of uninsured Americans with chronic conditions.¹⁸ For example, middle-aged adults with no coverage for eye care report difficulties in reading or recognising a friend across the street more frequently than do comparable individuals with coverage.¹⁹ Uninsured individuals with diabetes spend, on average, \$1446 out of pocket for medical services each year, and more than 30% do not have a primary care provider.²⁰ Similarly, low-income and uninsured Americans with psychiatric disorders are far more likely than the insured and those on higher incomes are to experience difficulties obtaining care.²¹ For poor Americans, gaining insurance boosts access to care (although it does not fully close the gap between poor and affluent patients), leading to more visits for preventive screenings and greater satisfaction with care than before gaining coverage.²²

Medicaid insurance for low-income Americans

Medicaid, the public insurance programme that covers 58 million low-income Americans, improves health outcomes and access to care for its beneficiaries.²³ Gaining Medicaid coverage reduces rates of clinical depression,²⁴ financial problems due to illness,²⁴ and mortality.²³ The generosity of the Medicaid programme, which is largely controlled by state governments, is a key determinant of access-related disparities. Before the passage of the ACA, most states restricted Medicaid eligibility to poor children and pregnant women, disabled people, and the poorest adults with children. Childless adults and parents with incomes above stringent state-specific thresholds (eg, 10% of the poverty level in Alabama) were generally excluded.

The ACA's expansion of Medicaid to all citizens with annual incomes at or below 138% (\$16 643 for an individual in 2017) of the poverty level promised to cover millions of previously uninsured Americans. However, the US Supreme Court ruled in 2012 that states could opt out of the Medicaid expansion, and the Trump administration is likely to further erode or repeal it. As of 2016, 19 states (mostly in the South) have opted out, cutting the number of citizens who would otherwise have gained coverage by about 5 million. An additional 5–6 million undocumented immigrants do not have insurance because the ACA specifically excluded them from its coverage expansion,²⁵ perpetuating major constraints on their access to care.²⁶ Fortunately, the ACA increased funding for community health centres, which deliver much-needed care to millions of low-income Americans, and extended mental health parity regulations aimed at improving insurance coverage for mental health and addiction treatment.

Although Medicaid improves access to care, specialist care is often unobtainable because the programme pays low fees to physicians,²⁷ who are free to turn away Medicaid patients. For example, 76% of orthopaedists' offices in a nationwide audit study refused to offer an appointment to a Medicaid-insured child with a fracture, whereas only 18% refused a child with private insurance.²⁸

Cost sharing and private insurance

In the private insurance market, cost sharing by patients (ie, through user fees) has increased substantially since the 2000s.²⁹ Many plans now impose co-payments of more than \$30 for primary care and more than \$45 for specialist visits.³⁰ More than 80% of employer-based plans include an annual deductible (the amount a patient must pay before insurance covers additional costs), which averaged \$1478 in 2016, an increase of 2·5 times since 2006.³⁰ Cost sharing by patients is even higher in plans sold through the insurance exchanges created by the ACA. In mid-level, so-called silver tier plans (which account for about 70% of exchange coverage), deductibles averaged \$3064 in 2016,³⁰ although some subsidies were available to cushion the deductibles for enrollees with incomes 100–250% of the poverty level.

Many private plans also reduce premium costs by restricting patients' choice of providers to narrow networks of doctors and hospitals, which often exclude academic and cancer referral centres.³¹ Enrollees who seek out-of-network care (either by choice or because of medical necessity) generally must pay the entire bill out of pocket.

Predictably, **patients' use of care declines as their cost-sharing obligation rises,** and people with the worst health are most likely to cut back on care.³² Paradoxically, this **reduction in care-seeking can fail to cut system-wide use, instead shifting care from the sick and poor to the healthy and wealthy.** At least in some cases, when poor patients avoid care, doctors and hospitals fill the empty appointment slots and beds with patients who are less price-sensitive³³—an example of supply-sensitive demand.³⁴ Strikingly, the USA has the world's highest health-care expenditures despite extensive cost sharing by patients.

Additionally, care forgone because of cost sharing might ultimately raise costs by increasing downstream health problems. When the Medicare programme (the public coverage for people aged 65 or older and those with long-term-disabilities) added new co-payments, outpatient visits decreased but hospital admissions increased.³⁵ Among patients who developed a myocardial infarction, elimination of medication co-payments after the cardiac event increased compliance, and (for racial and ethnic minority patients) led to a 35% reduction in major vascular events and a 70% reduction in total health-care spending.³⁶ Similarly, among children aged 5–18 years with asthma, those whose insurance required higher co-payments used fewer medications but had a 41% greater risk of asthma-related hospital admissions than did children with lower co-payments.³⁷ For nearly a third of children with asthma from low-income families with high cost-sharing coverage through the Kaiser Health Plan, parents reported delaying or avoiding outpatients visits, and 14·8% reported non-adherence to medications because of cost; 15·6% of all parents (including those with higher incomes) reported borrowing money or cutting back on necessities to pay for their children's asthma care.³⁸

Defining underinsurance

Rising deductibles and other forms of cost sharing by patients have eroded the traditional definition of insurance: protection from the financial harms of illness. The term underinsurance describes this problem, but it does not have a standard definition. Some studies of underinsurance have focused on financial vulnerability (eg, measurement of deductibles as a fraction of income),³⁹ others on out-of-pocket costs incurred (either in absolute dollars or relative to income),⁴⁰ whereas others have highlighted barriers to care (because of cost or narrow insurance networks).⁴¹ No standard quantitative thresholds exist for these different concepts.

The various definitions of underinsurance highlight two related but distinct problems: people with inadequate insurance risk financial harm when they receive medical services, and they are therefore less likely to obtain needed care. Despite the absence of consensus on the definition of underinsurance, it is clear that these problems affect many Americans with private coverage and have increased.

Between 2004 and 2013, high rates of uninsurance, rising cost sharing (ie, underinsurance), and stagnant incomes all contributed to a decline in overall health-care consumption (as measured by the total amount spent by insurers and patients) for poor Americans, a trend that was reversed in 2014 when the major provisions of the ACA came into effect (figure 2).⁴² For the first time since the 1970s, per-capita medical expenditures for the poorest fifth of Americans (who are, on average, much sicker than the wealthiest 20%) dipped below those of the wealthiest 20%.⁴² In Canada, by contrast, the poorest citizens receive the most medical services, commensurate with their increased health needs.⁴⁵ Meanwhile, health-care expenditures for the wealthiest 20% of Americans accelerated, raising their share of overall health-care consumption. The ACA, fully implemented in 2014, led to a surge in health-care expenditures for the bottom 20%, but expenditures for the middle class have flattened while health-care consumption by the wealthiest Americans continues to grow.

Access problems

Geography often affects access to care. Because physicians are concentrated in cities and affluent suburbs, many Americans living in rural areas find it difficult to obtain primary⁴⁶ and specialty care.⁴⁷ Many rural and Southern states also have a shortage of adequate family planning resources. Texas, for example, has imposed onerous regulations and funding cuts on family planning clinics, causing closure of many⁴⁸ and a subsequent increase in unwanted pregnancies.⁴⁹ Since the closure of the last local abortion clinic in 2013, women in Lubbock, Texas (population 244 000), are now more than 250 miles away from the nearest abortion provider.

Women are also at a financial disadvantage because of their greater health-care needs (including reproductive care) than those of men. Although fewer women than men are uninsured, those with insurance have higher out-of-pocket costs. For example, among people with employer-sponsored coverage, women's out-of-pocket costs were \$233 higher than men's in 2013;⁵⁰ among Medicare enrollees, such costs were \$640 higher for women than they were for men in 2011.⁵¹ These costs are especially burdensome because women's median incomes are 39% lower than those of men.⁵²

Illness-based disparities are particularly stark for mental illness and substance abuse. Historically, a large share of psychiatric care was paid for out of pocket or provided in underfunded public institutions. Jails remain the largest so-called inpatient mental health facilities in the USA. Although the 2008 Mental Health Parity and Addiction Equity Act mandated that most insurance plans provide equivalent coverage for mental and physical illness, implementation of this requirement was delayed until 2015, and its enforcement has proven difficult.⁵³ Moreover, most Medicaid programmes (which cover many people with mental disorders) are exempt from these regulations. Psychiatric—and particularly substance abuse—providers are in short supply on a national scale, especially in poor and rural areas;⁵³ these areas have been particularly hard hit by the epidemic of drug overdoses and self harm, which pushed up the overall death rate in the USA in 2015. The ACA, which applied the parity requirement to the plans sold through the exchanges, increased access to mental health, but not to substance abuse treatment; substantial racial and ethnic disparities persist.⁵⁴

Inequality and quality of care

For many conditions, **increased quality is implied by, and inseparable from, improved access** to care. An increased frequency of primary care visits, for example, is associated with improved control of diabetes.⁵⁵ Similarly, among patients who developed an acute myocardial infarction, the uninsured were 38% more likely (and the underinsured 21% more likely) than the well insured to delay seeking emergency care.⁵⁶

Yet it is unclear whether income-related disparities in access to care are accompanied by other gaps in global quality, which are harder to measure. Poverty itself causes ill health, compromises non-medical social supports and resources that improve medical outcomes, and is associated with worse satisfaction with care.⁵⁷ Hence, differences in the socioeconomic profile of patients, rather than true differences in quality of care, might explain why hospitals⁵⁸ and physicians⁵⁹ caring for poor patients score lower on some quality metrics than do health-care providers serving affluent areas.

Assessment of quality differences is increasingly difficult because tying quality indicators to financial incentives can induce so-called gaming, which distorts measurement.⁶⁰ Nonetheless, payers have implemented pay-for-performance schemes that reward providers on the basis of proxy measures of quality, and facilities serving poor patients have been disproportionately penalised. For example, safety-net hospitals have seen their payments reduced under Medicare's Hospital Readmission Reductions,⁶¹ Hospital-Acquired Condition Reduction,⁶² and Hospital Value-Based Purchasing programmes.⁶³ Disturbingly, such programmes introduce perverse incentives to avoid poor patients, while shrinking funding for hospitals and physicians continuing to care for them.

In view of the pitfalls of quality measurement, what can be said about the association between social disadvantage and the quality of medical services? A classic study of patients admitted to hospital in 1984 found that uninsured patients were at higher risk (odds ratio 2·35) of receiving substandard medical care than their insured counterparts.⁶⁴ However, safety-net hospitals (and hospitals in the Veterans Administration [VA] system, which serves mostly non-affluent veterans) have risk-adjusted mortality rates for older patients similar to those of other hospitals. By contrast, small hospitals serving isolated rural areas appear to deliver a lower quality of care for medical conditions than other hospitals do, as measured by both process-of-care metrics and mortality.⁶⁵ Studies of differences in surgical quality and safety are inconclusive,⁶⁶ although risk-adjusted outcomes appear worse for poor patients across a range of surgical procedures.⁶⁷ Poor patients are more likely than affluent patients to receive dangerous drugs: 27% of low-income Medicare beneficiaries with dementia, hip or pelvic fracture, or chronic renal failure received contraindicated medications compared with 16% of higher-income individuals.¹⁷ Poor Americans older than 50 years are also far less likely than their affluent counterparts to receive recommended influenza and pneumonia vaccinations, and cancer screening tests,¹⁷ although cost-related barriers might underlie these differences.

There is strong evidence showing that **quality of care is worse for racial and ethnic minorities**,⁶⁸ although racial disparities in the quality of hospital care could have narrowed between 2005 and 2010 as a result of improvements among hospitals serving patients from minority backgrounds and more equitable care within all hospitals.⁶⁹ Yet unequal access to care, along with institutional racism, remain important drivers of persistent disparities in health-care quality for racial and ethnic minorities. For example, although **African-Americans tend to live closer than white patients to high-quality hospitals, they are less likely to have their surgeries there.**⁷⁰ The intersection of race, racism, and the health-care system in the USA is reviewed elsewhere in this Series.

Health-care financing inequality

The USA finances medical care through a complex network of public and private insurance programmes, as well as substantial direct payments by patients. Figure 3 shows the proportion of Americans covered by the main insurance programmes, and the major sources that fund health care. Taken together, government insurance programmes—principally, Medicare, Medicaid, and military health care—account for 42% of personal health-care expenditures.⁷² Yet this figure substantially understates the government's share, because it excludes two large, tax-funded outlays for private insurance: government agencies' expenditures to purchase private insurance for public-sector employees (representing 28% of all employer payments for private coverage) and tax subsidies for private firms' purchase of insurance for their employees. Taking into account these two additional categories boosts the public share of total health funding in the USA to 65%.⁷³ Total health-care expenditures by the government in the USA exceed the total public and private spending per head of any other country except for Switzerland.⁷³ In light of this fact, **the stark inequalities in health care faced by millions of Americans seem particularly unjust.**

The complexity of health-care financing in the USA obscures not only the magnitude of public funding but also the regressive pattern of who ultimately pays. In fact, **health care takes a substantially larger share of income from the poor than from the wealthy, exacerbating inequalities in disposable**

income.⁷⁴ Although comparative international studies are scarce and mostly old, financing schemes in other wealthy countries are generally less regressive (although cost sharing is rising in some European countries⁷⁵). Health-care systems financed primarily through income taxes, as in Ireland, the UK, and Portugal, tend to be the most progressive, whereas those relying on private insurance and out-of-pocket payments, as in Switzerland and the USA, are more regressive.⁷⁶

The redistributive effect of specific health-care financing programmes

Direct out-of-pocket spending is the most regressive form of health-care financing. The uninsured (who are disproportionately poor) pay for much of their care out of pocket and, because they do not have insurers' negotiating leverage, are charged the highest prices.⁷⁷ As noted previously, insured patients often bear a heavy (and regressive) out-of-pocket burden for deductibles, co-payments, and out-of-network care. Even older patients, almost all of whom are covered by Medicare, face high out-of-pocket costs for their share of the premiums, as well as co-payments and deductibles,⁷⁸ a burden that falls most heavily on low-income senior citizens. For Medicare enrollees, out-of-pocket medical expenses consume 11.2% of income among those with incomes above 300% of the poverty level, and between 22.7% and 26.8% among those with incomes below 200% of the poverty level.⁵¹

In an effort to reduce the burden of catastrophic medical bills, the ACA imposed limits on out-of-pocket medical costs in private plans (\$6850 per year for individual plans and \$13 700 for families in 2016). Yet these limits, which do not apply to out-of-network and so-called non-essential services, vastly exceed most families' savings.⁷⁹

Private insurance premiums are also regressive and have risen faster than earnings (figure 4); premiums for employer-based plans increased by approximately three times between 1999 and 2016.²⁹ The poorest fifth of Americans spend, on average, 6% of their income on private insurance premiums, while the wealthiest fifth spend just 3.2%.⁷⁴ Although employers typically make sizeable contributions to their employees' premium costs, economists believe that this expense is mostly passed on to employees in the form of lower wages.

Medicaid is the most progressively redistributive health insurance programme in the USA. It requires little cost sharing by patients, is financed through federal and state taxes (with progressive income taxes providing the largest share),⁸¹ and most of the benefits go to poor citizens.

Medicare is funded largely through federal general revenues and a payroll tax, which remains less progressive than Medicaid's funding base (despite the ACA's extension of the payroll tax to some investment income). Medicare covers both affluent and poor senior citizens, but its high and regressive cost-sharing requirements discourage many low-income beneficiaries from seeking care.⁸² Moreover, the growing gap in life expectancy between the rich and the poor means that wealthier Americans will, on average, live to enjoy many more years of publicly funded benefits after becoming eligible at the age of 65 years.⁸³ As a result, among men born in 1960, lifetime Medicare outlays are expected to be 28% higher for the wealthiest fifth than for the poorest fifth, a reversal of the pattern 30 years earlier.⁸³ Similarly, immigrants (especially the undocumented) collectively contribute billions more in taxes to Medicare each year than they receive in benefits.⁸⁴

Medical bills and financial hardship

The health-care financing system in the USA leaves millions of Americans facing medical bills that deplete their assets and drive them into debt. One in four non-elderly adults younger than 65 years (and one in three with annual household incomes <\$50 000) reported difficulty paying medical bills in 2015; more than half of these individuals owe more than \$2500.⁸⁵ People with deductibles higher than \$1500 (or families with deductibles >\$3000) and worse health than the overall population are particularly at risk^{85, 86} (figure 5), as are African-Americans and Hispanics.⁸⁶

Medical bills are a major contributor to household debt and bankruptcy,¹⁴ comprising more than half of all unpaid personal debts sent to collection agencies⁸⁷ (figure 6). One in ten families with medical bill problems has declared bankruptcy.⁸⁸ Although the uninsured are at greater risk than the insured of declaring bankruptcy,³⁹ most medical bankruptcies involve debtors who are insured.¹⁴

Financial hardship is especially common among people with serious illness.⁸⁹ Among non-elderly adults with cancer, more than a third borrowed money or went into debt because of their treatment, and 3% filed for bankruptcy.⁹⁰ Such financial catastrophe appears to increase mortality for treatable cancers,⁹¹ perhaps because it leads to forgone care. Medicare⁹² and Medicaid⁹³ coverage provide better (although still imperfect) protection from financial hardship.

Medical bills force families to make difficult choices: 34% of insured Americans with difficulty paying medical bills were unable to pay for food, heat, or housing, 15% took out high-interest payday loans,⁹⁴ and 42% took on extra jobs or worked additional hours.⁸⁵ Most people reporting problems with medical bills say they have skipped or delayed needed medical care.⁹⁵ Moreover, defaulting on medical bills and medical bankruptcies often has long-term repercussions; these blemishes remain on credit reports for many years, compromising access to credit, insurance, housing, and employment.

Although medical costs impoverish many Americans, this issue is not captured by the US Census Bureau's official measure of poverty. In response, the US Census Bureau has introduced alternative poverty measures that subtract medical costs and other mandatory expenses from income, and add non-cash government aid (eg, housing vouchers). These alternative measures indicate that more Americans experience poverty than are reflected in official statistics,⁹⁶ with medical costs being the largest contributor to the difference between the official and alternative measures, pushing an additional 10 million Americans below the poverty line.⁹⁷

The medical system in the USA also influences inequality as an employer of nearly 17 million Americans. Although physicians and nurses are generally well paid, many other health-care workers are not. The health-care system employs more than 20% of all black female workers; more than a quarter of these health-care workers subsist on family incomes below 150% of the poverty line, and 12.9% of them are uninsured (Himmelstein DU; unpublished analysis of the 2015 Current Population Survey).

A longer lens on health reform

A century ago, medical care in the USA had little influence on health or wealth. Burgeoning medical capabilities and costs in the 20th century made health care an industry ripe for corporate investment and profit. The transformation from a largely charitable service to a market-driven enterprise ensued.

Markets distribute goods on the basis of purchasing power, and for mostly non-discretionary purchases, such as medical care, this results in particularly lopsided financial burdens. In many other wealthy countries, social democratic and labour parties have successfully implemented policies that offset these market tendencies by creating national health programmes, or by tightly regulating private insurers and health-care providers. The USA does not have such a party, perhaps because the low-income voters most buffeted by the market are divided by racial animosities. After the 2010 passage of the ACA, congressional stalemates blocked incremental reforms that might have restrained medical markets and democratised care. Republicans, now in control of both houses of Congress and the executive branch in Washington, DC, promise to replace the ACA with measures that are even more market-friendly than the ACA, which would tilt care further towards the wealthy.

The health-care dilemma in the USA, characterised by unequal access and unfair financing, echoes that of the 1950s and 1960s, prior to the passage of Medicare and Medicaid, when one in four Americans (and half of older people and minorities) did not have health coverage.

After 8 years of Republican rule, the Democratic President Kennedy was inaugurated in 1961. The impetus for reform was bolstered by the popular mobilisation for civil rights and enabled by the Democratic Party's landslide victory in the 1964 election. The 1965 passage of Medicare and Medicaid vastly improved access to care and desegregated hospitals. But these health-care initiatives were just one part of a broad legislative agenda that transformed American society, including the Civil Rights and Voting Rights Acts, laws that improved opportunities for women in universities and the military, the first major federal aid programmes for local (particularly poor) public schools and college students, fairer immigration laws, and the establishment of the National Endowment for the Arts. The redistributive agenda, dubbed the War on Poverty, also vastly expanded non-cash benefits such as food subsidies, free pre-school programmes for poor children, and community health centres, and boosted social security benefits, lifting 2.5 million senior citizens out of poverty. When President Kennedy came into office in 1961, 40 million Americans were poor. When his successor President Johnson left office in 1969, that number had fallen to 24 million. In 1972, the gap in remaining life expectancy at the age of 60 years was only 1.2 years between men with incomes above and below the median.²

Half a century on, neoliberal policies have eroded these gains. Today, 43.1 million Americans are poor, many health and social inequities persist, and some have worsened. Even after the ACA's coverage expansion—reviewed elsewhere in this Series—27 million Americans remain uninsured and, for many with insurance, access to affordable care remains elusive. At the same time, unneeded and even harmful medical interventions remain common (due, in part, to the fragmented health-care delivery system), bureaucracy consumes nearly a third of health spending, and wealthy Americans consume a disproportionate and rising share of medical resources.

Conclusion

Many physicians in the USA are working to advance health-care justice. But increased efforts in this direction are needed. The brave cadre of colleagues who face constant threat for delivering abortion services (which are disproportionately needed by poor women) must be supported and augmented, especially as anti-choice politicians now hold sway in Washington, DC. Doctors should follow the lead of trainees, such as those in the WhiteCoats4BlackLives movement, who have spoken out against the structural racism that still tarnishes many medical institutions and policies that deny care to immigrants. Physicians should reflect on the ways we—and the institutions we practice within—embrace or evade the responsibility to care for the disadvantaged.

Doctors should also join in demanding reforms that move forward, not backward, from the ACA. Republicans aspire to roll back the law's coverage expansions, fully privatise Medicare and the VA, and give state governments free rein to cut Medicaid—changes that must be resisted to avoid a public health disaster.

However, Hillary Clinton's 2016 presidential election defeat suggests that defending the health-care status quo cannot win the day. Moreover, proposals for incremental steps that could cushion the worst inequities—such as tighter insurance regulations, allowing a government insurance plan to compete in the market, regulation of drug prices, and extension of public coverage to immigrants—failed to excite voters. Until November, 2016, mainstream politicians and pundits

deemed such steps politically feasible, and more thoroughgoing reform unattainable. Now, a more inspiring and egalitarian vision—a health-care reform that address the problems felt by most insured Americans—seems a more effective rebuttal to the Republican mantra of “Repeal and replace [the ACA]”. A bolder step towards health-care equality—straight on to universal public insurance—could offer the best way forward.⁹⁸

Comprehensive studies prove that insurance is the most important factor in accessing care.

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Perhaps no research question better encapsulates this policy debate than, “Does coverage save lives?”

Beginning with the Institute of Medicine’s 2002 report Care without Coverage, Some analyses have suggested that lack of insurance causes tens of thousands of deaths each year in the United States.⁴⁴ Subsequent observational studies had conflicting findings. One concluded that lacking coverage was a strong independent risk factor for death,²⁸ whereas another found that coverage was only a proxy for risk factors such as socioeconomic status and health-related behaviors.²⁷ More recently, several studies have been conducted with stronger research designs better suited to answering this question.

The Oregon study assessed mortality but was limited by the infrequency of deaths in the sample. The estimated 1-year mortality change was a nonsignificant 16% reduction, but with a confidence interval of -82% to +50%, meaning that the study could not rule out large reductions — or increases — in mortality. As the authors note, the study sample and duration were not well suited to evaluating mortality.

Several quasi-experimental studies using population-level data and longer follow-up offer more precise estimates of coverage’s effect on mortality. One study compared three states implementing large Medicaid expansions in the early 2000s to neighboring states that didn’t expand Medicaid, finding a significant 6% decrease in mortality over 5 years of follow-up.²² A subsequent analysis showed the largest decreases were for deaths from “health-care-amenable” conditions such as heart disease, infections, and cancer, which are more plausibly affected by access to medical care.²⁹ Meanwhile, a study of Massachusetts’ 2006 reform found significant reductions in all-cause mortality and health-care–amenable mortality as compared with mortality in demographically similar counties nationally, particularly those with lower pre-expansion rates of insurance coverage.⁹ Overall, the study identified a “number needed to treat” of 830 adults gaining coverage to prevent one death a year. The comparable estimate in a more recent analysis of Medicaid’s mortality effects was one life saved for every 239 to 316 adults gaining coverage.²⁹

How can one reconcile these mortality findings with the nonsignificant cardiovascular and diabetes findings in the Oregon study? Research design could account for the difference: the Oregon experiment was a randomized trial and the quasi-experimental studies were not, so the latter are susceptible to unmeasured confounding despite attempts to rule out alternative explanations, such as economic factors, demographic shifts, and secular trends in medical technology. But — as coauthors of several of these articles — we believe that other explanations better account for this pattern of results.

First, mortality is a composite outcome of many conditions and factors. Hypertension, dyslipidemia, and elevated glycated hemoglobin levels are important clinical measures but do not capture numerous other causes of increased risk of death. Second, the studies vary substantially in their timing and sample sizes. The Massachusetts and Medicaid mortality studies examined hundreds of thousands of people gaining coverage over 4 to 5 years of follow-up, as compared with roughly 10,000 Oregonians gaining coverage

and being assessed after **less than 2 years**. It may take years for important effects of insurance coverage — such as increased use of primary and preventive care, or treatment for life-threatening conditions such as cancer, HIV/AIDS, or liver or kidney disease — to manifest in reduced mortality, given that mortality changes in the other studies increased over time.^{9,22}

Third, the **effects on self-reported health** — so clearly seen in the Oregon study and other research — are themselves predictive of reduced mortality over a 5- to 10-year period.^{42,43} Studies suggest that a **25% reduction in self-reported poor health could plausibly cut mortality rates in half** (or further) for the sickest members of society, who have disproportionately high rates of death. Finally, the links among mental health, financial stress, and physical health are numerous,⁴⁵ suggesting additional pathways for coverage to produce long-term health effects.

DIFFERENT TYPES OF COVERAGE

In light of recent evidence on the benefits of health insurance coverage, some ACA critics have argued that private insurance is beneficial but Medicaid is ineffective or even harmful.⁴⁶ Is there evidence for this view? There is a greater body of rigorous evidence on Medicaid's effects — from studies of pre-ACA expansions, from the Oregon study, and from analyses of the ACA itself — than there is on the effects of private coverage. The latter includes studies of the ACA's dependent-coverage provision, which expanded only private insurance, and of Massachusetts' reform, which featured a combination of Medicaid expansion, subsidies for private insurance through Medicaid managed care insurers, and some increase in employer coverage. But there is no large quasi-experimental or randomized trial demonstrating unique health benefits of private insurance. One head-to-head quasi-experimental study of Medicaid versus private insurance, based on Arkansas's decision to use ACA dollars to buy private coverage for low-income adults, found minimal differences.^{11,19} Overall, the evidence indicates that having health insurance is quite beneficial, but from patients' perspectives it does not seem to matter much whether it is public or private.⁴⁷ Further research is needed to assess the relative effects of various insurance providers and plan designs.

Finally, though it is outside the focus of our discussion, there is also quasi-experimental evidence that **Medicare improves self-reported health**⁴⁸ and reduces in-hospital mortality among the elderly,⁴⁹ though a study of older data from Medicare's 1965 implementation did not find a survival benefit.⁵⁰ However, since universal coverage by Medicare for elderly Americans is well entrenched, both the policy debate and opportunities for future research on this front are much more limited.

IMPLICATIONS AND CONCLUSIONS

One question experts are commonly asked is how the ACA — or its repeal — will affect health and mortality. The body of evidence summarized here indicates that coverage expansions significantly increase patients' access to care and use of preventive care, primary care, chronic illness treatment, medications, and surgery. These increases appear to produce significant, multifaceted, and nuanced benefits to health. Some benefits may manifest in earlier detection of disease, some in better medication adherence and management of chronic conditions, and some in the psychological well-being born of knowing one can afford care when one gets sick. Such modest but cumulative changes — which one of us has called "the heroism of incremental care"⁵¹ — may not occur for everyone and may not happen quickly. But the evidence suggests that they do occur, and that some of these changes will ultimately help tens of thousands of people live longer lives. Conversely, the data suggest that policies that reduce coverage will produce significant harms to health, particularly among people with lower incomes and chronic conditions.

Do these findings apply to the ACA? Drawing on evidence from recent coverage expansions is, in our view, the most reasonable way to estimate future effects of policy, but this sort of extrapolation is not an exact science. The ACA shares many features with prior expansions, in particular the Massachusetts reform on which it was modeled. But it is a complex law implemented in a highly contentious and uncertain policy environment, and its effects may have been limited by policies in some states that reduced take-up,⁵² Congress's partial defunding of the provisions for stabilizing the ACA's insurance marketplaces,⁵³ and plan offerings with high patient cost sharing. Furthermore, every state's Medicaid program has unique features, which makes direct comparisons difficult. Finally, coverage expansions and contractions will not necessarily produce mirror-image effects. For these reasons, no study can offer a precise prediction for the current policy debate. But our assessment, in short, is that these studies provide the best evidence we have for projecting the impact of the ACA or its repeal.

The many benefits of coverage, though, come at a real cost. Given the increases in most types of utilization, expanding coverage leads to an increase in societal resources devoted to health care.⁸ There are key policy questions about how to control costs, how much redistribution

across socioeconomic groups is optimal, and how trade-offs among federal, state, local, and private spending should be managed. In none of these scenarios, however, is there evidence that covering more people in the United States will ultimately save society money.

Are the benefits of publicly subsidized coverage worth the cost? An analysis of mortality changes after Medicaid expansion suggests that expanding Medicaid saves lives at a societal cost of \$327,000 to \$867,000 per life saved.²⁹ By comparison, other public policies that reduce mortality have been found to average \$7.6 million per life saved, suggesting that expanding health insurance is a more cost-effective investment than many others we currently make in areas such as workplace safety and environmental protections.^{29,54} Factoring in enhanced well-being, mental health, and other outcomes would only further improve the cost-benefit ratio. But ultimately, policymakers and other stakeholders must decide how much they value these improvements in health, relative to other uses of public resources — from spending them on education and other social services to reducing taxes.

There remain many unanswered questions about U.S. health insurance policy, including how to best structure coverage to maximize health and value and how much public spending we want to devote to subsidizing coverage for people who cannot afford it. But whether enrollees benefit from that coverage is not one of the unanswered questions. Insurance coverage increases access to care and improves a wide range of health outcomes. Arguing that health insurance coverage doesn't improve health is simply inconsistent with the evidence.

Specifically, health costs are the biggest driver of income inequality. Wasteful spending decreases wages and benefits the wealthy.

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A new Kaiser Family Foundation survey reports that health-insurance premiums rose by a "modest" 3% in 2013. Even more modest, however, was the 2.3% growth of workers' earnings last year. These figures merely illustrate a long-term trend of rising health costs eating away at wages. The real story is even more dramatic: Government data show that health costs are the biggest driver of income inequality in America today.

Most employers pay workers a combination of wages and benefits, the most important of which is health coverage. Economic theory says that when employers' costs for benefits like health coverage rise, they will hold back on salary increases to keep total compensation costs in check. That's exactly what seems to have happened: Bureau of Labor Statistics data show that from June 2004 to June 2014 compensation increased by 28% while employer health-insurance costs rose by 51%. Consequently, average wages grew by just 24%.

But here's what the news headlines miss: Rising health costs don't affect every employee the same. An average family health policy today costs employers nearly \$12,000 per year, up from only \$4,200 in 1999. Had employer premiums not risen, average salaries today would be around \$7,800 higher. For a lower-income worker who today makes \$30,000, that could have meant a 26% salary increase. By contrast, a "one percenter" making \$250,000 today would have seen his earnings rise only by 3.1%. Health costs are a bigger share of total compensation for lower-wage workers, and so rising health costs hit their salaries the most. The result is higher income inequality.

Data from the BLS National Compensation Survey show this is what happened. For low-income workers, total pay and benefits rose by 41% from 1999 through 2006. But these workers' wages increased only by 28%, barely outpacing inflation. The reason: Employer costs for these workers' health costs nearly doubled, from 6.5% to 12.2% of compensation, and ate up money that could have gone toward salaries.

Now consider a worker who earns \$250,000 or more a year. BLS data show that total compensation for these workers rose by 36% from 1999 through 2006. That's actually less than for low-income workers. But the one-percenters' health costs rose from just 4% of compensation in 1999 to only 4.3% in 2006.

Medicare For All Master File

It's not that their health costs didn't rise in dollars terms, it's simply that health benefits are a much smaller part of their total pay and benefits. As a result, salaries for the one-percenters grew by 35%, a faster rate than for low-wage workers. The inequality of total compensation barely changed from 1999-2006, but rising health-care costs held back the growth of lower- and middle-class earnings.

Ordinarily, what workers care about is their total pay and benefits, not merely salaries. For instance, an employer might make up for a lower salary by paying more generous retirement benefits. But a lot of health spending today is wasted through overuse or excessive costs. This truly does hurt the poor more than the rich.

We can't settle the health-reform debate here. But federal tax policy regarding health coverage almost certainly increases income inequality. Employer-provided health care is exempt from income taxes. As MIT Prof. Jonathan Gruber puts it, this subsidy makes health insurance "artificially cheap relative to other goods bought with taxed dollars, leading to over-insurance for most Americans." And the more we spend on health care the more unequal Americans' incomes become.

Reducing the tax preference for health care over other forms of compensation could lower health costs directly, as well as providing incentives to shift from "first-dollar coverage" of all health outlays to true insurance against large and unforeseen health costs. The classic Rand Health Experiment that ran from 1971 to 1982 showed that high-deductible health plans reduced spending by 30% compared with a plan with no copayments, while producing very comparable health outcomes. Cost-sharing has broadened in the private sector, which some analysts believe has contributed to the recent slowdown in health-cost growth. We should apply these principles to Medicare and Medicaid as well.

Health costs are by no means the only factor affecting income inequality. But it is shocking that health costs are seldom mentioned with regard to income inequality when the BLS data show that rising health costs can fully account for the increasing inequality of workers' salaries from 1999 through 2006.

These data give us a different perspective on the inequality debate. Most people think of income inequality as money "redistributed" from the poor to the rich. In reality, much of what we're seeing is more of low-income workers' compensation going toward their health benefits and less ending up in their pockets. That's a different problem and points toward different solutions.

Health care is the key sector for redistribution – poor health drives chronic unemployment. Progressive taxation and state responsibility for health care costs creates aggregate demand increases necessary for full employment.

Stephen DUNN Senior Strategy Advisor in Department of Health (England) '8 The 'Uncertain' Foundations of Post Keynesian Economics' p. 195-200

EVALUATION AT THE WHOLE SYSTEM LEVEL

Post Keynesians would obviously seek to emphasise the macrofoundations of healthcare. The distribution, financing and organisation of healthcare have ramifications for consumption and investment patterns, government spending and even net imports, and thus will affect the distribution and level of aggregate demand. The health sector is one of the biggest industries and employers in most advanced Western industrialised societies. Healthcare spending typically accounts for between 10 to 20 per cent of government spending. In the 1990s, OECD governments spent between 5 and 8 per cent of GDP on healthcare (Table 4). Health spending is rising even higher over the current decade.

The level of healthcare spending is likely to have causal and consequential effects on both the level and distribution of health and the broader economy. For example the level of aggregate demand and its components will affect and reflect the age structure of the population and impinge on the dependency ratio, i.e. the number of people working relative to those that are retired, in ill health and/or are not in the labour market. This will have implications for consumption and saving rates, which in turn impact on the level of effective demand and the level of employment. Assumptions about the level of employment exhibited by advanced industrial systems will also have consequences for health-related expenditures. The precise nature of healthcare financing is also likely to have macroeconomic consequences. These issues are considered in turn below.

First, Post Keynesians acknowledge a positive role for state intervention and activist macroeconomic policy. Keynes' General Theory provides a theoretical foundation for the elaboration of the consequences of a monetary production economy for macroeconomic coordination (Davidson, 2002). It outlines a role for governments to assume responsibility to ensure an adequate level and distribution of effective demand and thus employment. In rejecting Say's law, Post Keynesians point to the chronic unemployment and excess capacity

that characterise many advanced industrialised countries. They highlight the social consequences of unemployment and how labour market exclusion contributes to poverty and ill health, and how ill health can contribute to labour market exclusion and thus poverty. As Rowthorn (2000, p. 157) notes:

For people below pensionable age, long-term illness rates range from 3 percent in the most prosperous areas up to 18 percent in the most depressed. The very high rates in depressed areas must surely conceal a greater deal of disguised unemployment. Many of those who are classified as too sick to work are probably capable of holding down a job, but have such poor employment prospects that doctors have certified them as unfit to work as a humane way of providing them with a secure income in the form of sickness benefit. Even where their incapacity is genuine, some of those concerned must have become sick because of the stress and poverty of job insecurity and unemployment.

Poverty and ill health can be part of a downward vicious circle of causation whereby sluggish market adjustments and low levels of effective demand are transformed into structural unemployment, leading to poor health and poverty which in turn threaten to reproduce themselves across generations, reducing opportunities for groups and classes of people to make their contributions to society.

Post Keynesians start from the position that public expenditure should be undertaken for its social value, reflecting (broadly) the principles of functional finance. Public expenditures, which operate through the lens of the welfare state, may serve to prevent downward cycles of cumulative causation that result in poverty and ill health. Although health expenditures are typically absent from debates about the extent, nature and future of the welfare state - which tend to revolve around the nature of government transfers - they represent a prime component of public spending and aggregate demand.

From a fiscal point of view, public health care expenditures can be used to underpin the level and distribution of aggregate demand. Public healthcare expenditures may be a major part of any expansionary or stabilisation policy. They can be used counter-cyclically to support the level of aggregate demand. Similarly, the composition and distribution of public healthcare spending will impact on the structure of aggregate demand across regions. For instance, consider the consequences of reductions in the level of aggregate demand at a regional level:

This will cause an immediate fall in employment and total income in the region. There will be a short-run multiplier effect on employment as local suppliers lay off workers, and consumer expenditure on housing, shopping, leisure activities and the like is reduced. The scale of this short-run multiplier will be limited by the operation of the welfare state, whose expenditures in the region will help to maintain local demand following a blow to the local economy. Government transfer payments to the newly unemployed will allow them to continue spending, albeit at a reduced rate, on local goods and services. Hospitals and schools will continue to operate as normal, providing jobs for those who work in them and supply them.

(Rowthorn, 2000, p. 159)

Government healthcare spending which has the objective of contributing to the mitigation of health disparities and inequalities has the effect of a regional policy, contributing to regional spending and investment. Thus public healthcare spending can decelerate long-term decline by lubricating structural adjustment and supporting higher levels of regional employment and investment than might otherwise be the case (cf. Kaldor, 1970).

The nature of budgetary policy will also have ramifications for the nature and extent of access to health services. For example it has been argued by the WHO (2002) that ill health and poverty induce a vicious circle of cumulative causation which simultaneously increases budget demands and reduces budget revenues, resulting in budget deficits that destabilise the macro-economy. From this perspective poverty and ill health are to be prevented so as to avoid the problems of deficit financing which only seek to destabilise social spending programmes in the long run. In contrast, Post Keynesians, building on Keynes' revolutionary General Theory, would argue that adherence to balanced budgets is likely to exacerbate economic downturns and lead to unnecessary reductions in social welfare programmes, impacting on healthcare access. They argue that falling employment and falling tax revenues, when combined with a balanced budgetary policy, will lead to unnecessary reductions in funding for social welfare programmes, which will in turn impact on the eligibility and coverage (implicit or explicit) of publicly provided healthcare and impact on health. Instead, Post Keynesians advocate deficit financing combined with a range of automatic fiscal stabilisers to intervene and prevent vicious downward spirals of unemployment, reduced healthcare expenditure, poverty and ill health (cf. Davidson, 2002).

Second, Post Keynesians consider the impact on health on economic growth for the macroeconomic framework, i.e. how healthcare investment contributes to health, productivity, economic growth and macroeconomic stability. For example,

Bloom et al (2001b) have highlighted the fact that when health, in the form of life expectancy, is introduced into cross-country growth regressions it appears to have a significant positive effect on the rate of economic growth. They note that a one-year improvement in a population's life expectancy contributes to a 4 percent increase in output. Post Keynesians argue that there is a need to broaden the human capital conceptualisation of the nexus between health and growth. They highlight that although public expenditure on health may create 'human capital' for the individuals receiving healthcare resources, which may augment aggregate economic growth, there is also a variety of other macroeconomic benefits that flow from one individual to others, e.g. increased income multipliers and greater tax revenues to governments, that need to be recognised and studied.

Third, health, as it contributes to increases in life expectancy, is likely to impact on savings rates over time, further affecting the growth and level of effective demand. The impact of life expectancy on savings rates has been recognised by health economists and explored by rationally maximising lifecycle models developed to study this issue (see Bloom et al., 2002). The macroeconomic implications of such effects are then considered in terms of a 'loanable funds' concept of savings whereby the direction of causality runs from saving to investment and economic growth. Post Keynesians reject the lifecycle hypothesis and the loanable funds model of savings and investment on both theoretical and empirical grounds.

Post Keynesians focus on the scarcity of demand and the attention that must be accorded to income effects, its distribution, its impact and links to effective demand and its associated impact on savings. This suggests an alternative macro-economic conception of the links between health and saving. Post Keynesians reverse the direction of causality between investment and savings, arguing that in modern credit-money economies investment creates savings, rather than the other way around. The expansion of effective demand requires an extension of credit, and that generally involves the creation of money. Money is viewed as endogenously created within the private sector 'to meet the needs of trade'. (Post Keynesians argue that loans create deposits and reserves, rather than reserves and deposits creating loans, as in the traditional credit multiplier story.) Higher levels of saving induced by improved life expectancy would reduce spending, aggregate demand and employment.

A seminal study by Sheldon Danziger et al. (1982-3) of the Institute for Poverty of the University of Wisconsin, for example, using cross-sectional data of 9494 households, found that the average propensity to save actually rose for cohorts of age 65 and older. 70-year-olds saved more than 65-year-olds, and 75-year-olds saved more than 70-year-olds, and so on, at all levels of income. This result appeared robust for many different definitions of income. The authors concluded that many suppositions of the life-cycle hypothesis about the relationship between savings and age which underlies much theorising, many measures of economic well-being, and important policy judgements did not appear to accord with reality. There is a need to update and refine such studies; but the basic point is that there is a need to examine the actual relationship between the income, spending and saving of the elderly and evaluate its impact on the structure of aggregate demand and levels of investment, i.e. to assess the empirical adequacy of life-cycle explanations of consumption and savings decisions.

Fourth, modelling assumptions about the level of employment are relevant in considering the effects of a rising dependency rate and its implications for economic growth and medical expenditure (see Jackson, 1998). The standard neoclassical approach to modelling demographic change assumes that the economy exhibits full employment in the long run. The import of this assumption is that there is no demographic slack in the economy. Given that their working life is ostensibly over, the rising healthcare needs of the elderly adversely affect the rate of economic growth by inducing non-income-generating healthcare expenditures. An increasing dependency ratio thus results in employment substitution from other, more productive, areas of the economy to less productive and more labour-intensive care industries, i.e. a sort of elderly crowding-out hypothesis (cf. Bloom et al., 2001a).

Post Keynesians reject such full employment assumptions, maintaining that a posteriori advanced monetary production economies typically operate with a degree of chronic unemployment and excess capacity. This means that at the aggregate level there is unlikely to be any shortage of workers. An increasing dependency effect need not directly impact on economic growth nor give rise to intergenerational conflicts. Fluctuations in the level of employment instead may insulate labour markets from demographic shifts in the labour market. (Economies that exhibit historically high levels of employment may find themselves dealing with the problems of lack of demographic slack. In the absence of global monetary institutions that permit the coordinated expansion of global aggregate demand and employment, such considerations are likely to be the exception and not the rule.) Fifth, the nature of healthcare financing will have consequences at both the macroeconomic and microeconomic levels as well as in terms of the overall level of healthcare spending. Post Keynesians argue that the structure of taxation should reflect some egalitarian principles, not least because this underpins the level of aggregate demand:

If fiscal policy is used as a deliberate instrument for the more equal distribution of incomes, its effect in increasing the propensity to consume is, of course, all the greater.

(Keynes, 1936, p. 95)

Broadly speaking, healthcare spending that is financed through general taxation is more progressive and equitable. Financing of healthcare expenditure through the whole tax base typically reduces tax distortions in the economy and lowers administrative and transaction costs.

The gross injustice of health and economic inequality threatens global well-being. Our moral imagination must focus on long-term equality of essential public goods.

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Widening disparities in health within and between nations reflect a trajectory of 'progress' that has 'run its course' and needs to be significantly modified if progress is to be sustainable. Values and a value system that have enabled progress are now being distorted to the point where they undermine the future of global health by generating multiple crises that perpetuate injustice. Reliance on philanthropy for rectification, while necessary in the short and medium terms, is insufficient to address the challenge of economic and other systems spinning out of control. Innovative approaches are required and it is suggested that these could best emerge from in-depth multidisciplinary research supported by endeavours to promote a 'global mind-set.'

The human development approach begins from a premise that has deep roots in liberal political theory – namely, the idea that justice is properly about the basic social structure[s] ... (political, legal, social and economic institutions of a community that have a profound impact on the health status of community members) and whether these structures guarantee community members the 'fair value' of their most basic human capacities.¹

Descriptions abound of the extent to which we live in an unjust world and of how disparities in wealth and health within and between nations have been widening inexorably over many years.² The state of the world in the early years of the twenty first century is characterized by multiple, deep and interlinking crises in health, education, energy, water, food security, the economy and the environment that constitute an 'organic global crisis,' with already evident and further predictable adverse implications for the lives and well being of all globally.³ It is arguable that these crises and escalating injustice are to a considerable extent the outcome of the way in which the global political economy has been re-structured over the past 40 years,⁴ and that this is causally related to a value system that has failed to lead to the benefits of economic growth and scientific and medical advances (including those in public health) being applied to processes that could reduce inequities in health and human well being.⁵

A recent review of four prominent theories of justice (consequentialist, relational, human rights and social contract approaches) reveals general agreement on the ethical requirement for international assistance to relieve poverty and improve the health of the most deprived. An example is the widespread agreement to pursue the Millennium Development Goals (MDGs).⁶

However, many such approaches are arguably minimalist in the sense that they have a dominant emphasis on philanthropy, although some attention is directed to the need to rectify previous economic and other harms. It should be noted that for every \$1 of Official Development Assistance (much of which is used to pay donor country staff who assist in delivering aid),⁷ developing countries pay about \$6 in debt repayment – mostly interest on debt.⁸ The beneficial effects of well directed philanthropy are acknowledged, but the limited success of philanthropy in narrowing disparities, illustrated by inability to raise the resources for the MDGs, provides insights into the need for a bolder vision for poverty reduction. Briefly, achievement of the MDGs (and these are modest in terms of needs beyond the severely poor) requires about \$3/4 trillion over 15 years. The sad fact is that this sum has not been raised (and that donor fatigue is increasing) while about \$17 trillion (22 x as much) was mobilized in three months for the bailouts of financial institutions during the early stages of the 2008 global economic crisis. This asymmetry between the privatization of profits and the socialization of losses reflects the extent to which the lives of a minority are valued and protected while the lives of the majority are devalued and undermined.⁹

Furthermore, while discussions on health and justice are conducted under the rubric ‘global health,’ they are located within what would more accurately be called an ‘international health’ approach. International health, with its focus on the provision of biomedical health care assistance, in one form or another across regional or national boundaries, has long been an item on the agendas of many wealthy countries and academic institutions. Global Health is a newer term and properly used, goes beyond international health to include acknowledgment of health in more than merely a biomedical sense, and the critical interdependence of the health of all in a world characterized, inter-alia by excessive (often wasteful) consumption of limited resources, population growth, demographic changes, porous borders and environmental and biological dangers that threaten all lives globally.¹⁰ Seeing the health of all as interconnected and intimately linked to social and economic forces, and to the values that underlie these requires a new perspective on ways of viewing ourselves and the world.

In this commentary I provide a personal view of some distortions of our values that may in part explain our predicament of persistent global injustice¹¹ and suggest that ignoring these prevents us from acting with the vision and wisdom to use available intellectual and financial resources to reduce injustice, improve health and ensure better lives for billions of people.¹² I conclude by considering some attitudes and approaches that could facilitate reduction in injustice. Throughout this commentary I ask readers to keep in mind the implications of ongoing widespread poverty, depletion of limited and unrenewable natural resources, population growth, global warming and the threat of new infectious diseases as major threats to global health in the 21st century.

Distortions of Our Values

Widely and strongly held values over many centuries include respecting the lives, rights and freedoms of all within democratic systems characterized by a significant degree of social solidarity and driven by both ongoing scientific advances and well structured economies. The extent to which many of these values have become distorted, with potentially adverse effects on modern life, has long been perceived by prescient scholars,¹³ and it has been argued that these inter-linked distortions are underpinned by a desire and strategy for power and control through hegemonic ideas.¹⁴

Hyper-individualism

The analysis, offered here, of a variably distorted value system, centres on an ongoing process of shifting from hard-won and highly prized individualism that has enabled magnificent economic, scientific and technological advances for the benefit of individuals and many societies, to a form of hyper-individualism characterized by demands for immediate gratification and endless economic expectations by the most privileged, whose short-term horizons and lavish consumptive patterns endanger the future for us all. Charles Taylor has described this ‘dark side of individualism,’ as excessively focused on individuals in a way that:

... flattens and narrows our lives, makes them poorer in meaning and less concerned with others and society. [He contends moreover, that] social relationships are depersonalised by the rise of ‘instrumental reasoning’ that values specialised knowledge, the extension of technical rationality to favour calculation, systematization, formal procedures, cost-benefit evaluations, maximizing efficiency and control over nature.¹⁵

Extreme individualism and three other characteristics underpinning the economic system, (viz. unlimited desires, short-term self-interest and a form of ‘rationality’ that emphasizes calculable and measurable issues), were identified many decades previously by John Kenneth Galbraith, who predicted that these would pose long-term threats to all.¹⁶

Within healthcare systems, hyper-individualism is revealed by expectations that everything that can possibly be done for any individual comes to be incorporated into a sense of entitlement regarding what should be provided – often at little or no cost to the recipient. As a result, health care is driven by the desire to postpone death at all costs, with little appreciation of the limits of life and of medicine.¹⁷ This applies particularly when futile health care is continued with public resources in healthcare systems that aspire to be egalitarian. Patients kept alive for extended periods in ICUs, when they have multiple organ failure and large, untreatable, suppurating pressure sores exemplify this.¹⁸ As a consequence, a high proportion of health budgets in many ‘developed countries’ is spent on prolonged end-of-life treatments that have only marginal benefits. Largely ignored in the pursuit of such ‘rescue medicine’ are the lost opportunities to prioritize many effective treatments that, if promptly applied, would result in greatly improved lives for many who are relegated to long waiting lists by current health funding priorities. Under such ideological pressures, all healthcare systems are to some extent, and in varying combinations, distorted (not structured to meet local health needs), dysfunctional (driven by vested interests with

money/profits as the bottom line, within increasingly corporatized frameworks) and unsustainable (costs rising more rapidly than can be afforded even in wealthy nations).

Narrow conceptions and distorted application of human rights

Human Rights, now a widespread moral language used to promote respect for life and individuals, has been remarkably successful in many complex situations. However, instead of a comprehensive approach as outlined in the Universal Declaration of Human Rights (UDHR), the focus has largely been on civil and political rights. Protection of the privacy and confidentiality of those with HIV/AIDS is a good example of successful use of this approach. However, it is notable that there has also been considerable inconsistency and selectivity in the application and pursuit of human rights. For example security threats in the USA have led to abuses of civil and political rights that Americans have long-championed and chastened others for abusing,¹⁹ with 'significant implications for the moral authority of civil societies in more authoritarian regimes'.²⁰

In the context of identifying and punishing individual perpetrators of human rights abuses, a narrow conception of rights and perpetrators of abuses has also neglected powerful 'systems-based' forces that could promote either achievement of rights or abuses of these. The role of many structural forces (including the granting of rights to corporations as 'persons') imposed on the global economy by wealthy nations (and their collusion with despots) that undermine the basic rights to life for billions of people is one example.²¹ Other distressing examples of systemic misuse of the idea of Human Rights include the many failings of the United Nations Council on Human Rights (UNCHR), as recorded by UN Watch,²² and through the Canadian experience within the UNCHR.²³

Regrettably a narrow focus on human rights tends to neglect social, cultural and economic rights as integral components of the UDHR that has been widely praised and advocated as a set of 'indivisible' and 'inalienable' rights. It is gratifying that the rationale for promoting and ensuring a more comprehensive application of rights is being advanced.²⁴

Erosion of social solidarity and of stewardship for the future

Further distortions of our value system arise from erosion of the sense of community and social cohesion required to meet aspirations for fairness and solidarity in society, thus reducing the ability to adequately protect valued public goods (highways, urban infrastructure, legal systems etc) and to reproduce caring social institutions (such as basic educational facilities, colleges, universities, and health care), universal access to which are essential for community well being.²⁵ Indeed private (consumer) goods are increasingly viewed as having priority over essential public goods. A restricted concept of 'freedom' as 'freedom to act' (liberty) that focuses on narrow and short-term self-interest does injustice to the concept of freedom that should also include 'freedom from want', that requires a sense of obligation, duty and commitment to others.²⁶

Dedication to economic dogma

Another major distortion stems from dedication to a poorly regulated market system that is now increasingly widely acknowledged as based on flawed economic theory and the notion of endless economic growth within practices that are riddled with corruption and fraud, propagated by obtuse bureaucratic processes, all of which increasingly pervade all facets of life.²⁷ Galbraith has eloquently described how the modern economic system is characterized by fraud, perpetrated not necessarily by bad people, but rather under the influence of corporations²⁸ that seem to have all the defining characteristics of psychopaths,²⁹ and which others more recently have recognized as unsustainable.³⁰

The still unfolding recent global economic crisis (with associated major increases in food prices) is seriously harming the lives and health of about 50% of the world's population who live on less than \$3–4 per day. The middle classes in the USA, UK, Europe and elsewhere are also affected, and even in the USA millions of families are losing their homes.³¹ Between 1980 and 2006, the wealthiest 1% of Americans tripled their after-tax percentage of national income, while the share of the bottom 90% dropped by 20%. Between 2002 and 2006, 75% of national economic growth went to the top 1% who own 70% of national wealth. The fact that four hundred US billionaires own more than 155 million Americans combined³² and that disparities in wealth are wider in the USA than in all other wealthy countries (with associated higher indices of morbidity, mortality, imprisonment and other social pathologies),³³ speaks volumes about the distortion of values in that society – the worst of which many seek to emulate. Once a much admired nation with the intellectual and economic potential to lead the world into a more equitable and sustainable 21st century, it is arguable that the USA's opportunity to improve global health is being squandered by short-sighted policies that undermine its own citizens, and many others globally.³⁴ Among other highly adverse effects of a pervasive market ideology is the transformation of medical care into a product for

consumption in a 'free market'.³⁵ With increasing commodification, much else that is valued in life is demeaned, by turning 'goods' that should not be sold into marketable commodities.³⁶ Moreover, the world is rendered increasingly unstable and insecure when lives are reciprocally devalued by poverty of moral imagination that ignores the concept of social justice and the role of fairer distribution of resources.³⁷

These criticisms also apply to the new South Africa, where adoption of the above-mentioned economic dogma generally and in relation to provision of health care services specifically, combined with pervasive corruption, has led to widening disparities in wealth (Gini co-efficient increased from 0.6 in 1995 to 0.66 in 2007 and to 0.679 in 2009),³⁸ and health.³⁹ This has contributed to escalating social unrest, and undermining of the hope for greater equity in this new constitutional democracy.⁴⁰

Most nations now have larger debts than they can easily sustain.⁴¹ Corporate goals have come to dominate in life generally and in health care specifically.⁴² The now threatened middle classes are coming to appreciate the fact that their plight results from the same processes that, in the past, allowed them to flourish at the expense of those lower in the chain of exploitation. It is also arguable that within the professions, greed and personal aspirations increasingly eclipse professionalism.⁴³

The idea of living a life in which there is place for at least some degree of modesty in expectations has seemingly been suppressed. Living beyond our means and accumulating debt seems to have become a norm. Few individuals or nations seem to realize that the solution to global health problems, the economic crisis and all the other social crises we face, lies in doing better with less rather than demanding more. Of course this is also the challenge for dealing with climate change and environmental degradation.⁴⁴ Whether or not this crucial message can be absorbed and internalised by those who feel the world owes them long, luxurious and safe lives, while billions of others face daily risks and premature death, is an issue that has not been adequately addressed.⁴⁵

Over-reliance on science for solutions

While it is undisputed that scientific advances have provided, and will continue to provide many solutions to the manifold problems we face,⁴⁶ undue faith in 'science' as the solution to all problems, results in selective and idiosyncratic value being placed on knowledge, with distinct preference for old knowledge over new knowledge, and preference for both new and old knowledge over wisdom in the application of knowledge.⁴⁷ For example, it should be asked why there is so much emphasis on ensuring that all who could benefit from anti-retroviral drugs (ARVs) have access to these, but insufficient attention is paid to providing food to starving people (much easier to do than supplying drugs).

Another example is how, in child health research, 97% of grants are designed to develop new technologies that could reduce child mortality by 22%. If more were spent on research on effective delivery of existing treatments, child mortality could be reduced by 66%.⁴⁸ In health care, new research agendas and arrangements that include explicit priority setting and allocation of resources could address the distortions, dysfunctionality and unsustainability that characterize health services everywhere.⁴⁹

The Report, 'Beyond Technology: Strengthening Energy Policy through Social Science', notes that despite having spent over \$70 billion since 1977 on research programs in the USA to develop advanced, more efficient, cleaner and more cost-effective energy technologies, these have not been widely implemented.⁴⁹ Reasons given for this lack of implementation include the complexity of a diverse political milieu with multiple layers of governance and weak public understanding of energy-related challenges and opportunities.

Seeking Solutions

A decade ago we described several values that need to be widely promoted to address the moral challenges posed by global health disparities: respect for all life and universal ethical principles; human rights, responsibilities and needs; equity; freedom; democracy; environmental ethics; and solidarity.⁵⁰ It seems that distortions of these values may in part account for inadequate progress. In addition to the transformative approaches we suggested at that time, some additional suggestions are provided here.

Individual level

Faced with such daunting crises, I suggest that in order to overcome feelings of helplessness, the first task for each of us, as privileged people, is to become more introspective about our privilege and to re-examine our lives. Questions we need to ask ourselves include: Who am I? What does it mean to be a privileged person? What are my goals in life? What are my academic responsibilities in relation to global health? Should the pursuit of social justice be a priority for health care professionals? Am I a citizen of the world, and should global health be a significant focus for those with an interest in bioethics?

Social level

In responding to what needs to be done at the levels of institutions, states and internationally to seek and achieve significant constructive changes, an important task is to recognize that faith in a market 'guided by an invisible hand' as the means of improving the lives of all, has been severely undermined by decades of widening disparities between the wealthy and the poor, and by the implications of the most recent and ongoing severe global economic and other social crises world wide.⁵¹

On one account, systematic abuses of basic human rights, including those rights that are critical for achieving a basic, decent minimum good life, are contingent on the absence (or perversion) of an ethics of virtue both in individuals and in institutions.⁵² Allen Buchanan provides a conceptual framework for what he calls 'social moral epistemology' that considers individual virtues to be either strengthened or subverted by the extent to which institutional frameworks are based on factually correct and morally virtuous concepts.⁵³ The pervasiveness of the moral corrosion of institutions and individuals, that allows the perpetuation of harmful or evil practices, poses daunting and complex global problems.⁵⁴ Addressing these may require a 'Grand Challenges' approach, and new depths of understanding to assist in re-framing the ways in which we see ourselves, and the world that could foster thoughtful and constructive approaches towards more sustainable life trajectories.⁵⁵

A new Grand Challenges agenda

By 'Grand Challenges' I mean a large scale, multi-disciplinary series of research projects to explicate in some detail the workings of a complex global system that is undergoing entropy.⁵⁶ Identification of 'nodal points' and 'receptors' to target for generating and amplifying change could serve as a prelude to modelling possible ways of effecting constructive changes with the potential to improve global health through structural changes to our economic and values systems. The magnitude of this task is arguably no less than the task of producing an HIV vaccine, which also requires profound understanding of the ways in which the HIV damages the immune system, and how systems' defences can be mounted to oppose such damage. There are no simple answers to either of these challenges, hence the need for a visionary research programme. Similarly suggested solutions for energy sustainability include creating a national vision for future energy use through systematic interdisciplinary social science-based research and policy formulation.⁵⁷

Among the many issues that need to be pursued through such an agenda would be promotion of understanding and acknowledgment of the values and processes that have shaped the world over the past century, and of the modes of reasoning that have played a central role in framing and driving these values and processes.⁵⁸ A critical, open and well-publicized re-appraisal of the currently dominant value system and of the adverse effects of the global political economy on health will require interrogation and modification of overt and covert power structures.⁵⁹ Exposure and critiques of how the wealthy are deeply causally implicated in causing and perpetuating poverty and inequality, and what this implies in terms of distributive and retributive justice,⁶⁰ could lead to new ways of thinking about progress through nurturing progressive values.⁶¹

These would include enhancing literacy and empowerment among women, socialization of many of the 'risks experiences' suffered by the global majority,⁶² and modification of taxation with reduction of tax avoidance and evasion mechanisms.⁶³ Reviewing and restructuring many current institutional arrangements⁶⁴ could lead to rebuilding the social commons. Within health care, re-examination of the quest for health and how health care services are structured and could be improved, would be a major task.⁶⁵

The impacts of inequality are far greater than that of nuclear conflict

Lee 16 – Brandy, Yale University, New Haven, CT, USA "Causes and cures VII: Structural violence"
Aggression and Violent Behavior Volume 28, May–June 2016, Pages 109-114,
<http://www.sciencedirect.com.dartmouth.idm.oclc.org/science/article/pii/S1359178916300441>) RMT

While an embryonic idea of structural violence may be as old as the notions of conflict and injustice, the concept as a topic of scientific study gained salience through a seminal essay by the Norwegian sociologist Johan Galtung (1969). He defined structural violence as a deliberate impairment of fundamental human needs by actors of power. He rejected the narrow definition of violence as somatic incapacitation or deprivation of health alone, with killing as the extreme form, at the hands of an actor who intends the consequence. If this were all violence is about, he argues, highly unacceptable social orders would still be compatible with peace. If people were starving when this is objectively avoidable, then violence has occurred, regardless of whether there is a clear subject-action-object relation, as it is less and less relevant to world economic relations today. Therefore, he stated the idea that violence is present when forces influence human beings so that their actual somatic and mental realizations are below their potential—in other words, violence is the cause of the difference between the potential and the actual, regardless of the presence of an identifiable actor. He acknowledges his inspiration from the leader of the Indian independence movement Mohandas Gandhi, who called poverty "the worst form of violence." Galtung (1985) commented that by getting away from the actor-oriented perspective of much Western social science, he could focus on the settings within which individuals may do enormous amounts of harm to other human beings without ever intending to do so, just by performing their regular duties as the structure defines them. Structural

violence is then a process that works slowly through general misery, eroding and ultimately killing human beings, sometimes without even the awareness of doing so.

He therefore believed that **we could easily avoid structural violence if people became conscious of the limitations social structures imposed on them** (Beyer, 2008). Liberation theologists have made their own contribution to shaping the concept, starting in the 1950's and 1960's with the Catholic Church in Latin America, principally as a moral reaction to the poverty and the social injustice in the region (Gutiérrez, 1973). Canadian peace researchers Gernot Kohler and Norman Alcock (1976) devised ways to quantify the excess deaths that social, political, and economic inequalities cause, through two measures. In the first, they used Sweden as a model, for it had come closest to eliminating structural violence, with the greatest equities in living standard and the highest life expectancy among nations. They asked: **how many deaths would we avoid, if all countries enjoyed the same living conditions as Sweden?** The second measure they used was "the egalitarian model," one that postulates **complete and equal redistribution of the available global wealth**. They asked: **how many deaths would we avoid, if we equally distributed the available global wealth around the world?** When the authors compared life expectancies everywhere else in the world with Sweden, they found that **18 million deaths a year could be attributed to "structural violence,"** or the socioeconomic inequalities that exist globally. Considering life expectancy to be a function of relative socioeconomic position (Galtung and Høivik, 1971), when they plotted gross national product (GNP) per capita for each nation on earth, they were able to show that the life expectancy for nations with a GNP per capita at world average was 68.3 years for the year 1965. One remarkable aspect of the egalitarian life expectancy is its magnitude, the authors note, which is about forty years higher than the lowest life expectancy in 1965 (27 years for Guinea) and only six years less than the highest life expectancy (74.7 years for Sweden). In other words, under conditions of complete global equality, **rich countries would lose only minor amounts of life expectancy, whereas poor ones would gain tremendously.** British social epidemiologists Richard Wilkinson and Kate Pickett (2009) make similar observations, concluding that egalitarian societies do better overall, with only minor compromises from "the wealthy."

Behavioral violence, in measurements by the tolls of street violence or war, is more noticeable, even though the "tranquil" waters of structural violence may contain much more violence. American violence scholar James Gilligan (1999) compared structural violence to the most deadly military conflicts: estimating 49 million military and civilian deaths from World War II, or about 8 million per year from 1939 to 1945, or **even a hypothetical nuclear exchange between the United States and the former Soviet Union at 232 million, could not even begin to compare with structural violence,** which continues year after year, during times of peace as well as of war. In other words, **every fifteen years, on average, as many people die because of relative poverty as would in a nuclear war** that caused 232 million deaths. This is, in effect, the equivalent of an ongoing, unending, in fact accelerating thermonuclear war or genocide, perpetrated on **the weak and poor** every year of every decade, throughout the world. He also described structural violence as increased rates of disabilities and deaths among the people who occupy the bottom class. He noted that **the suffering of people from lower classes are the product of people above who have collective bargaining power making choices that determine the allocation of resources.** Unlike behavioral violence, its lethal effects operate continuously rather than sporadically; it can occur independently of any intention to kill anyone (for example, it can be a byproduct of wishing to maximize one's wealth and power); and it is usually invisible, in the sense that deaths from structural violence may appear to have other causes, natural or violent. More **recent figures bear out these conclusions even more startlingly,** as we will see in the next section. Gilligan (2001) also articulated how, **through the mechanisms of shame, humiliation, and inferiority, the disparities in classes are the most potent cause of behavioral violence, such as suicide, homicide, warfare, or capital punishment** (Bloom, 2001). American anthropologist Paul Far1mer (2003) also developed the concept of structural violence by first defining structure as a pattern of collective social actions within institutional practices, law, economic policies, and other habitual elements. These structures can materially manifest through facilities such as roads, server systems, hospitals, and schools. He described violence as suffering resulting from social arrangements that put individuals in harm's way. Since the exertion of **structural violence is systematic**—that is, **indirect—by everyone who belongs to a certain social order, no one is at fault, at the same time as everyone of that order is at fault.** Cumulative historical forces and processes work together to constrain individual agency inversely, if not always neatly, with the ability to resist marginalization and oppression, and deny them the benefits of social progress.

Universal insurance coverage is the foundation of a right to health care and would ensure high quality outcomes and redistribute wealth

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*health capability paradigm – Ruger's philosophical grounding for a right to health care

Universal health insurance coverage is fundamental to the health capability paradigm.

One of the primary economic barriers to high-quality health care is **lack of health insurance**. Moreover, resource allocation in this paradigm rests on medical necessity and medical appropriateness, not ability to pay. The costs of health care can also affect health directly by reducing demand for necessary care or increasing consumption of unnecessary care. And finally, the uncertainty of health need, the catastrophic costs of medical care, individuals' risk averse nature, and the need to redistribute resources from well to ill and rich to poor place risk pooling at the centre of health care financing.

The health capability paradigm requires that health system financing, organization, and delivery ensure access to medically necessary and medically appropriate care and protect individuals from health-related financial burdens that could substantially erode their freedom to flourish.

This means that **health policy should provide continuous universal health insurance so that gaps in coverage do not handicap health functioning and health agency. This arrangement should include all individuals at all times**, regardless of changes in income, employment, marital or health status.

This account argues for financing health care according to ability to pay (adjusting contributions to health care costs by income level) and delivering it according to medical necessity and medical appropriateness (see Chapter 8). Thus, society distributes health care resources according to individuals' health capability (health functioning and health agency), not according to their ethnicity, how much money they have, where they live, whether they are married, or what they do for a living.

An equitable health system requires financial protection of all individuals, especially the poor and most disadvantaged, against the monetary burdens associated with health risks. Pooling risks and collecting prepayments unrelated to health status or use secures this protection. Thus, provision of health care rests on community-rating (where health insurance premiums are the same across individuals) as opposed to experience rating, with premiums based on previous health care expenditures or preexisting health conditions, and not on an individual's health status.

Maximizing the quantity of resources available for health care improves the ability to meet individuals' health needs. At the same time, health care financing must be efficient in any country adopting universal coverage because limited resources must be used wisely, and wasted resources undermine important health goals. To achieve both administrative and technical efficiency (Mills and Ranson 2001), systems should minimize the costs of collecting and distributing revenue and guard carefully against corruption and fraud (below). The US and numerous developing countries do not provide universal health insurance coverage to their populations.

Academic approaches to health insurance (Pauly et al. 2006) have typically adopted a neoclassical economic perspective, assuming that individuals make rational decisions to maximize their preferred outcomes, and businesses (including insurance companies) make rational decisions to maximize profits. In that particular approach, individuals who are risk averse will purchase health insurance to reduce variation in the costs of health care between healthy and sick periods (Cutler and Zeckhauser 2000). In empirical studies, however, individuals do not always make rational choices. They also find it difficult to assess their health risks and to know how much insurance they need (Cutler and Zeckhauser 2004).

By contrast, medical ethics has focused on the issue of equal access to health care, but provided little in the way of philosophical justification for risk management through health insurance per se. Nor has the field shown how the practice whereby many at-risk individuals pay premiums to cover one individual's expensive health outcome (risk-pooling) is ethically desirable, except insofar as it ensures equal access to health care and equal funding to purchase it for all contributors.

This book offers an alternative moral framework for analysing health insurance: that universal health insurance is essential for human flourishing. In this theory, the central ethical aims of universal health insurance coverage are to make and keep people healthy, to develop their health functioning and health agency, and to enhance their security by promoting health and protecting them from both ill health and its economic consequences, issues not adequately considered to date. Universal health insurance coverage requires redistribution through taxation, and so individuals in societies providing this entitlement must voluntarily embrace sharing these costs. This redistribution is another ethical aim of universal health insurance unaddressed by other frameworks; as such it must be analysed in the context of mainstream economic theory of health insurance.

A right to health care would frame policy around an ethical commitment through the health capability paradigm that prioritizes human functioning and agency. This necessitates expansive public financing and regulation.

Ruger 16 (Jennifer Prah, Amartya Sen Professor, Health Equity, Economics, and Policy, School of Social Policy & Practice at the University of Pennsylvania, Associate Dean, Global Studies, School of Social Policy & Practice at UPenn, Senior Fellow at the Leonard Davis Institute of Health Economics, Master of Studies in Law from Yale, PhD in Health Policy from Harvard, Master of Science in Comparative Social Research from Oxford, lifetime member of the Council on Foreign Relations, Guggenheim Fellow, "The health capability paradigm and the right to health care in the United States," 8/20/2016, Theoretical Medicine and Bioethics, pg. 123-124, <https://link.springer.com/content/pdf/10.1007%2Fs11017-016-9371-y.pdf>//duncan

Actualizing a right to health involves both legal and non-legal instruments. The health capability paradigm proposes an ethical commitment to the right to health. This commitment sees the right to health as the basis and inspiration for new and specific legislation. It also sees it as an ethical claim, in this case on all individuals, especially the wealthier, to redistribute some of their resources to help meet the health needs of others, those who are unable to afford care. Under a health capability paradigm, this obligation involves an interest in the significant capabilities and freedoms of others, operationalized in terms of health needs, health functionings, health agency, and health capabilities, not preferences, desires, or utilities.

Because fulfilment of a right to health requires social organization for redistribution of resources and related legislation and regulation, this paradigm rests on an ethical commitment on the part of all individuals — those most fortunate and those in need—to the end goal of providing all people the capability to be healthy. Without this ethical commitment, redistributing resources from the wealthy to those less fortunate and from the well to the sick will not be possible, because the effort to do so must be voluntary, not coercive. As such, individuals must internalize the public moral norm that

health is worthy of social recognition, investment, and regulation to the point of successfully operationalizing such a right. The ethical significance of the right to health provides strong grounding for individual and state action to respect, protect, and fulfil it through institutional change. The obligation and duties fall on all individuals, regardless of their specific relationship to any other particular individual, but the allocation of specific responsibility for respecting, protecting, and fulfilling the right to health depends on the respective roles of institutions and individuals at different levels of society (global, national, sub-national) as discussed elsewhere (Ruger 2006b). The specific allocation of responsibility for effective action may rest on personal and institutional relationships, but there is also a more practical turn to allocate duties based on functional effectiveness in respecting, protecting, and fulfilling a right to health as discussed elsewhere (Ruger 2006b).

From an ethical point of view, individuals and, by extension, states must address threats to human rights. Immanuel Kant's category of duties known as 'imperfect obligations' to human rights analysis may be applied as the basis for this obligation. In this analysis, **human rights yield both perfect and imperfect obligations** (Sen 2004, pp. 340–42). In the health domain, determining the extent and scope of these claims, our perfect and imperfect obligations to respect, protect, and fulfil an individual's right to health, requires a framework of normative reasoning. Such reasoning involves dialogue about the ethical dimensions of health and health policy and about the need for collective action through public financing, regulation, and in some cases, provision of services. It also requires regulation and oversight of the health system, and it calls for establishing social norms of inclusive diversity to create the conditions in which each individual may achieve her potential in health. In short, such realization is more likely to occur when individuals within a given society take ownership of the public moral norm as a guiding principle for their individual and collective efforts, as evidenced by their domestic social, political, and economic activity. Blunt legal instruments cannot fully embody this framework. Legal instruments will ultimately require interpretation in any case. This argues for a particular type of normative reasoning about justice and health policy, leaving the discussion of legal instruments and the role of the courts vis-a-vis legislation and policy to other works.

*We should reframe economics around meeting capabilities and reducing inequality, not maximizing growth.

Berik et al. 09 Guñseli Berik, Department of Economics, University of Utah; Yana van der Meulen Rodgers, Department of Women's and Gender Studies; Stephanie Seguino, Department of Economics, University of Vermont "Feminist Economics of Inequality, Development, and Growth" Feminist Economics 15(3), July 2009, 1–33

We argue that **macroeconomic** theory and **policy should be constructed within the broader framework of human well-being, rather than** being solely concerned with **how economies function** and the achievement of macroeconomic fundamentals such as price stability and robust growth rates. **Human well-being requires at a minimum adequate provisioning** (through interconnected paid labor and unpaid care activities and entitlements from the state or community); **capabilities** (the ability to do or be, based on provisioning); **and agency** (the ability to participate in decision making so as to shape the world we live in). This definition of wellbeing is consistent with that envisioned by the capabilities approach (Amartya Sen 1999; Martha Nussbaum 2003). **This evaluative framework draws on the argument that** social conditions and **policies should be assessed according to the extent to which people have the capabilities to lead the kind of lives they want** to lead and to be the person they want to be, **such as the ability to be healthy** and to seek education. Accordingly, development – what we refer to as broadly shared development – is synonymous with expansion of capabilities. In **this framework, income inequality constrains the achievement of human well-being because it translates into unequal political and social power.** **This power differential inhibits not only equality of opportunities** in access to education and health, **but also agency** and voice, **which are constrained by the social and political institutions that emerge to justify material imbalances.**

These linkages make clear why we argue not only for equality of opportunities but also equality of outcomes. By outcomes we refer not only to capabilities but also to income, wealth, and other assets. The quest for equality of outcomes in the case of incomes and other measures of resource control does not refer to the goal of attaining equality across all individuals. Rather, we envision equality of outcomes as a condition of similar group distributions, such that no one group is systematically disadvantaged even though within-group inequality may exist. In the case of capabilities, we interpret the goal of equality of outcomes to be one of expanding capabilities of all without, however, the pursuit of equality through downward harmonization. For example, in countries where women live longer than men or have higher completion rates in education, we do not seek a process that reduces women's well-being in order to achieve equality of outcomes.

While feminist economists emphasize the gender-equitable achievement of an adequate level of provisioning and the expansion of capabilities, many feminist economists are also concerned with other types of inequality that may intersect with gender inequality (Lourdes Benería and Gita Sen 1982; Marilyn Power 2004). This broader concern with inequality is based on the premise that women and men are not homogeneous groups and that any systemic form of stratification based on invidious group characteristics inhibits the ability of the subordinate group to provision, with multiple forms of inequality compounding these disadvantages.³

We view economic growth as a means for expanding capabilities, especially in very low-income economies. Growth can add to the entitlements that one's labor and asset ownership, governments, and community-based arrangements make available for provisioning. In low-income countries, high-growth is more conducive to institutionalize and implement equitable policies that require a larger allocation of funds. In high-income countries, however, policies that focus on redistribution rather than economic growth will provide more scope for achieving expansion of capabilities (Hu''lya Dagdeviren, Ralph van der Hoeven, and John Weeks 2004). 4 In either case, however, achieving an equitable expansion of capabilities depends crucially on how countries achieve growth and how they utilize the proceeds of growth.⁵ Growth is not sufficient to ensure expansion of capabilities because policies enhancing equality are likely to generate distributional conflict and resistance from groups who benefit from the status quo distribution. For example, dominant groups could point to added costs as a basis for resisting policies designed to strengthen social protection and to create jobs that would enable adequate provisioning.

In this contribution we build upon research in feminist economics that has sought to integrate gender into macroeconomic theory and develop gender-equitable macroeconomic policy recommendations. Since the early 1980s this body of research has examined the links between gender equality and macroeconomic aggregates such as trade, investment, and economic growth, and it has established that macroeconomic policies have gendered effects. In this contribution we provide further insight into the connections between inequality related to gender, class, and ethnicity on the one hand, and macroeconomic outcomes on the other. Our goal is to examine more closely than previous studies the multifaceted linkages between inequality, development, and growth, and to integrate insights from this volume's studies to show the relevance of gendered analysis of macroeconomics.

We begin with a consideration of contrasting notions of equality that shape differing policy agendas, and we argue for the salience of equality of outcomes in the pursuit of broad-based development. Our examination of the impacts of macroeconomic policies on inequalities in light of contributions in this volume adds new evidence to earlier conclusions on the inimical effects of market reforms on human well-being. We also present a clear case that gender inequality in alternative measures can hinder as well as promote economic growth. In view of this analysis we aim to identify macroeconomic policies that can promote gender equality in its various dimensions and to delineate the appropriate roles for the state and market in helping to achieve broadly shared development.

Right to health strategically reverses exclusionary biomedicine.

Nikolas **ROSE** Department of Social Science, Health & Medicine @ King's College (London) '1 "The Politics of Life Itself" *Theory, Culture & Society* 18 (6) p. 17-21

I have argued that life, today, is not imagined as an unalterable fixed endowment, biology as destiny, where the reproduction of individuals with a defective constitution is to be administered by experts in the interests of the future of the population. No longer are judgements organized in terms of a clear binary of normality and pathology. Of course, there are many practices where identification of high risk plus biological incorrigibility can switch the affected individual – or potential individual – onto the circuits of exclusion: whether that be via therapeutic abortion for a severely damaged foetus or preventive detention – or the death penalty in some states in the United States – for those thought to have a biological propensity to violence or sexual predation. But the dream – of doctors, geneticists, biotech companies and many 'afflicted individuals' and their

families – is of that pre-symptomatic diagnosis followed by technical intervention at the biological level to repair or even improve the sub-optimal organism. For the political vocation of the life sciences today is tied to the belief that in most, maybe all cases, if not now then in the future, the biological risky or at risk individual, once identified and assessed, may be treated or transformed by medical intervention at the molecular level. In the process, the familiar distinction between illness and health has become problematic and contested. As claims are made to identify the genetic bases of ‘normal’ variability in aspects of vitality – from sexuality to longevity – the line of differentiation between interventions targeting susceptibility to illness or frailty on the one hand, and interventions aimed at the enhancement of capacities on the other, is beginning to blur.

I have suggested in this article that, in and through such developments, human beings in contemporary Western culture are increasingly coming to understand themselves in somatic terms – corporeality has become one of the most important sites for ethical judgements and techniques.

Two modes of such a ‘biological ethics’ are particularly striking. On the one hand, human rights now have a biological dimension and, partly in consequence, have gained a new kind of ‘species universality’. Legal, political and social rights were first linked to the capacities and obligations of individuals who were elements of a political association. But now, it seems, each human being has such rights, simply by virtue of their existence as beings of this human kind. Individuals seem to have acquired a kind of biological citizenship – a universal human right to the protection, at least, of each human person’s bare life and the dignity of their living vital body. In the geopolitics of famine, drought, war and ethnic cleansing, in the vociferous anti-capitalist and anti-globalization movements, and in the local politics of health, it is now possible for human beings to demand the protection o

f the lives of themselves and others in no other name than that of their biological existence and the rights and claims it confers.

Such arguments suggest that biological ethics ascribes each human life equal worth. But our practices and techniques show us that, on the contrary, the biological lives of individual human beings are recurrently subject to judgements of worth. We do not have to look to the controversies over euthanasia or the rights to life of severely damaged neonates to see this – each session of genetic counselling, each act of amniocentesis, each prescription of an anti-depressant is predicated on the possibility, at least, of such a judgement about the relative and comparative ‘quality of life’ of differently composed human beings and of different ways of being human. As biomedical technique has extended choice to the very fabric of vital existence, we are faced with the inescapable task of deliberating about the worth of different human lives – with controversies over such decisions, with conflicts over who should make such decisions and who cannot, and hence with a novel kind of politics of life itself. In this article, I have argued that this politics is not one in which authorities claim – or are given – the power to make such judgements in the name of the quality of the population or the health of the gene pool. On the one hand, in the new forms of pastoral power that are taking shape in and around our genetics and our biology, these questions about the value of life itself infuse the everyday judgements, vocabularies, techniques and actions of all those professionals of vitality: doctors, genetic counsellors, research scientists and drug companies among them, and entangle them all in ethics and ethopolitics. And, on the other hand, the politics of life itself poses these questions to each of us – in our own lives, in those of our families, and in the new associations that link us to others with whom we share aspects of our biological identity.

Of course, we should not overestimate the novelty of what is happening here. But nonetheless, to a greater extent and in different ways than before, we have become the kinds of people who think of our present and our future in terms of the quality of our individual biological lives and those with whom we identify. The melancholy refrain of those who condemn the arrogance of biomedicine for meddling in such areas, who convict all references to the biological of reductionism, individualism and determinism, or who predict a new eugenics are of little help to us in understanding the issues at stake here. For once our very biological life itself has entered the domain of decision and choice, these questions of judgement have become inescapable. We have entered the age of vital politics, of biological ethics and genetic responsibility.

International Human Rights

Foundation of Human Rights

Human rights are grounded in human needs

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Adler's distinction between natural needs and acquired wants provides a basis for determining what is objectively good. Human wants are highly variable, but the universality and sameness of human needs as inherent attributes of human nature provides the objective standard whereby our value judgments and obligations can be considered true or false, and for determining right desires and real goods (Adler, 1981, p. 101). Moreover, human rights are grounded objectively in universal human needs, including the need for health, and consequently, the need for health care services and medical supplies such as prescription medication. Thus both health and health care constitute human needs and human rights grounded objectively in reality—the reality of human nature—irrespective of circumstances such as whether or not a society's laws ensure these rights. It is not particular human laws, but a universal human nature which provides the standard of objective value judgments including assertions of human rights (Adler, 1981, pp. 219-220). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5972-5976). AuthorHouse. Kindle Edition.

Health Care is a Human Right

The US has signed international agreements that obligate it to protect health care as a human right

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

There are acts we would consider a violation of human rights (hence unjust), even if no existing law prohibited them (Adler, 1981, p. 203). Beauchamp and Childress (2001) used the term “common morality” as a basic affirmation of human rights (p. 348; cf. 227-229, 401f). Obvious examples include the right to be protected from murder, torture, stealing, or kidnapping. Browlie (1981) and Marks (2006) have cited several international declarations and covenants affirming human rights to both health and appropriate health care. These are universal, human rights, which apply always to everyone, everywhere, even if a particular government does not secure them as legal rights (Adler, 1981, p. 203). The fact that the United States has signed such international covenants obligates the federal government to protect and promote universal health care as a human right. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5892-5893). AuthorHouse. Kindle Edition.

Lack of health care access in the US violates international human rights

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

The United States is a member of both the United Nations General Assembly (1948, 2000) and the World Health Organization (WHO, 1948), both of which have declared access to health care as a human right. The failure of our government to fulfill this obligation suggests it is guilty of human rights violations because millions of Americans have been denied the human right to health care due to their restricted access resulting from their condition of being uninsured. This egregious moral failure qualifies as grounds for a complaint to both the U.S. and U. N. Commissions on Human Rights. Even the Affordable Care Act of 2010 leaves an estimated 23 million Americans uninsured, of whom about half are citizens and half are undocumented immigrants. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5920-5925). AuthorHouse. Kindle Edition.

Natural Rights

Natural Rights Good

Natural rights critical to human flourishing

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Another term for human rights is natural rights, that is, rights we can claim by virtue of our common human nature. In speaking of rights, the adjective “natural” generally refers to human nature. Natural rights are usually based on natural needs, which humans must satisfy in order to survive and thrive as living beings. For example, we have a natural/human right to sufficient food, shelter, clothing, unpolluted air and water because these are real goods based on natural needs, fulfillment of which is necessary to human existence. We cannot survive if we are deprived of these needs or rights, nor can we achieve well-being or flourish as human beings (Kraut, 2007). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5893-5898). AuthorHouse. Kindle Edition.

Natural rights are inalienable

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

A comparable theory of moral naturalism was asserted more than 200 years ago by the writers of the Declaration of Independence, when in 1776 they used the term “unalienable rights” (currently spelled “inalienable”). By definition an inalienable right cannot be given or taken away, neither transferred nor surrendered. Inalienable rights must never be relinquished, renounced, expropriated, expropriated, or abandoned. They must be secured and protected, maintained and held firmly by and for everyone, everywhere, at all times. These are absolute, definite, positive rights; inviolable and unchallengeable. More broadly conceived, inalienable rights are natural rights, intrinsic to what it means to be human—a universal human right. We can claim these rights by virtue of our human nature as members of the species called Homo Sapien—because we are human. To protect and promote natural rights is one meaning of natural law. Consequently, it would be both contrary to human nature (unnatural) and in violation of natural law to be separated or alienated from these fundamental rights. According to the Declaration of Independence a primary duty of government is to protect and promote these human rights, such as the right to life, liberty, and the pursuit of happiness. No government is justified which deprives its citizens of such rights, or if they are so deprived, the injustice constitutes warrant for reform or revolution to obtain and restore these human rights for all its residents. It was for the sake of these inalienable rights that men fought and died in the American Revolutionary War, based on the convictions that it is not longevity, but liberty that distinguishes a good life; it is not power, but justice that defines a good society. To which we might add, it is not wealth but health that enables us to pursue happiness and makes it possible to live well. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for

Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5993-5998). AuthorHouse.
Kindle Edition.

Health care is a natural right

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Health is a natural need because disease, injury, and disability impair our capacity to survive and thrive. Although most everyone wants to be healthy, even if they did not consciously desire it or acted in unhealthy ways, health would still be a natural need. Stated another way, health is not merely an apparent good we want; health is a real good we need, hence it is also a natural human right. Because effective health care is a means to protect this natural need to be healthy, it follows logically that access to effective health care is also a real good to which everyone has a human right (Adler, 1981, p. 189) Churchill (2007) construes the right of access to health care as a human right to health security. The purpose of a health care system is to promote and ensure health security. His definition of health security is as follows: the ability to live without fear that basic health needs will go unmet, and freedom from fear of impoverishment when seeking medical care. Americans should not die of treatable diseases and suffer avoidable disability, and they should not have to sacrifice food, shelter, or other necessities of life in order to obtain medical care.... . Further, affirming health security as the goal of a system leads to a deep sense of solidarity. Solidarity emerges as individuals realize that their own access to health services will not be secure unless everyone is secure. (p. 202) If we accept the argument that health is a natural human need, and secondly that effective health care is a real, instrumental good, which we need when we are seriously ill or injured, then universal access to effective health care becomes morally justified by this argument based on human need and human rights. A health care system that fails to provide equitable access to medically necessary care for everyone is unjust because it violates this human right grounded in the natural need for health, for protection from disease, and for treatment provided by the health care system. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5915-5918). AuthorHouse. Kindle Edition.

Access to health care needed to protect inalienable rights

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Health, and consequently, access to effective health care are prerequisite conditions to obtain and sustain the inalienable rights to life, liberty, and the pursuit of happiness. A corollary is that the denial of access to health care is a violation of human rights and therefore unjust. It is also contrary to this country's declaration of what it means to be a free and civilized nation governed as a constitutional democracy. It follows that it is the ultimate responsibility of the government to secure and protect the right of equitable access to medically necessary care based on natural human need. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5999-6003). AuthorHouse. Kindle Edition.

Equality in Health Care

Main Equity Contention Cards

Lack of access to insurance exacerbates social, economic, and environmental factors that create racial death gaps---the historical record proves the gap is not static, success stories can be replicated nationally.

Rust et al. 12. Professor of Family Medicine and Director of the National Center for Primary Care at Morehouse School of Medicine. 05/2012. "Paths to Success: Optimal and Equitable Health Outcomes for All." Journal of Health Care for the Poor and Underserved, vol. 23, no. 2 Suppl, pp. 7–19.

***rounded 83,570 to 80,000 for readability reasons

U.S. racial-ethnic and socioeconomic health disparities are **real, pervasive, and persistent**, but they are **not inevitable**. Some communities demonstrate relative equality in health outcomes, even when poverty and social inequities persist. Geographic variation in disparities may serve as a natural experiment which shows critical elements and common pathways to success for communities which have moved toward greater health equity. Instead of getting stuck on what are the causes of health disparities, we propose a very different question to guide our work—What has already been successful in decreasing health disparities in real-world communities, and how could we replicate and expand these patterns of success to a nationwide scale? Go to: The Problem In the year 2000, Black-White disparities accounted for over 83,570 [80,000] excess deaths each year. Black-White mortality rate-ratios have not changed significantly over the past half-century, despite dramatic improvements in civil rights and economic opportunity.¹ The Black-White neonatal mortality rate increased from a 20th century low of 1.4 in 1946 to 1.7 in 1958, where it plateaued until increasing to 2.5 between 1971 and 1992. It has averaged 2.4 since then.^{2,3} To put this in human terms, eliminating the Black-White infant mortality gap nationwide could save a hundred African American babies every week. On other measures, disparities are more widely distributed. For example, Hispanic and Latino populations experience diabetes complications such as leg amputations and retinopathy at rates at least twice that of non-Hispanic Whites. American Indians and Native Alaskans have the highest death rates due to sudden infant death syndrome (SIDS), and the second highest rates of diabetes-related deaths.^{3,4} Disparities in the Asian population are often overlooked because of a lumping of various Asian communities into one artificial racial grouping. Asian Indians have higher odds of physical inactivity and diabetes than Whites, while Filipino individuals are more likely to have hypertension.⁵ Cervical cancer and hepatitis C rates also vary widely from one Asian group to another. Inequities also occur along socioeconomic lines.⁶ Lower socioeconomic status (both at the individual person and community levels) is associated with higher all-cause mortality and cause-specific mortality rates.^{7,8} The prevalence of multiple risk factors for heart disease and stroke is highest among people with the lowest household incomes (52.5%), and almost twice as high as the prevalence of those with the highest household income (28.8%).⁹ Individuals who are uninsured are substantially more likely to be hospitalized for a preventable condition,^{10,11} or to be diagnosed with a later-stage cancer.^{12,13} Regardless of income level, lack of health insurance is associated with decreased use of recommended health care services for cancer prevention, cardiovascular risk reduction, and diabetes management.¹⁴ There are also substantial disparities within disparities. For example, the strongest modifiable predictors of health care utilization for African-American persons in 1999 were whether or not individuals had health insurance and/or a usual source of care. These factors accounted for up to six-fold differences in utilization of doctor's office visits and prescription medication.¹⁵ While socioeconomic inequalities contribute to racial/ethnic inequalities, they are not the sole cause. For example, there are persistent disparities in treatments offered and delivered to patients based on race and gender.¹⁶ Standardized clinical scenarios in a simulated video experiment demonstrated bias in cardiac interventions based solely on race and gender of the patient.¹⁷ Our studies in the Medicaid population have demonstrated racial and ethnic differences in rates of treatment for influenza, HIV-AIDS,

Medicare For All Master File

depression, and the pain of labor and delivery, despite similar poverty levels and identical health insurance coverage.^{18–21} Even for college-educated African American women, birth-outcomes are significantly worse than among similar White women.²² Therefore, it is important to identify, monitor, and address both socioeconomic and racial/ethnic disparities simultaneously to achieve total health equity for the entire population. Go to: Reason for Hope Despite the persistence of disparities at a national level, more fine-grained analyses demonstrate that trends in disparities are not static. For example, Black-White mortality rate-ratios improved significantly for women from 1960–2000, but this was offset by a worsening of inequalities in health outcomes among men.¹ The conscious exclusion of non-disabled men from Medicaid and social welfare programs, plus high rates of unemployment and incarceration, have had a devastating impact on the health status of African American men.²³ In contrast, the combination of programs targeting women (especially those with dependent children) ranging from Medicaid to WIC to AFDC/TANF, combined with gains in employment and income levels for African American women relative to White women, all may have contributed to significantly decreased health disparities for women. Specifically from 1960 to 2000, Black-White mortality rate ratios decreased from 3.2 to 2.2 for women age 25 to 34 and from 2.5 to 1.6 for women ages 55–64. Disparities are not inevitable. Policies, programs, and other factors do matter, and can influence health equity both positively and negatively. Another notable but less well understood success in the elimination of disparities is reflected in alcohol-related mortality trends. From 1979 to 2007, these declined from age-adjusted Black:White mortality rate-ratios of 2.8 to 0.8 for adult women and 2.7 to 0.9 for adult men. Does this reflect more accurate recording of a potentially stigmatizing cause-of-death for Whites, or is it a true success story in the elimination of disparities? If so, how was equality achieved? There is also wide variation in the level of disparities from one local community to another, demonstrating that success is possible, and perhaps providing models for what such successful communities might look like. Some communities even show paradoxically good outcomes and relative health equity despite significant social inequities. In other words, there are community-level strategies that can mitigate the most harsh health effects of poverty and social inequality. In our Georgia Health Disparities report, we analyzed disparities in seven domains at the county level in each of Georgia's 159 counties. Some counties showed no racial disparities in health outcomes at all. Although socioeconomic inequalities were predictive of health outcome disparities in two-thirds of Georgia's counties, there were 28 counties in which broad measures of minority health outcomes were paradoxically good (minimal health disparities despite major social inequalities). Conversely, 23 counties had minority health outcomes that were worse than socioeconomic indicators would have predicted.²⁴ Levine,^{25–27} Fry-Johnson,²⁸ and Pisu²⁹ have explored such variations in overall mortality and mortality from breast cancer, HIV-AIDS, and infant mortality. Four patterns of Black-White outcomes as measured by mortality rate ratios (MRRs) have been observed, including places with high Black and White mortality rates and low Black:White ratios (i.e., equally bad outcomes), low Black and White mortality rates with Black:White equality (optimal and equitable outcomes), high Black and low White mortality rates with high MRRs (high-disparity with bad outcomes disproportionately affecting Blacks), and low Black and high White mortality with MRRs under 1.0 (reverse disparity). Disparities in mortality are clearly not the same in every community. Interestingly, the successes reflected in low Black mortality rates have not been restricted to wealthier counties or those without socio-economic inequities, suggesting that some communities may have mitigated negative social determinants and may demonstrate key elements of more healthy, successful, or resilient, communities. These hypotheses are testable in mixed-methods research, which would combine quantitative analytic epidemiology with qualitative investigations of social, cultural, and contextual factors. Where communities have achieved success, we must ask, Why? Go to: Paths to Success for Overall U.S. Health What might be the components of achieving such success? We have previously published analyses demonstrating the essential components that have led to success in most of the major breakthroughs in U.S. health status, as measured by substantial reductions (more than 50%) in mortality rates within leading causes of death over the past 50 years.³⁰ We were able to identify innovations that enabled these successes, and then to identify mechanisms of diffusing those innovations to achieve survival success. We now must find similar paths to success for achieving health equity. The triangulating on success model (research innovation spread through dual-channel diffusion of public health plus medical care) has both advantages and disadvantages. On the one hand, it explains America's success for seven of nine leading causes of death that have seen a 50% mortality reduction in the past 50 years (Table 1). The model also reminds us that all three stakeholder groups—researchers, public health professionals, and medical practitioners—share a success story and have a common stake in improving health outcomes for the American people, but must increasingly work together in common purpose, in partnership rather than in parallel. On the other hand, many of these seven success-story categories of disease are the very conditions which have seen widening disparities, because life-saving innovations do not appear to diffuse equally through all segments of the population.³¹ Specifically, Phelan et al. have shown that disparities in mortality are greatest for those conditions we know most about treating and/or preventing.³² In general, advantaged segments of the population may adopt lifesaving innovations more quickly and more completely than disadvantaged communities. While social determinants provide a root cause explanation of health disparities, the cure is not always the inverse of the cause.

The path out is not always the same as the path in. Identification of **paradoxically successful** (positive deviance **communities**) and **replication of their protective resiliency factors**, along with equitable diffusion of effective innovations, **may be another path to success**. Go to: Paths to Success for Eliminating U.S. Health Disparities Is there a path to success for communities currently afflicted with exceedingly disparate health outcomes? The **Madison, Wisconsin** (Dane County) **experience exemplifies a community that achieved success in moving the needle from high disparity** infant mortality **rates to dramatically better Black health** (IMR) **outcomes**, ultimately resulting in the **complete elimination of the Black-White gap**. According to the CDC's Morbidity and Mortality Weekly Report, Wisconsin had the **highest Black infant mortality rate** in the nation (17.6 deaths per 1,000 live births), approximately **three times the state rate for Whites** in 2002–2004. However, in contrast to other states and other metro areas of Wisconsin, **the Black infant mortality rate in Dane County dropped 67%** (Fig. 1), **from 19.4 per 1,000 live births in the years 1990–2001 to 6.4 per 1,000 in 2002–2007**.³³ These results must be viewed with cautious optimism at this time, as they represent a reduction of only about three infant deaths per year. Even so, the decrease in mortality is tied to two related trends affecting many more infants, e.g., a decrease in the occurrence of births of very low birthweight (VLBW) Black babies (less than or equal to 1500g) from 391 per 1000 live births to 154 per 1000 (61% decrease), and a decrease in the number of extremely preterm births (less than or equal to 28 weeks estimated gestational age) among Black or African American women from 2.8% to 1.1%. Some elements of the interventions that contribute to this success are known, but the full picture is not clear. **The New York Times contrasted the experience of one young mother in Madison (Dane County) with her previous pregnancies while living in Racine**, which still has one of the highest Black infant mortality rates in the country. This mother **specifically mentions** both home **visits by county public health nurses** and increased **social support** from her local church. Additional factors include **a legal advocacy group** assisting with housing and Medicaid issues, **and a community health center** with a robust cadre of nurse-midwives providing relational pre-natal care. Referrals to medical, dental, and mental health services are coordinated. **Transportation and social work support are also provided, including assistance with education and employment**. The county public health director says, "I think it's a community effect. Pregnant women need to feel safe, cared for and valued."³⁴[p.A-20] **The Dane County example highlights the need to coordinate public health, health care delivery, and social supports** (both concrete services and relational support) **to achieve optimal and equitable health outcomes**. **Somehow in Dane County the multi-dimensional interventions have reached critical mass and completely reversed the Black-White disparities, rather than incrementally or partially reducing them**. In biologic ecosystems this would be called **hysteresis, a tipping point** of sorts **when multidimensional changes combine to achieve a rapid reversal of alternative "steady-states."** Much research is needed to see if this reversal of disparities will be stable over time, and whether hysteresis is demonstrable in other communities—if so, it would define at least one path to achieving health equity. How do we learn from such success stories? Surveillance to identify paradoxically successful communities (health equity despite persistent social inequalities) must be followed by qualitative follow-up to ask the why and how questions. What worked? Nobel laureate Amartya Sen has shown in the Kerala India model that **disparities are neither inevitable nor deterministically associated** with poverty.^{35,36} One strategy for seeking wisdom from such positive outlier communities and applying it to less successful or resilient communities can be found in the Positive Deviance model, which has demonstrated impact on issues as diverse as education, nutrition, health, and child endangerment in more than fifty countries across six continents.³⁷ **There is likely no single magic bullet for eliminating most health disparities. Different communities may require different interventions, but these interventions are typically multi-dimensional and focus on multiple levels from person to system to community.** Research is also needed to see if results in one community are replicable in other high-disparity communities, and if so, whether the model will be scalable to a broad range of communities across the nation. **Can we take such solutions to scale? Can we reduce disparities at a state or regional level?** Childhood immunization rates have improved nationwide, but regional differences in disparity trends suggest that state-level and local implementation matters. For example, the Black-White immunization gap narrowed significantly in the Midwest region among non-poor children between 1998 and 2003, even as the gap widened in the Northeast region. Graphs of the disparity rates in these two regions literally crossed each other during that six-year period, with the Midwest Black-White rate ratio dropping over 75% from 13.9 to 2.5 even as the Northeast region saw a dramatic increase in Black-White disparities (0.5 to 15.5).³⁸ Such large-scale success appears to require multi-level intervention addressing downstream, midstream and upstream levels of involvement of the individual, community, and policymakers, all at the same time.^{39,40} Is such success scalable to a **national level?** Within the medical care arena, quality of care **differences** cited in the Institute of

Medicine's Unequal Treatment report¹⁶ persist, but are perhaps mitigated in settings which have consciously sought to improve care for the underserved. There is some evidence to suggest that practices proactively serving high-disparity segments of the population (e.g., community health centers and Veteran's Health Administration sites) actually achieve lower disparities or near-equal care across racial strata of their patients, even though they both serve disproportionately low-income and minority (i.e., high-disparity) populations.^{41,42} Shi's study of the 2003 National Health Care Disparities Report and the 2002 Community Health Center (CHC) User Survey found that patients of federally qualified health centers experienced fewer racial/ethnic and socioeconomic disparities in access and quality of care compared to patients of non-CHCs.⁴³ In a separate study of the Veterans Administration Health System, McGuire et al. found that implementation of community-based primary care clinics decreased access disparities to VA services for homeless veterans with serious mental illness.⁴⁴ Rehman found that the ethnic disparity in BP control between African Americans and Whites was approximately **40% less at VA than at non-VA health care sites.**⁴⁵ The American Heart Association's Get-with-the-Guidelines program on treating coronary artery disease provides one example of how to transfer these lessons learned into the private sector or into the broader health care system. They report the elimination of treatment disparities in acute myocardial infarction, achieved by adopting critical paths and standardized processes of care, along with explicit surveillance of minority health outcomes and disparities.⁴⁶ Elimination of variation to make excellence automatic may provide a de facto elimination of racial health disparities, but explicit surveillance of disparities is needed to assure equitable outcomes. The Higher Path So how do we improve health outcomes without exacerbating health disparities? The path is clear—focus on improving overall U.S. health outcomes precisely by expanding achievable health gains to all segments of the population. Elimination of the Black-White mortality gap, for example, would save 83,000 lives per year in the U.S. Elimination of the Black-White infant mortality gap could save roughly 100 infants every week in America and add more than 390,000 years of potential African American life each year. Evidence is mounting that communities can indeed move from disparities to equity, even on measures as resistant to change as the Black-White infant mortality gap. The bottom line is that achieving health equity is the most direct path to radical improvements in U.S. health status. Woolf et al. demonstrated that the number of lives saved by medical advances averted 176,633 deaths between 1991 and 2000, but that equalizing the mortality rates of Whites and African Americans would have averted 886,202 deaths.⁴⁷ The authors conclude that "achieving equity may do more for health than perfecting the technology of care."⁴⁷[p.526] Thankfully, we do not need to choose one or the other, but instead may achieve both optimal and equitable health outcomes by distributing lifesaving innovations equally to all Americans.

Robust statistical research verifies the impermanence of disparities.

George Rust **17.** George Rust is with the Center for Medicine and Department of Behavioral Sciences and Social Medicine, Florida State University College of Medicine. 03/2017. "Choosing Health Equity: Investing in Optimal and Equitable Health for All." American Journal of Public Health, vol. 107, no. 3, pp. 361–363.

Health equity is a choice. Worldwide, humanity is consciously choosing to make progress toward health equity. The World Health Organization has reported more than a 50% reduction in under-five child mortality since the year 2000. The Lancet Commission's Global Health 2035 report asserted that, with strategic investments, nearly all countries could achieve "a grand convergence in health within a generation," reducing maternal-child deaths in high-mortality countries to the levels of the best-performing middleincome nations by 2035.¹ The World Health Organization has similarly endorsed the Sustainable Development Goal of eliminating preventable deaths of infants and children under age five years. WHAT IS A STRATEGIC INVESTMENT? Spending money does not automatically buy better health outcomes. In an American Journal of Public Health report published in 2014, Barthold et al. found "robust differences" among Organization for Economic Cooperation and Development (OECD) nations from 1991 to 2007 in the efficiency of their health spending, as measured by life-expectancy improvements achieved for each one percent increase in annual health care expenditures.² The United States ranked poorly in these international comparisons, ranking number one in per capita health expenditures, but 19th among OECD nations in the translation of spending into increased OECD life expectancy. The human return on US health dollars invested was only one fifth to one sixth that of Germany and Switzerland. A most basic choice is total spending. Budhdeo et al. showed that a one percent decrease in health care spending in European Union countries was associated with short- and long-term increases in mortality across a wide range of age–gender groups.³ How the money is spent also matters. Among nations, greater public-sector spending had far greater impact on survival than total spending, and up to a certain level, publicsector government spending was significantly more efficient.⁴ The United States continues to be the outlier in these international comparisons. The moral choice to favor health care

provider autonomy and free market economics over the collective good provides an ongoing demonstration of the US capacity to achieve market fragmentation and collective inefficiency in spending. A related outcome is the persistence of gaping inequalities in health care access and health outcomes, which exact not only a human cost, but also a significant and avoidable economic burden. ELIMINATING HEALTH DISPARITIES Eliminating health disparities and making progress toward health equity comes down to a series of choices. Expanding Medicaid and providing health insurance subsidies in the Affordable Care Act were small steps toward the progressive universalism that is necessary but not sufficient for ensuring population health. Repealing only those portions of the Affordable Care Act preferentially supporting the poor while maintaining only the provisions supported by families already able to purchase health insurance for themselves and their families will be a decision to move away from health equity, a choice violating the moral principles of justice and nonmaleficence. Even so, we can choose to make progress on racial/ethnic disparities in health outcomes. Fuchs recently documented mounting evidence of Black gains in life expectancy, and even greater gains among lower-income segments of the Black population.⁵ More than a decade ago, under the intellectual and moral leadership of David Satcher and Robert Levine, our team at the National Center for Primary Care at Morehouse School of Medicine dared to imagine, “What if we were equal?”⁶ We demonstrated that although Black–White disparity rate ratios had changed little over the decades from 1960 to 2000, the 40-year flatline was actually the average of significant reductions in Black–White disparities for women and increasing disparities for men. The choices we made as a nation mattered. Black women’s income as a percentage of White women’s increased significantly, even as antipoverty programs explicitly favoring women and children (the Special Supplemental Nutrition Program for Women, Infants, and Children; Medicaid; family planning; etc.) were being implemented. Black–White disparities for women declined. At the same time, our nation chose to systematically exclude men from these same programs, and to disproportionately incarcerate Black men, exacerbating male Black–White mortality disparities. Research on local-area variation in disparities shows that some communities are moving toward more optimal and equitable health outcomes without necessarily making conscious choices to pursue health equity or even being aware of their own progress. We have documented US counties that have moved from high levels of racial disparity to near equality in measures ranging from infant mortality to breast and colorectal cancer mortality across the entire population, as well as significant county-level variation in racial disparities in the low-income Medicaid population for conditions ranging from asthma to HIV. At the root of health disparities are social determinants. When policy decisions and systems combine to increase inequalities in equity. Behavioral health. Resiliency. Social cohesiveness. All of the above. Many income, wealth, and opportunity, they represent an explicit choice to move away from health equity. Even so, social determinants are not entirely deterministic, and demographics are not destiny. Levine et al. found 66 counties in the United States [have] with lower Black male mortality rates than the US average White male mortality rate, with no significant difference in Black–White poverty rate ratio or residential segregation index.⁷ Perhaps we can find replicable paths to health equity by learning from these positive outlier communities that have succeeded in making a way out of no way. The road out may not be the same as the road in. PROMOTING INTEGRATION It will not be easy. There are highly complex, bidirectional associations among upstream, midstream, and downstream factors driving disparities. No single intervention will produce health equity. We must consciously connect our efforts across sectors to achieve collective impact. We must become a cohesive and effective movement, promoting integration and managing the in-betweens of all sectors. Medical care. Public health. Community leadership development. Income equality. Economic development. Wealth equality. Educational communities have individuals or agencies working in each of these areas, but let us ask—whose full-time job is it to build the coalitions, to maximize collaboration, to deepen partnerships, to measure collective impact, and to create structures for mutual accountability on the specific objective of health equity? Who is actively measuring and reporting explicitly on progress toward equality of health outcomes and social determinants repeatedly in real time, to energize rapid cycle improvement across entire communities and nations? Global health research and US health equity research alike suggest that population health and economic efficiency are not incompatible. They are

mutually reinforcing. We can choose both health equity and economic efficiency by demanding the most effective human return on investment (whether measured as improved survival, or decreased suffering, or best possible health) for the greatest number of people—in other words, committing to spend every dollar efficiently to achieve optimal and equitable health outcomes for all. Other nations are achieving much higher economic efficiencies and much better health outcomes by using public-sector investments for the collective good. So let us choose to spend our money wisely. Let us demand the greatest human return on investment for every dollar we spend. Let us pursue optimal and equitable health outcomes for all with precise economic efficiency. We can achieve health equity—if we choose to.

Multiple, NOT root, causality best explains healthcare outcomes---NOR is any single cause prior to others---instead, they are concurrent and inextricably joined---assertions otherwise are unwarranted hubris.

Nancy Krieger & George Davey Smith 16. Department of Social and Behavioral Sciences, Harvard T.H. Chan School of Public Health, Boston, MA, USA and, 2 MRC Integrative Epidemiology Unit at the University of Bristol. 09/30/2016. “The Tale Wagged by the DAG: Broadening the Scope of Causal Inference and Explanation for Epidemiology.” International Journal of Epidemiology, p. 1-22.

Clarifying causation: the case for pluralism Before jumping into the epidemiological evidence, some clarifications are in order. First, we recognize that debates about what constitutes ‘causation’ and demonstrating its existence have a long history—at least a few millennia!⁴³—and we obviously will not resolve these controversies in one essay. Second, our vantage is as pluralists: both about causality and about evidence,^{44,45} and we explain below what this entails. Third, our motivation to enter this debate is because we want to strengthen epidemiological science and its capacity to contribute usefully to the multisectoral work urgently needed to improve population health and reduce, if not eliminate, health inequities.^{16,17} In brief, within philosophical discourse the lack of a single theory or definition of ‘cause’ is widely recognized, as is the notion that there is not just one method to identify causal processes and effects.^{37–46} Two recent reviews, for example, have helpfully clarified^{44,45} that not only are there five families of “standard view” on causality”—i.e. ‘regularity, counterfactual, probabilistic, process/mechanist and agency/interventionist’ (p. 769),⁴⁵—but also that, for research conducted as guided by any of these ‘views’, there also exists ‘evidential pluralism’, referring to how ‘evidence of a variety of kinds—say, probabilistic, mechanistic, regularity—can bear on a causal hypothesis and strengthen it’ (p. 27).⁴⁴ The implication is that ‘triangulation’ of evidence ‘from a number of independent methods’ is one and perhaps the only way to be reasonably confident about the truth of the hypothesis’ (p. 27).⁴⁴ Among the many reasons triangulation of evidence based on data from different contexts is important is recognition that the longer the causal ‘chain’ or the larger the causal ‘network’, the more likely that context-dependent effects are large enough to matter, implying that the observed ‘effects’ may be historically contingent.^{37–47} Suggesting that these are practical, not esoteric, concerns, UNAIDS in 2010 released a guide titled An Introduction to Triangulation⁶⁰ as part of their ‘monitoring and evaluation fundamentals’ series. Intended to improve the monitoring of and societal response to, the HIV epidemic and other health outcomes, the booklet reviews the strengths and limitations of four widely used types of triangulation: ‘(1) data triangulation; (2) investigator triangulation; (3) theory triangulation; and (4) methodological or method triangulation’ (p. 14),⁶⁰ and further provides diverse empirical examples of why all four types of triangulation are necessary, since no one approach can guarantee robust causal inference. In our section on empirical examples, we provide concrete illustrations as to what such ‘triangulation’ can entail for epidemiological research. Causal questions and answers, and hence inferences, may further depend on spatiotemporal scale and level.^{14,17,37–45} Consider the classic question posed by the neurobiologist Steven Rose: what caused the frog to jump? (pp. 10-13)⁶¹ At the fast-and-tiny molecular level, an answer might be: the reaction of actin and myosin within a muscle cell. At the much slower and bigger level of organisms, an answer might be: the frog saw a snake and jumped in order to avoid being eaten. At the long-term and still larger level of species, still another answer might be: evolutionary processes leading to co-evolution of frogs and snakes as prey and predators in ecosystems affording niches for them both. Analytically distinct, all three answers are not only valid: they are concurrent, not sequential, inextricably embodied and joined in the instant that the frog jumps.⁶² The same causal parsing applies to epidemiological outcomes, as per the example of adiposity and cardiovascular mortality.^{63,64} Thus, in a single instance, a death due to cardiovascular disease and cardiovascular mortality rates may be caused by individuals’ adverse

physiological and metabolic profiles (e.g. high blood pressure, high lipids) and by the sociopolitical and economic conditions that drive both the political economy of 'Big Food' and population distributions of risk of weight gain and inadequate medical care.^{54,56,65,66} Such a view expands options for different levels and types of

preventive interventions. For persons already with high adiposity, population research at the molecular and physiological levels suggests that causal links between adiposity and risk of death due to ischaemic heart disease can be alleviated, if not completely broken, by intervening pharmacologically, physiologically or through individuals' behaviour changes, on such biological parameters as lipid profiles and blood pressure.^{67,68} Additional research at the societal level points to the necessity of structural interventions to promote healthy ways of living, premised on conceptualization of food security and sustainability as a human right, as opposed to treatment of food as primarily a for-profit commodity, so that all people can have access to affordable, nutritious and pleasurable meals.^{54,65,66} The point is both/and, not either/or. Moreover, demonstrating that epidemiologists' concerns about narrow renderings of 'causation' that omit societal causes is not new, Textbox 1 presents an analogous 'fable', published shortly after the end of World War I by the epidemiologist F.G. Crookshank (1873-1933), in an essay titled 'First principles: and epidemiology', in which a single-minded police surgeon avers that if the cause of death by murder is a bullet, then the cause of death by war is many bullets (and sometimes also poisonous gas).⁶⁹ To Crookshank, it was ludicrous to posit that germs alone were the single 'true cause' ('causa vera') of epidemics and the only legitimate target of both inference and intervention; instead, for both war and epidemics, there could be no avoiding of discussion of 'racial, economic, or political conditions', not simply as 'predisposing factors' but as causes in their own right.⁶⁹ Social and political challenges to vaccine distribution, e.g. for polio, measles and human papilloma virus (HPV), serve to underscore this point.⁷⁰⁻⁷³ Of course, as with counterfactuals, the danger lies in where one draws the line, to avoid infinite regress as to the number of factors that need be considered.

Continuing the military metaphor, Figure 2 shows an alarming example of the ultimate arrow salad—or spaghetti: a PowerPoint slide prepared in 2009 about US military strategy in Afghanistan.^{74,75} Even Crookshank might have been daunted. Causal judgments: inference to the best explanation Fortunately, recent work on 'inference to the best explanation' (IBE), especially as articulated by the philosopher Peter Lipton (1954-2007),^{42,76,77} can provide epidemiologists—and other scientists—with an alternative cogent, historically grounded, conceptual approach to thinking about, sorting through, and arriving at robust explanations.^{5,42,45,48,49,78-80} Curiously, although epidemiological research has been integral to Lipton's arguments—as per his analysis of Ignaz Semmelweis's 1844-48 research on childbed fever (pp. 74-90)⁴² (see Textbox 2)—discussion of IBE in the epidemiological literature is surprisingly limited^{5,48,49,80} and nowhere to be found in many leading epidemiological publications on causal inference.^{1-4,6,7,30,32,35} What, then, is IBE? As explained by Lipton and other philosophers of science, IBE is a type of reasoning widely used by scientists (and most people in everyday life).^{42,76-79} It is also increasingly viewed by philosophers and historians of science as being, in the words of Douven, the 'cornerstone of scientific methodology' and also 'medical diagnosis',⁷⁸ with the latter notably and necessarily requiring cross-level inferences bridging from knowledge about unique individual patients to grouplevel regularities.⁸¹ IBE's primary concern is explanation, an expansive task that requires critical reasoning about extant (and missing) evidence and competing hypotheses that could explain the evidence. Reliant on one type of inductive reasoning, variously termed 'abduction' or 'defeasible' reasoning (see Table 1 for definitions),^{42,78,79,82} IBE does not and cannot afford the same pristine certainty provided by deductive reasoning, whereby the conclusion logically must be true if the premises are true (e.g. Sam is a person, all people are mortal, therefore Sam is mortal). Though this might seem a drawback, contemporary scholarship increasingly demonstrates that IBE far better reflects the actual practice of science, advances in scientific explanation and successful implementation of what has been learned, in such diverse fields as the physical, biological, epidemiological, clinical and social sciences, as compared with the idealized hypothetico-deductive approach^{37-42,76-79,82} which over the past 30 years has been variously lauded,⁸³⁻⁸⁶ rejected^{87,88} and accepted in modified form^{89,90} in the epidemiological literature. In brief, the essence of the IBE approach is to 'think through inferential problems in causal rather than logical terms' (p. 208)⁴² and to employ a 'two-stage mechanism involving the generation of candidate hypotheses and then selection from among them'.^{42, (p. 208)} IBE is thus driven by theory, substantive knowledge, and evidence, as opposed to being driven solely by logic or by probabilities. Absolute Cartesian scepticism is rendered moot, since the emphasis is on the best explanation, as opposed to the conjuring of any explanation however improbable (or useless).⁷⁸ Nor is IBE hobbled by a common problem that deductive reasoning cannot resolve: how to evaluate competing hypotheses when none are logically refuted by the extant evidence (p. 452-453)⁷⁶; for examples, see Textbox 2 regarding Lipton's analysis of how Semmelweis adjudicated between such competing hypotheses regarding cause(s) of childbed fever. Guiding choice among explanations for IBE is a contrastive approach geared to identifying what Lipton has termed the 'loveliest' as opposed to merely 'likeliest' hypothesis, whereby criteria for 'loveliest' include: 'scope, precision, mechanism, unification and simplicity' (p. 423)⁷⁶; 'prediction' does not garner special consideration because opposing hypotheses may still both predict a given phenomenon (e.g. disease rates higher in groups exposed vs not exposed to X), but not be equally 'lovely'. Moreover, by emphasizing the need to test aptly chosen contrastive hypotheses, the IBE approach (per the examples provided in Textbox 2 for childbed fever) provides guidance for explanatory causal reasoning that goes beyond listing whether the evidence is, minimally, coherent (as per the Hill criteria).^{42,76,77} IBE is additionally highly attuned to contextual knowledge, and hence to the claims involved when assertions are made about 'all else being equal'—whether via experimental design or statistical 'control'.^{46,47,78,79} It thus underscores the inevitable reliance, for good or for bad, upon scientific judgment. From the standpoint of IBE, 'causal inference' cannot be reduced to what the philosopher Stathis Psillos has termed 'topic-neutral and context-insensitive' algorithms (p. 441)⁷⁹, whether involving deductive logic or Bayesian statistics. Core to IBE is the understanding that there are no clear-cut rules or short cuts that minimize the need to amass substantive expertise and to generate and think critically about contrastive hypotheses—

but nor is it the case that ‘anything goes’. Stated another way, IBE clarifies that data never speak by themselves—either to computer algorithms or to people—and nor do beliefs about probabilities simply drop from the sky. Active scientific judgment is inevitably involved, with regard to who and what is included and excluded. Scientists accordingly are enjoined to think about the full range of evidence, not just data germane to one specific hypothesis, and also to test hypotheses with diverse sets of methods whose assumptions are uncorrelated, so as to strengthen causal inference^{5,42,45}—a point we discuss further in relation to the empirical examples we next analyse. Although epidemiologists have long been aware of the need to compare data across the proverbial ‘time, place, and person’^{5,12–14,91} (or, rather, social group¹⁷), the emphasis on comparison across methods and causal inference frameworks is more recent.^{5,42,45} IBE further points to the necessity of eschewing the hubris of assuming that scientists can exhaustively delineate the profound complexity and quirkiness of the biophysical and social worlds in which we live, a world in which unanticipated discoveries of unimagined phenomena and causal connections are as much the rule as they are the exception.^{16,17,37–42,47,76,77} One would need infinite knowledge, after all, to generate an exhaustive list of all conditions or factors that would ensure such assumptions as ‘other things being equal’ or ‘other things being absent’. Who would have thought for example, before work

conducted in the past decade, that olfactory receptors in both humans and other species occur in just about every organ including our skin, and are not just restricted to the nasal passage?^{92,93} Although the issue is far from closed, an explanatory reframing of these receptors as specialized evolved chemical detectors, not solely for smell, notably opens up a previously untheorized biological possibility, one with potential epidemiological as well as clinical relevance. An analogous case, relevant to cancer and cardiovascular disease, has been the explanatory reframing of estrogen from being a molecule primarily or solely preoccupied with ‘sex’ and reproductive tissues to being a steroid involved in cell growth and apoptosis throughout the body,^{94,95} with the expression of estrogen receptors being both tissue-wide and highly responsive to exogenous stimuli.^{96–98} Different conceptualizations of key parameters and different explanations entail different scientific programmes and different interventions, one of the many reasons that debates over causal inference are so charged. Seeking explanations: epidemiological examples We now redirect our focus to three concrete epidemiological examples. Our purpose is to show why we cannot restrict the work of causal inference to solely a counterfactual approach, and why we may well do better to rise to the challenge of attempting to infer the best explanation. What a DAG cannot discern: the case of pellagra We start with a seemingly simple yet informative example: explaining why rates of pellagra were high among children in the US South who were institutionalized in orphanages in the early 20th century, as compared with other children in the region who were not institutionalized.^{99–104} During this period, major debates within and across causal levels raged over whether pellagra—a disease whose prevalence was known to be both high and seasonal among people whose diet was primarily based on corn—was caused by an infectious agent, a fungus, stress, heredity or even capitalism itself.^{99–105} Why the association between institutionalization and the disease? The two leading hypotheses involved the same causal elements, but the arrows pointed in entirely opposite directions. The ‘germ theory’ hypothesis held that children who came to orphanages had a higher rate of infection, which they then more readily transmitted to other children within the crowded orphanages (but then: why did the staff not also get ill?). The contaminated food hypothesis held that the institutions caused the higher rates of pellagra because they served tainted food, i.e. contaminated corn mush (but then why did staff, who sometimes also ate the corn mush, not get ill?).¹⁰¹ The ‘stress’ and ‘capitalism’ hypotheses^{99,100} although perhaps accurately identifying causes and aspects of the plight of institutionalized children, nevertheless did not explain why institutionalized impoverished children everywhere did not get pellagra. Both hypotheses could be represented by a DAG including the same elements, but with causal arrows in the reverse direction. To resolve these conundrums, Joseph Goldberger devised an entirely new hypothesis: institutions caused the higher rates of pellagra because they served deficient food, whereby the orphanages fed children a poverty diet of corn mush supplemented by little else (whereas the staff ate not only the corn mush but also other more nutritious food, thereby preventing pellagra)^{99–104}—and he conducted experiments with people (including himself, relatives, colleague, and prisoners) and animals to test his hypothesis.^{99–104,106,107} Later research revealed the missing factor was niacin, i.e. Vitamin B3.¹⁰⁴ Of note, Goldberger’s hypothesis used the same three key variables (‘orphans’, ‘institutions’, ‘pellagra’) employed in the two dominant rival hypotheses (‘germ’ and ‘contamination’) but utterly transformed understanding of the causal relationships at play by introducing into the equation what was then a new way of thinking about aetiology: disease arising from deficiency, not excess. His alternative hypothesizing thus would yield a DAG with the same anchoring elements but totally different causal pathways, reflecting a new understanding of mechanisms of disease causation. Goldberger’s hypothesis, initially ill-received and unlikely, thus had to battle for recognition—and among the three it was also, in Lipton’s terminology, the ‘loveliest’. Why? Because, as Goldberger and his colleague Edgar Sydenstricker¹² emphasized at the time^{108–110} it explained not only: (i) who did and did not contract pellagra at the orphanages; (ii) the seasonal nature of the disease (as tied to when money for varied foods ran out, after the harvest season, among impoverished sharecroppers in the US South, leading to a diet of primarily corn mush leavened by some pork fat and perhaps a few greens); but also (iii) why the disease was so common in the US South among impoverished (and/or institutionalized) persons, but was not so common among impoverished (and/or institutionalized) persons in the US North (because the former relied far more heavily than the latter on corn mush diets).^{99,106,108–110} Granted, Goldberger’s hypothesis was not popular among US Southern politicians or public health officials.^{99–104} Why? Because it placed blame on not only the orphanages but also the structural institutions that protected sharecropping and high rates of southern poverty.^{99,100,110} To Goldberger and Sydenstricker however, understanding the interplay of causes across and within levels was essential for effective action in public health^{12,99,100,110}—a truncated account would not suffice. One final useful point raised by the example of pellagra concerns why technical manipulability should not be confused with causal powers. Thus, whether or not people had 10 International Journal of Epidemiology, 2016, Vol. 0, No. 0 at University of Hong Kong Libraries on October 1, 2016 <http://ije.oxfordjournals.org/> Downloaded from the technology to isolate and manipulate levels of Vitamin B3, its absence and presence still produced causal effects. Nevertheless, using a mixture of observational and experimental epidemiological evidence along with a hefty dose of theorizing informed by deep knowledge of infectious disease epidemiology, Goldberger was able to arrive at a pragmatic causal explanation that, using Susser’s causal lexicography, got it ‘right enough’¹⁴ to enable important effective preventive interventions to be implemented.^{99–104,106–110} When is a methodological solution not the answer: using biology and ‘triangulation’ to parse the puzzle of smoking, infant mortality, and the ‘birthweight paradox’ Next, we consider an example where it may be that the reasoning encoded in DAGs may have initially appeared to solve a paradox, only for further work to clarify that the proposed solution potentially may not be a satisfactory—or indeed ‘lovely’—deep explanation. The case is that of the well-known ‘birthweight paradox’, which first garnered attention in the early 1960s as part of the disputes (fueled by tobacco company funding^{22,23}) over whether smoking harms health.^{111,112} In brief, the apparent paradox was then (and remains now) that although the average birthweight is lower for liveborn infants exposed vs not exposed to tobacco smoke as fetuses, nevertheless the infant mortality rate among low-birthweight infants is higher among infants unexposed vs exposed to tobacco smoke when in utero^{111–114} The counterintuitive implication is that maternal smoking is protective for infant mortality for liveborn low-birthweight infants. Over the past 40 years, many rounds of arguments have appeared in the pages of many journals, offering diverse appraisals as to whether the ‘paradox’ is ‘real’, as opposed to an artefact created by selection bias, choice of wrong referent or ‘at risk’ groups (e.g. fetus vs liveborn infant), etc.^{111–118} As interest in using DAGs in epidemiology began to rise in the early 21st century, this ‘paradox’ not surprisingly presented itself as a ripe candidate for analysis. The first round of papers using DAGs to address this paradox generally concluded that ‘collider bias’, i.e. introduction of confounding by an unmeasured factor due to stratifying or conditioning on an intermediate factor (in this case birthweight), is the cause of the apparent ‘paradox’.^{114,116,117} The take-home message of these papers is that the paradox is resolved: the problem has been dealt with by appropriate methods. In other words, the explanation to explain away the observed association as a consequence of bias induced by faulty methods. But is this apparent end of the story? Suggesting there may be yet more wags to this particular tale, an elaborate and biologically plausible alternative explanation exists, one that may well do a better job at being ‘lovelier’ by virtue of elucidating mechanisms and opening up possibilities for unifying understanding of other seemingly unrelated ‘paradoxes’. It is that infants who are low-birthweight for reasons other than smoking may well have experienced harms during their fetal development unrelated to and much worse than those imposed by smoking, e.g. stochastic semi-disasters that knock down birthweight as a result of random genetic or epigenetic anomalies affecting the sperm or egg before conception or arising during fertilization and embryogenesis.^{16,114,118} Of note, the proposed alternative biological explanation cannot be discerned from a DAG. Indeed, as pointed out in a new reflection on using DAGs to parse this paradox, the DAGs for collider bias and for heterogeneity of low-birthweight phenotypes have a similar structure.¹¹⁷ A larger and ‘lovelier’ point is that profoundly different causal pathways can result in two distinct groups nevertheless exhibiting the same state—and a DAG, by itself, cannot resolve which hypothesized pathways, if any, are correct. An IBE approach further recognizes that no one study design can provide a definitive robust test of the hypotheses at issue. Instead, as noted above, what is required is evidential pluralism, i.e. triangulation of evidence from empirical studies whose methodological assumptions, limitations, biases and errors (which inevitably affect all studies) are uncorrelated^{5,42–45,48,49,60,76,77,119}. In Textbox 3 we provide examples of what such systematic triangulation of evidence, derived using approaches with different biases, entails for the example of smoking and birthweight.^{119–125} A similarly structured paradox, also involving children’s health, generated even more heated discussion 70 years before the birthweight paradox and likewise demonstrates the important value of the type of reasoning encoded in DAGs and also the work needed to determine if the underlying encoded assumptions are biologically and socially sound. In 1910, Karl Pearson and colleagues reported data apparently showing no detrimental effects of parental alcoholism on the health and development of

their offspring,^{126,127} results which not surprisingly generated fierce controversy.¹²⁸ The economist A.C. Pigou, in an elegant riposte, pointed out how selection of the sample could generate such a null association even when an adverse influence existed in the overall population,¹²⁹ thereby describing what would today be termed ‘collider bias’.¹³⁰ Pigou’s description of how this seeming paradox could arise was specific to the particular conditions of Pearson’s investigations.¹²⁹ Attesting to the value of DAGs for identifying the ‘transportability’ of the identified type of bias, i.e. the conditions under which it can affect other investigations,³³ other similarly structured explanations for particular issues have been produced in the epidemiological literature many times since, from Berkson’s presentation of what became his eponymous bias,¹³¹ to Greenland and Neutra’s discussion of a potentially misleading study design proposed to investigate the influence of endogenous estrogens on endometrial cancer.¹³² As these examples suggest, formal formulation of such potential biases, which can be represented in DAGs, clearly provides an incisive way of extending thinking about bias from one situation to another, one that can aid the overall evaluation of evidence in any given particular situation. It is another matter entirely, however, to elucidate empirically, whether the hypothesized biases do indeed exist and if they are sufficient to generate the observed associations. Continued Method Strengths in comparison with conventional observational analysis Key assumptions correctly specified model (this assumption relates to all methods to a greater or lesser degree) Cross-contextual comparisons Will reveal context-specific confounding No unmeasured confounding which (unlike the assessed confounders) is similar in magnitude between contexts and contributes substantially to the observed associations Negative control studies Reveals existence of potential unmeasured confounding. Negative control is associated with confounders to the same extent as the exposure (or outcome) of interest is associated with these confounders Within-sibship studies Robust to fixed maternal effects that could confound the association The important confounders do not change between pregnancies in a manner that is associated with change in maternal smoking behaviour Children of twins Between-MZ maternal twin pair analysis not subject to genetic confounding, or confounding by other factors that are shared between monozygotic twins. Comparison of between-MZ with between-DZ twin analyses allows estimation of extent of genetic confounding No unmeasured confounding by factors that differ between twins Mendelian randomization (MR) no reverse causation No pleiotropic effect of the genetic variants that influence the outcome independent of the exposure of interest Non-genetic IVs No systematic confounding The instrumental variable does not relate to confounding factors and does not impact on the outcome except through the exposure of interest Randomized controlled trials (RCTs) Randomization leads to no systematic confounding The intervention does not have effects except through changes in the exposure of interest The above is a non-exhaustive list of study designs that can contribute to triangulation of evidence. Whereas the findings of all study types can be biased, as can be seen above, the source of potential bias is different across the study types and will not associate in such a manner that possible biases would all point in the same direction (and with the same magnitude of effect) to produce the same misleading causal inference. International Journal of Epidemiology, 2016, Vol. 0, No. 0 13 at University of Hong Kong Libraries on October 1, 2016 <http://ije.oxfordjournals.org/> Downloaded from At issue is not simply whether a potential bias exists, but also whether the plausible magnitude of its quantitative effect is sufficient to meaningfully bias the study results.^{133,134} Nor can a DAG provide insight into what omitted variables might be important or whether a variable is even conceptualized appropriately (as per the *pellagra* example); only use of relevant scientific theories (including epidemiological theories of disease distribution) can aid conceptualizing the phenomena that co-produce the hypothesized causal relationships^{13–17,20,21,37–43}. A corollary is that despite the clear value of DAGs for formalizing certain types of biases, this feature does not mean this approach has more inferential value compared with components of evidence that cannot be disciplined in this way, e.g. the structuring effects of macroeconomic and social forces. An appeal for ‘evidence-based’ policies that relies solely on randomized clinical trials or other interventions carried out on individuals, will inevitably lead to debased policy making, as we have argued elsewhere.^{135,136} Causes do not cease being causes if they are challenging to study or to address. Racism and health: the harm caused by spurious ‘causal inference’ and ‘counterfactuals’ Our final example accordingly concerns a structural determinant, using the long-argued case of racism and health.^{137–141} One alarming feature of late 20th and current 21st century epidemiological literature on ‘causal inference’ is the re-appearance of previously rebutted causal claims that ‘race’ is an individual ‘attribute’ and that it cannot be a ‘cause’ because it is not ‘modifiable’.^{1,34,36,142–145} Five such examples are provided in Textbox 4, culled from diverse public health, epidemiological, biostatistical and sociological publications.^{1,34,142–144} They are congruent with new lines of contested work, supported by considerable NIH funding, that seek to ‘re-molecularize’ race.^{146–153} However, we clarified back in 2000⁵⁰ and reiterated since,¹⁵⁴ in accord with a considerable literature extending back to the 19th century,^{17,137–141,147,152–163} the problem— one with enormously harmful public health and policy

implications—that this approach to causal inference and counterfactuals starts at the wrong level, and uses DAGs to bark up the wrong tree and indeed miss the forest entirely. **What is the problem with viewing ‘race’ as an ‘inherent feature of individuals’ (p. 70), or as an ‘immutable characteristic’ (p. 775)?**¹⁴⁴ The problems are two-fold: bad biology and bad social science, compounded by an ahistorical approach to both the literature and the evidence. First, with regard to bad biology, this belief fails to acknowledge reams of genetic evidence demonstrating that *H. sapiens* cannot meaningfully be parsed (including by so-called ‘cluster’ programmes) into discrete genetically distinct ‘races’ who can be singularly identified by a set of traits and for whom variation within groups is less than variation between groups.^{146–153} By now, the notion of discrete, let alone ‘fixed’, ‘races’, especially in countries such as the USA with its history of being a colonial-settler and immigrant nation that also imported slaves and upheld legal slavery for centuries (1619–1865), is especially absurd.^{17,28,54,146–153} Second, with regard to bad social science, the view of ‘race’ as, in effect, a ‘natural’ kind (existing *a priori* ‘real’ grouping that exists independent of human classificatory schemes), completely disregards nearly two centuries’ worth of scholarship on the histories of the social creation—and enforcement, by law, by force and by terror—of the varied ‘racial’ categories deployed in diverse societies, let alone their changing permutations over time.^{17,28,54,137–141,146–156,162–168} It also ignores how these ‘racial’ categories, like any social relationship, are **co-constitutive**: each is defined and bounded in relation to the other, just as are **master and slave**, and masculine and feminine.^{28,137,169,170} **Change the social relationship, and the categories and how people relate to them and what they mean for their lives and their health will consequently change as well.** This type of dynamic co-causation replete with feedback loops, however, is not what is conventionally (or easily) depicted in DAGs. Even so, epidemiological evidence provides supportive evidence for the hypothesis that **modification of race relations causes changes in the population distributions of health**. The relevant counterfactual pertains to racism, not ‘race’. Examples include studies showing the beneficial impact of the **abolition of Jim Crow** in the mid 1960s on US Black/White inequities in **infant mortality rates, above and beyond** improvements linked to such Great Society programmes as the ‘War on Poverty’ and the introduction of **Medicare, Medicaid and desegregated health care facilities**.^{172–176} Causing these ‘modifications’ was the power of **social movements which challenged structural racism, forced repeal of unjust laws, and created space and resources for health and social scientists and health and social work practitioners to provide input into newly possible programmes**.^{177–180} Treat ‘race’ as a given and focus only on discrete ‘factors’ such as ‘income’, as some proponents of the **DAG approach** propose,^{34,142,145} and a DAG will tell a **biased tale** that is woefully incomplete for guiding policy and promoting health equity. Although such realities do not sit easily with admonitions for epidemiologists to focus only on ‘causes’ that can be ‘modified’ by health or policy professionals,^{181–183} they are the facts we confront when dealing with health inequities. The larger implication is that the ‘loveliest’ **explanation of racial/ethnic inequities in health** is the one that

engages most deeply with the ugly social facts of past and present realities of racial inequality and its myriad social, economic and embodied manifestations.^{17,62,137–141} Far more comprehensive explanations of the epidemiological evidence can be achieved if, rather than treating ‘race’ as an unmodifiable ‘inherent feature’ and positing either an endless and illusory set of ‘racial’ genetic differences in gene frequency for each and every ailment or a set of material conditions that are held to be ‘modifiable’ without addressing inequitable race relations, we instead tackle the causal relationships between racism and health head on. To do so, we can be aided by the central insights of the ecosocial theory of disease distribution and focus attention on how people literally embody, biologically, their societal and ecological context, thereby producing population patterns of health, disease and well-being.^{17,62,184,185} Conclusion We deliberately have not offered one prescription for how epidemiologists can best infer causation. No such prescription exists. Nor, of course, do we suggest that some approaches (e.g. use of DAGs where appropriate) be ruled out of court and banished to the dog-house. Instead, as we hope the examples we have provided demonstrate, there is no short cut for hard thinking about the biological and social realities and processes that jointly create the phenomena we epidemiologists seek to explain, always with an eye towards producing knowledge that we and others can use to improve population health, reduce preventable suffering and, we add, advance health equity. To accomplish these goals, we advocate that the field of epidemiology consider judicious use of the broad and flexible framework of ‘inference to the best explanation’. This stance requires not only that we be open to being pluralists about both causation and evidence but also that we also rise to the challenge of forging explanations that aspire to ‘scope, precision, mechanism, unification and simplicity’ (p. 423).⁴² No single study, however beautifully designed, can unequivocally demonstrate causation. To improve our causal explanations, we would do best instead to opt for causal triangulation.^{5,42,44,48,49,60,186,187} In practical terms, as illustrated by Textbox 3, this means systematically employing and assessing evidence in relation to diverse study designs, involving different methodological assumptions and biases,^{5,48,49,60,186,187} and also testing our hypotheses in different populations and in different historical periods^{5,60,186–190} to see if results are robust to the confounding structures encountered and the analytical methods used. In essence, the biases for each method employed—since, of course, all methods have potential biases—would be through different processes and unrelated to the biases in the other methods. DAGs and counterfactual approaches are but one set of conceptual tools that epidemiologists can employ, and should not occupy a privileged place in delimiting the kinds of questions we ask or causes we theorize. We would hazard the guess that many who advocate these styles of thought would probably agree with our position, but might not see the current emphasis on applying formal rules as leading to questions becoming restricted to those which fit neatly within these rules. Suggesting, however, that we are not raising straw arguments are narrow framings of what constitutes legitimate causal inference accompanying the burgeoning use of these methods and advocacy to do so.^{1,6–8,11,30–32,34,35,142–145} Our fear is that these new ‘cutting-edge’ methods will, by virtue of their rule-bound nature, limit the scope of epidemiology and its impact on the urgent real-world problems of global population health.^{9,10,17,33,53–56} We close by noting that in 1957, Jerry Morris’ included in ‘Uses of Epidemiology’ a section he titled ‘Changing People in a Changing Society’, in which he raised a series of questions that have fruitfully shaped the field’s research programme for now well over a half-century (pp. 19–23).¹³ Among his many questions were: ‘What are the implications to Public Health of more married women going out to work? And less of the older men? Of still increasing urban – and suburbanization? The rapid growth of new towns? Smokeless zones (still with sulphur)? The building of new power stations? Of less physical activity in work and more bodily sloth generally? ... Of the more than 1000 extra motor vehicles a day? Of the rising consumption of sugar ... Of the cheapening of fats? ... Such questions (of contemporary history, it might be said) could readily be multiplied’ (p. 22).¹³ Noting that ‘[s]ome of the issues mentioned above cannot yet be framed in scientific terms; but parts at least of others could be tackled more energetically’, Morris’ nonetheless optimistically averred: ‘Perhaps epidemiology with its special skills in identifying what matters more and what matters less, its concern for woods rather than trees, perhaps the epidemiological method can simplify such issues and usefully raise some bold questions about these too’ (p.23).¹³ Any approach to causal inference that cannot help us answer the kinds of prevention-oriented questions that Morris’ posed, that cannot brook analysis of inequitable social relations as a cause of population health and health inequities^{50–56,137–141} and that cannot conceive how to address the causal epidemiological implications of the planetary crisis of global climate change^{57–59,191,192} is inadequate—and if it restricts what questions can be asked, it is wrong. We can—and must—do better.

Assess the case AND our impacts on a pre-theoretical level; that episodes of injustice in healthcare share traits with other violence does NOT justify transcendental attribution to a single social force. Theories are only useful as far as they explicate context.

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Pragmatism: Problematic Situations of Injustice as Starting Point Anderson's claim is that the pragmatists' "method is unorthodox" because it starts "from a diagnosis of injustices in the actual world" (2010, 3). However, under Dewey's formulation, the pragmatist methodology is more "unorthodox" and more demanding than Anderson thinks it is, because beginning with a diagnosis is already to start with a theoretical account and not with the concrete problems of injustice as they are experienced in the midst of social life. Let us examine the methodological reasons why Dewey thinks designation should precede diagnosis in an empirical philosophy. In Experience and Nature, Dewey names the empirical way of doing philosophy the "denotative method" (LW 1:371). What Dewey means by "denotation" is simply the phase of an empirical inquiry where we are concerned with designating, as free from theoretical presuppositions as possible, the concrete problem (subject matter) for which we can provide different and even competing descriptions and theories. Once we designate the subject matter, we then engage in the inquiry itself, including diagnosis, possibly even constructing theories and developing concepts. Of course, that is not the end of the inquiry. We must then take the results of that inquiry "as a path pointing and leading back to something in primary experience" (LW 1:17). This looping back is essential, and it never ends as long as there are new experiences that may require a revision of our theories. Injustices are events suffered by concrete people at particular times and in particular situations. We should start by pointing out and describing these problematic experiences, instead of starting with a theoretical account or diagnosis of them. Dewey is concerned with the consequences of not following the methodological advice to distinguish designation from diagnosis. Definitions, theoretical criteria, and diagnosis can be useful; they have their proper place and function once inquiry is on its way. But if stressed too much at the start of inquiry, they can lead us to overlook aspects of concrete problems that escape our theoretical lenses. We must attempt to designate the subject matter pretheoretically, i.e., to "point" in a certain direction, even if it's with only a vague or crude description of the problem. This is a difficult task for philosophers because we are often too prone to interpret the particular problem in a way that confirms our most cherished theories of injustice. One must be careful to designate the subject matter in such a way as to not slant the question in favor of one's theory or theoretical preconceptions. A philosopher must make an honest effort to designate the injustices based on what is experienced as such, because a concrete social problem (e.g., injustice) is independent of and neutral with respect to the different possible competing diagnoses or theories about its causes. Moreover, without this effort, there is no way to test or adjudicate between competing accounts. That designation precedes diagnosis is true of any inquiry that claims to be empirical. To start with the diagnosis is to start with something other than the problem. The problem is pretheory or preinquiry not in any mysterious sense, but simply in the sense that it is first suffered by someone in a particular context. Otherwise, efforts to diagnose the causes of the problem lack an object and the inquiry cannot even be initiated. In his Logic, Dewey lays out the pattern of all empirical inquiries. All inquiries start with what he calls an "indeterminate situation," prior even to a "problematic situation" (LW 12). Here is a sketch of the process: Indeterminate situation → Problematic situation → Diagnosis: What is the problem? What is the solution? (operations of analysis, ideas, observations, clarification, formulating and testing

hypothesis, reasoning, etc.) → Final judgment (resolution: determinate situation). To make more clear or vivid the difference between Anderson and Dewey on the starting point, we can use the example of medical practice. The doctor's starting point is the experience of a particular illness of a particular patient, i.e., concrete and unique embodied patients experiencing a disruption or problematic change in their lives (LW 6:6). The problem becomes an object of knowledge once the doctor engages in certain interactions with the patient, analysis, and testing, which lead to a diagnosis. For Dewey, "diagnosis" occurs when the doctor is engaged in operations of experimental observation in which she is already narrowing the field of relevant evidence, concerned with the correlation between the nature of the problem and possible solutions. Dewey uses the example of the doctor to emphasize the radical contextualism and particularism of his view. The good doctor never forgets that this patient and "this ill is just the specific ill that it is. It never is an exact duplicate of anything else" (MW 12:176). Similarly, the empirical philosopher in her inquiry about an injustice brings forth general knowledge or expertise to an inquiry into the causes of an injustice. She relies on sociology and history, as well as knowledge of all forms of injustice, but it is all in the service of inquiry about the singularity of each injustice suffered in a situation. Just as with the doctor, empirical inquirers about injustice must return to the concrete problem for testing, and should never forget that their conceptual abstractions and general knowledge are just means to ameliorate what is particular, context-bound, and unique. The correction or refinement that I am making to Anderson's characterization of the pragmatists' approach has methodological and practical consequences for how we approach an injustice. The distinction between the diagnosis of the problem and the designation of the problem (the illness, the injustice) is an important functional distinction that must be kept in inquiry because it keeps us alert to the provisional and hypothetical aspect of any diagnosis. To rectify or improve any diagnosis we must return to the concrete problem; as with the patient, this may require attending as much as possible to the uniqueness of the problem. This is in the same spirit as Anderson's preference for an empirical inquiry that tries to "capture all of the expressive harms" in situations of injustice (2010, 6). But this requires that we begin with and return to concrete experiences of injustice rather than beginning with a diagnosis of the causes of injustice provided by studies in the social sciences. For instance, a diagnosis of causes that are due to systematic, structural features of society or the world disregards aspects of the concrete experiences of injustice that are not systematic and structural. Making the designation of problematic situations of injustice our explicit methodological starting point functions as a directive to inquirers to locate the problem before venturing into descriptions, diagnosis, analysis, clarifications, hypothesis, and reasoning about the problem. These operations are instrumental to its amelioration and must ultimately return to and be tested against the problem that sparked the inquiry. This directive makes inquirers more attentive to the complex ways in which such differences as race, culture, class, or gender intersect in a problem of injustice. Sensitivity to complexity and difference in matters of injustice is not easy; it is a very demanding methodological prescription because it means that no matter how confident we may feel about applying solutions designed to ameliorate systematic evil, our cures should try to address as much as possible the unique circumstances of each injustice. This directive is not opposed to inquiry into how big categories (race, capitalism, colonialism, modernity) produce and perpetuate injustices. However, such abstract and general inquiries are ultimately just tools to illuminate particular injustices, just as knowledge of research about diseases of entire populations can assist a doctor. The directive keeps us honest, fallible, and aware of our limitations as intellectuals because it implies that there is always a gap between our best diagnoses and theories of injustice, and the concrete problems of injustice. We cannot assume that our theories or our ways of gathering evidence have captured all there is in concrete problematic contexts. This is relevant to the second qualification that I want to make to Anderson's characterization of pragmatism as a nonideal: the breadth of experiential resources. Pragmatism: A Broad View of the Experiential Resources for Inquiry Given its starting point, pragmatism has a broad view of the initial experiential material to be analyzed by inquiry. Contrary to what Anderson seems to suggest, there is no good reason for a pragmatist approach to injustice to limit its experiential resources to the empirical research and material provided by scientific studies. In fact, without the use of other resources, we risk not capturing those aspects of injustices that may not be amenable to scientific types of inquiry. Starting inquiry with the features of events or injustices that are already known or as they are diagnosed or accounted for by a scientific investigation (such as the

social sciences) is valuable, but prior to these theoretical lenses there is the problem experienced (sometimes suffered) by concrete human beings in their robust and raw character. We cannot ignore the crudities of life just because they are crude. In making a diagnosis, we are already reflectively removed from the problem and have been selective in disregarding those features that seem irrelevant to our inquiries. For pragmatism, admitting the selectivity of theoretical lenses in all inquiries does not undermine the notion that some inquiries are better than others (more on this later). But it does imply that what scientific research reveals about a concrete problem is partial and may need to be supplemented by other approaches and experiential resources. In *The Imperative of Integration*, Anderson reaches her conclusions based on empirical academic research, including social science findings in economics, sociology, and psychology. These findings are important since they seek causal regularities behind the problems, but they need to be complemented with other ways of capturing the complexity and uniqueness of the concrete problems of injustice. For instance, Anderson's diagnosis would have benefited from more concrete interactions with the marginalized of whom she wrote, just as a doctor can enhance her diagnosis via interaction with her patient. Jane Addams used this method of first-order empiricism to inform her work (1902). She thought that one must interact and converse with others to understand, as closely as possible, their experiences of social inequality, discrimination, and oppression. Addams did not confine herself to academia; she put herself into the world. Importantly, experience was her data—interactions unmitigated by statistical compilations, theoretical interpretations, and the like. Sometimes a doctor needs to engage, be participant, and take a sympathetic interest in the condition of the patient to gather new evidence. To understand persons, communities, and even social structures requires that we experience them as historically evolving in a particular context. I am not claiming that Anderson's conclusions are invalidated by her distance from the raw data of experience, or her lack of interaction with the experiences of those who directly suffer injustice; they may be perfectly sound. The point I want to make is a more general one about how pragmatists should try to approach problems of injustice. Both empirical research and first-order experiences can be utilized together in an effort to identify the problems that persist in society and to develop solutions to these problems. The idea of enmeshing oneself in the circumstances of others, and thereby gaining a broad and rich perspective, received uptake in sociology (e.g., Robert Park) under the influence of John Dewey and George Herbert Mead in Chicago in the first part of the twentieth century. This is what today is known as the qualitative and ethnographic approach to sociology. However, it would be a mistake to identify the pragmatist approach as one that negates the importance of other techniques such as the ones stressed in quantitative research; they too have their proper place and function. Recently, there has been a new generation of sociologists that has rectified this narrow conception of the pragmatist approach. In fact, pragmatism is now considered the philosophical basis of mixed-methods research (MMR).² However, in regard to methodologies and experiential resources, pragmatism has an even more inclusive view than does MMR. Quantitative and qualitative methods are sociological and as such are only interested in the sort of data that interest sociology: facts about human beings as social animals or members of groups. Therefore, in the study of concrete injustices, they will be selective in ways different than other sciences like psychology. There are as many different ways to capture and understand experiences of injustice as there are types of inquiry. This pluralism is a strength of pragmatism, one that sets an inclusive framework that supports interdisciplinary and cooperative research about problems of injustices. What the philosopher provides is the critical perspective needed to help inquirers from different disciplines avoid reductionism and other common mistakes by reminding them of their particular biases. However, the pragmatist approach is even more radically open with regard to the evidence it can draw on in its designation and diagnosis of problems of injustice. It isn't restricted to the evidence of any particular academic discipline; neither is it restricted to the evidence that is gathered and validated via the academic disciplines, full stop. Among the experiential resources that pragmatism can draw on are also autobiographical texts, narratives, and stories that the Eurocentric paradigm of knowledge and science often discard as irrelevant, as fiction, or art. For example, Gloria Anzaldúa's *Borderlands / La Frontera* (1987) is a first-person autobiographical account of multiple forms of oppression suffered by Mexican Americans growing up in the border. Without the stories of different oppressed groups, academics would lack the resources needed to begin to understand the complex experiences of oppression as they are lived and the structural constraints as they are experienced in everyday lives. By explicitly holding a broader sense of the "empirical," Anderson's view could have avoided some of the objections that have been raised since the publication of her book. More than one commentator has raised questions about whether a privileged, white scholar like Anderson is too removed or out of touch with the Black community's experience to be able to offer a reliable inquiry about their experiences of injustice. Paul Taylor, for example, writes, "Anderson endorses the Deweyan thought that social and political philosophy needs to be grounded in an empirically adequate understanding of the problems we face. But Dewey never tired of explaining that empirical adequacy had to do with experience in all of its existential and phenomenological depth" (2013, 201). And V. Denise James has argued, "my deepest concern [about Anderson] is rooted in another of classical Deweyan pragmatism's central claims that our work should attend to and get not only data from, but also be interpreted through, lived experience" (2013, 1). These are concerns about Anderson's experiential basis for the knowledge that she has produced. To be sure, the view that just because an inquirer is a member of a privileged group (e.g., a white intellectual) she could not possibly produce reliable knowledge about the injustices suffered by the oppressed is an extreme and implausible view. But one could, and sometimes should, raise the question of whether an investigator's position in her society may have in some way limited the experiential resources of her inquiry into an injustice. In the case of someone like Anderson, one can ask, beyond relying on the best social sciences, whether she considered other experiencebased resources that may have had an impact on the scientific research. One could ask, of course, the same questions about Black scholars who for some other reason, such as being academic intellectuals, may be too far removed from the same experiential resources. In the case of Anderson, what became a red flag for her critics was the simple fact that she did not realize that the term "integration" has many negative connotations in Blacks' lived experience.³ Anderson's personal distance from the problem of injustice in the lives of Blacks may not invalidate her conclusions, but it raises the question of whether she missed experiential data obtainable via other means, such as a cross-racial dialogue about the very causes of the problem. There is in Anderson's work an oversight; that is, she does not acknowledge other sources for

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inquiry. She may reply that the only sources of knowledge she needs are the causal mechanisms reproducing undemocratic and unjust race relations as they have been revealed by studies in the social sciences. But even these studies are limited if they are too far removed from and not sensitive enough to the particular experiences, daily struggles, and circumstances of particular communities and situations in the United States. Pragmatism's Methodological Warnings to Contemporary Nonideal "Empirical" Approaches The pragmatist approach to problems of injustice can be distinguished by its starting point and its broad view of empirical inquiry. There is in this view a demanding commitment to be sensitive to the uniqueness and complexity of the problematic contexts that trigger inquiry. However, does pragmatism provide more specific lessons or directives that can be useful for today's nonideal theorists in their efforts to provide a better alternative to traditional ideal theories in addressing problems of injustice? First, pragmatism issues the warning to contemporary nonideal theories not to take for granted that their approach is "empirical" simply because they are critical of ideal theories or because they have the intention to be empirical. Theories and categories, no matter how empirically grounded they may seem by virtue of the fact that they are grounded in history or science, can function as "binders" in our efforts to capture and resolve concrete injustices. Second, while Dewey provided no infallible method by which one can guarantee success in the empirical method he proposes, he would suggest that nonideal theorists learn from other philosophers' mistakes. In this respect, Dewey's occasional efforts to summarize the general and systematic kinds of mistakes nonempirical philosophers tend to make can prove helpful. Specifically, he identifies a series of methodological fallacies that nonideal theorists would do well to avoid. Dewey formulated different ways in which philosophers have made the same basic mistake, which is the tendency to begin with reflective products or theoretical abstractions, as if there is no prior nontheoretical problematic context. Hence, Dewey concludes that "the most pervasive fallacy of philosophic thinking goes back to neglect of context" (LW 6:5). I will sort out how the different versions of this fallacy have made their way into sociopolitical philosophy, in particular, in philosophical inquiry about injustice. While these fallacies are more common or even to be expected from ideal theories, it is worth demonstrating that nonideal ones are not immune from them either. The Fallacy of Unlimited Universalization When philosophers ignore the fact that judgments arise out of limiting conditions set by the contextual situation of particular inquiries, they tend to elevate the conclusions of their inquiries to the point of giving them unlimited application. Philosophers are prone to this fallacy because they are the ones who are usually trying to formulate theories about truth, good, justice, or the absolute, writ large. In many instances of this fallacy, "It is easy and too usual to convert abstraction from specific context into abstraction from all context whatsoever" (LW 6:16). Dewey was aware of how abstract conceptions such as justice, freedom, and democracy have been used by intellectuals and politicians to ignore or divert attention from the concrete social problems in need of our intelligence. However, he was also aware of how the categories of nonideal theories, while seemly empirical, may have the same effect. In fact, one could argue that these categories are more pernicious since they foster the illusion of empirical grounding in solving problems. Rationalist philosophers are not the only ones liable to forget the instrumental and context-bound character of their abstract conceptions. Political philosophy inspired by sociology often focuses on broad universal-general abstractions (categories) such as the state, individuals, groups, society, capitalism, racism, [and] white supremacy, oppression, structural racism, and the people, even though in the end there are only particular and unique instances of all of these categories in a situation at a particular time and place. To be sure, abstractions, generalities, and universal concepts have a legitimate function in inquiry. They are "tools" to be employed and tested in clarifying concrete social problems. The danger is when intellectuals (especially philosophers) tend to forget both the proper function of these tools and the details of concrete particular contexts. When this happens, they impose their theoretical abstractions upon particulars and oversimplify their empirical complexity. But the concrete troubles or evils that provoke our philosophical inquiries are situation specific and often far more complex than our intellectual analysis may suggest. The failure to recognize this specificity and complexity is an oversight with serious consequences, especially reductionistic, oversimplified, and one-sided solutions to serious social problems. This oversight also tends to generate among academics theoretical problems that are based on false oppositions among their abstract conceptions, which are barriers to continuing inquiry. In this regard, Dewey mentions debates about individualism and collectivism, but today, examples include debates about whether race, class, or gender is the key cause of an injustice. Anderson seems to be aware of the same danger with abstract conceptions when she replies to the charge that she disregards capitalism and white hegemony in her analysis of racial injustice in the United States. She replies that these concepts are "too lumpy to do the practical work" non-ideal theory needs" (Anderson 2013, 4). She would not mind "white hegemony" if all it means is "the entire interlocking and mutually reinforcing set of mechanisms that reproduce systematic black oppression today" (2010, 16). But the concept

is one that covers in broad strokes a lot of history across time and place when nonideal theory should be more meticulous and focused on more specific problems of the here and now. She claims that nonideal theory "demands splitting, not lumping" and should be committed to being "meticulous and precise in differentiating the variety and interaction of discrete causal mechanisms underlying the problem at hand" (2013, 4). This resonates with Dewey's metaphysical standpoint, but given Dewey's starting point (his radical particularism and contextualism), he would wonder if Anderson's view is immune to the same danger of "lumpiness" that worries her about others' analysis of racial injustice. Anderson argues in *The Imperative of Integration* that, even though the United States may have legally abolished segregation, de facto segregation is worse; it is the cause of racial injustice. Her solution is that we must integrate in all areas of social life. From Dewey's perspective, Anderson should recognize that her use of "segregation" and "integration" may be as susceptible to the same dangers as "white supremacy" or "capitalism"; they are all abstract concepts that, while useful, may sometimes cover over or lump together too much. Even if one can theoretically discriminate the same general structural cause across cases of racial injustice, there is no single cause called "segregation." Segregation is experienced differently in a variety of complex and unique injustice events. Without this qualification, one runs the risk of lumping all cases together under one name and even disregarding other causes that may be operative in an inextricable way in a problematic situation. Even the specific mechanism of segregation that Anderson identifies varies depending on what other contextual conditions are present in different areas of the United States. In inquiry, simplicity or lumping in the diagnosis by means of an abstract concept usually results in an answer or solution that has the same, simplistic character. In Anderson's case, the solution is integration. To be fair, Anderson does provide plenty of differentiation in the variety of multiple strategies needed to undertake the problem. But nonideal theorists must be careful not to forget that behind a single conceptual handle there is a plurality of means depending on the particular problem. The temptation to seek and want a single cure under a single name has to be one of the most common temptations in any inquiry about injustice, and nonideal theorists are not immune from this. The Analytic and Selective Fallacies When inquirers forget their intellectual dissections, they commit the analytic fallacy. When they forget that evidence of their intellectual dissections indicates that they have been selective from the original subject matter, it is called the fallacy of selective interest. The analytic and selective fallacies are for Dewey two facets of the same general tendency to neglect context, and they are counterproductive in ameliorating concrete problems. Let us consider how they can undermine inquiries about injustice. Anderson claims that "Non-ideal theory demands splitting, not lumping" (2013, 4). She is, of course, correct. However, the analytic fallacy represents a way of splitting that is undesirable from a pragmatist point of view. Analysis is that process where we discriminate some particulars or elements within a context. Of course, what hangs those particulars together, i.e., what gives them their connection and continuity, is the context itself. Philosophers commit the analytic fallacy when "the distinctions or elements that are discriminated are treated as if they were final and selfsufficient" (LW 6:7). Philosophers, as a result of their analyses (e.g., as a result of adopting historical accounts and scientific studies), have provided a diagnosis of a particular injustice. For instance, Anderson has shown that inquiry can result in a meticulous and precise differentiation of "the variety and interaction of discrete causal mechanisms underlying the problem" of racial injustice (2013, 4). This is as it should be. However, the danger comes when inquirers neglect or forget the concrete, integral contexts from which things were dissected in the first place. They may then invent artificial, intellectual problems that center on how the variety of causal mechanisms discriminated (analyzed) can be brought together or unified, or, what is more likely, engage in endless debates about which among the plurality of diagnoses is the correct or "real" one. However, these causal mechanisms (after inquiry has formulated them) are not antecedent to the concrete problem, nor can the problem be reduced to their intellectual analysis. Nonideal theorists must also guard against committing the related fallacy of selectivity. Different types of inquiry will discriminate different causal mechanisms underlying the same problem because each is selective in some way. Pluralism of diagnoses about the same problem of injustice is not problematic unless, by failing to recognize selectivity (i.e., ignoring context), we postulate some ontologically or epistemologically privileged access or approximation to some antecedent "reality" of the problem. When we forget or overlook the unavoidable selectivity of even our best theoretical tools, we run the risk of becoming complacent in the belief that our accounts exhaust all of the causes in the case, or we may proclaim it as the "real" cause and anything else as illusory. Anderson is correct in that ideal theories tend to overlook or ignore concrete injustices like racism. This is a function of their starting point, which is unreasonably, and some may argue, suspiciously, selective. But even the best nonideal "empirical" views will be selective as well, for, as Dewey says, "there is selectivity (and rejection) found in every operation of thought" (LW 6:14). Pragmatism, however, does not think that admitting or embracing selectivity means that all selectivity is

equally good or equally distortive (i.e., biased or partial) with respect to an antecedent reality. Standpoints and perspectives are not things that stand against a uniform and antecedent reality of a problem of injustice. While selectivity is unavoidable, there are usually contextual grounds, depending on the nature of the problem, for distinguishing better from worse selections in a situation without the need to presuppose an Archimedean standpoint or privileged epistemic access by some group or person. For pragmatism, all selectivity or bias in inquiry has both a positive and a negative aspect. The positive is that it makes available for inquirers aspects of a concrete problem that someone without that particular bias would not have experienced or appreciated. The negative is that no matter how productive our bias is, one may have left out something from the concrete problem that has not been disclosed by our tools of analysis. In other words, the particular forms of selectivity that we bring to an inquiry account both for our limitations and for our particular power- capacity to inquire and ameliorate the problem. The particular selectivity that we bring to an inquiry into a problem of injustice can have different sources. We would do well to distinguish two broad categories of selectivity or bias: theoretical ones (of the type of inquiry) and pretheoretical (of the investigator).

Plan: The United States federal government should create a single payer national health insurance plan, conditioning provider coverage on universal informed consent requirements in medical research, cultural safety training for physicians, community interventions informed by triennial race-conscious Community Health Needs Assessments, and a racially and culturally representative healthcare workforce, and conduct binding audits to ensure equitable distribution of medical facilities, personnel, and research spending.

Single payer health insurance instantiates a world in which quality of healthcare is not determined by financial status and eliminates profit motives that contribute to disparate outcomes. This dramatically improves lived conditions for millions of people and reduces premature death

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The US healthcare system provides unequal care. Just as life expectancy is determined by which neighborhood you live in, for many Americans what hospital or doctor you can see is influenced by neighborhood, insurance, race, and ethnicity. And if you live in a high-mortality neighborhood, a trip to the local hospital might just be a matter of life and death. There are three major reasons why health care delivery in the United States is not equitable. The first is that health care is treated as commodity, not a right. The poor (with or without insurance) living in neighborhoods of concentrated disadvantage often have more limited access to quality health care.² Those who are uninsured and underinsured experience great difficulty accessing needed care.³ Minorities and the poor are less likely to have private health insurance than white middleclass Americans.⁴ When minorities and the poor do have insurance, it is more likely to be one of the publicly funded insurance policies that not all hospitals and doctors accept. The second reason is that minorities sometimes get different treatment for the same illness from what whites get, regardless of insurance. Health care providers' implicit racial bias and patients' mistrust may be the causes of this differential treatment.⁵ The third reason why health care delivery is unequal is that the health care institutions that serve the poor in general suffer from cash and capital shortages. Neighborhoods of concentrated advantage where people with better insurance live have better-resourced hospitals and clinics than poor neighborhoods do. This is how structural violence works within the fabric of the health care system. It is not as if great care cannot be delivered in underserved settings. It is, every day. But it is inconsistent or constrained by

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a lack of resources. Thus minorities and poor people die disproportionately, as a result of an unfairly structured American health care system. The Deadly Divide Take breast cancer care. It is a gruesome fact that in the United States, black women are 40 percent more likely to die from breast cancer than white women. While black and white American women now develop breast cancer at the same rates (something that was not always the case), more black women will die of the disease.⁶ Why does this particular death gap exist? An oncologist will tell you that black women first seek treatment with larger, more deadly, laterstage breast cancers.⁷ But the truth is that the breast cancer death gap is not just a biological phenomenon but a consequence of structural violence. A woman's neighborhood can determine whether she will survive breast cancer or die from it. It would be grisly enough if breast cancer were the only disease that discriminated. It is not. From heart disease to hepatitis C, depression to diabetes, blacks throughout the United States suffer higher rates of illness and death than whites. It is tough to name many diseases that do not discriminate by race, place, and poverty. But breast cancer is a disease that demonstrates vividly how structural violence is woven into neighborhood fabric, especially in black communities. The Missed Breast Cancer The key to unlocking the inequity in breast cancer mortality came from a radiology reading room on the top floor of Mercy Hospital on Martin Luther King Jr. Drive on Chicago's South Side. The room was dark except for the projected image of a mammogram. Amid the cool gray background of fatty breast tissue was an unmistakable irregular-shaped mass, its speculated white tentacles invading the surrounding tissue—a telltale sign of advanced breast cancer. It was as obvious as a ticking bomb. Dr. Paula Grabler, a radiologist specializing in reading mammograms and diagnosing breast cancer, was then the director of breast imaging services. At most of the other small hospitals that served South Side African American communities, mammograms were read not by specialists but by general radiologists. Too often cancers were evident but missed. This case was no different. "She was a middle-aged African American woman," Dr. Grabler recalled.⁸ "The patient had been seen in the past at a small South Side hospital and had a screening mammogram that was reported to be normal. Months later she came to me with a lump in her breast. I asked to get a copy of the prior mammogram and there it was: a large, very obvious breast cancer." Grabler typically removes mammograms from the view box when she meets with patients. She does not want the image of the cancer to shock the patient. "But on this particular day, I forgot to," she said. The patient gasped when she saw the large white mass that exploded from the gray background of the x-ray. "How did they miss it?" she asked. It was a glaring mistake that could cost her her life. "I honestly don't know," Grabler replied. But she did know. The doctor who read her mammogram was not an expert. He was an itinerant radiologist who read all types of x-rays. Detecting breast cancer early requires meticulous attention to detail. Trained experts who read mammograms find six times more breast cancers than general radiologists do.⁹ In Chicago, most of the breast centers that are near or in the black wards do not have such specialists. Cancers are missed. Women die. An obvious breast cancer on a mammogram. The patient presented with a lump in her breast; the prior mammogram had been read as normal. Sometimes the cause of racial disparities in health care can be as banal as an inexperienced or busy doctor missing cancer. Source: authors personal collection. That missed breast cancer held the key to understanding an aspect of premature mortality: access to screening is important for finding breast cancer early—but the quality of that screening is even more critical. We found a screening facility serving Chicago's black community that found two breast cancers for every thousand women screened, when the correct number should have been at least six.¹⁰ More than half were missed. Add to this injury the insult a black woman feels later when she goes to see a doctor with a bad cancer and is told that her genetics are at fault. Institutional racism as a structural cause of increased mortality can sometimes be as banal as a poorly qualified doctor missing a cancer in a poorly run mammography center. In a Chicago study of missed breast cancers, poor women, minority women, and publicly insured women were significantly more likely than well-insured white women to have their cancers missed (they were there on the mammogram on a lookback).¹¹ Socially disadvantaged women (poor, minority, and uninsured) are significantly more likely to have a cancer missed on mammography because they are more likely to receive care at substandard facilities, in segregated neighborhoods, than advantaged women are.¹² Even if women of color do everything right—get screened, schedule follow-up appointments—they can still fare worse than white women simply by virtue of where they live. This is not just a product of poverty, though poverty itself is a big predictor of inequity. There are plenty of poor white women in Chicago, but there is not one poor white Chicago neighborhood.¹³ Poor white women can get their breast care in the same neighborhood hospitals as the more wealthy women in their neighborhoods. This is structural violence and institutionalized racism at work. Women living in Chicago's neighborhoods of concentrated advantage are 37 times more likely have ready access to a "breast center of excellence" than women living in high-poverty neighborhoods.¹⁴ This maldistribution of resources did not occur by chance. The Spread of Racial Disparity None of this mattered when there were no effective treatments for breast cancer. From the mid-i930S, when breast cancer mortality was first measured in the United States, until the early 1980s, when screening mammography and new chemotherapy agents were shown to be effective at reducing mortality, there were no black-to-white or rich-to-poor gaps in breast cancer mortality.¹⁵ But in the early 1990s, as breast cancer became more amenable to new treatments, the breast cancer death rate for white women across the United States began to plummet.¹⁶ The death rate for black women in Chicago did not budge.¹⁷ The improvement for white women was easy to comprehend. Years of effort to raise awareness about the importance of regular mammography screenings coupled with improvements in technology and the emergence of specialists like Grabler meant that more cancers were detected early. Meanwhile, advances in treatment further increased survival rates. But it was here that a new racial death divide emerged. It grew from a sliver to a chasm over the next twenty years. Poor women, and specifically poor black women, were not getting the same quality of breast cancer care as wealthier and white women. Researchers have described this growing racial gap in cancer mortality as the "amenability factor."¹⁸ As cancers such as breast cancer become more amenable to treatment interventions, racial cancer survival disparities widen because poor minority women do not have easy access to the lifesaving cures.¹⁹ Inequality in Quality In 2007, 160-plus doctors, researchers, and community activists in Chicago convened the Metropolitan Chicago Breast Cancer Task Force to investigate the gap and decide how to close it. We analyzed the data. We drilled into the deaths. We held focus groups of black and Latina women on the South and West Sides. We heard their stories of fragmented and disrespectful health care in their communities. We released a report.²⁰ It confirmed that access to quality of care was responsible for the wide racial gaps in breast cancer mortality. The report also made thirty-seven recommendations for closing the gap. Yet breast cancer researchers scoffed. They clung to the usual genetic and biological explanations. We fought back, pointing out the structural components of the death gap, both in Chicago and nationwide. Chicago's gap was twice as large as the national gap and seven times larger than the gap in New York City, suggesting that geography is a significant variable.²¹ Cities like Memphis and every major Texas city had even larger breast cancer death gaps than Chicago's.²² In Detroit, black and white women had the same terrible mortality rates. The cities with the greatest breast cancer death gaps were also the ones with the largest dissimilarity index scores, denoting advanced degrees of racial segregation.²³ Moreover, biology cannot explain the variability in the racial death rates in cities within the same state. For example, in Los Angeles black women are 71 percent more likely to die from breast cancer than whites. In Sacramento and San Francisco this gap does not exist.²⁴ A Map and a Story The task force published a map of Chicago showing the communities with the highest breast cancer mortality. Twenty-three were black communities and one was white. All were located on the West and South Sides. All the black communities were neighborhoods of concentrated US Health Care: Separate and Unequal * 119 Years Disparity ratio in breast cancer mortality between white and black women across New York City, the United States, and Chicago from 1990 to 2010 show that geography, more than biological and genetic factors, influences women's mortality. Source: Metropolitan Chicago Breast Cancer Task Force. poverty and disadvantage.²⁵ In mostly black neighborhoods, not one hospital has earned the American College of Radiology's seal of approval for breast imaging centers. Only one hospital in a high-mortality black neighborhood has been certified by the American College of Surgeons' Commission on Cancer as a cancer treatment center. In contrast, in the white wards there are fourteen cancer accredited hospitals. This was a bleak picture of the structural nature of racial inequality. It's one thing to look at disparity on a map. It's another to hear from the women who try to navigate the fractured system of care. Chicago and other cities have a hodgepodge of public and private hospitals and clinics, with little communication between them and poor coordination of care. Barbara Akpan is a retired nurse in Chicago. After her breast cancer diagnosis and treatment at an academic medical center, she began serving as a volunteer community advocate for other African American women on the South Side. Her observations reinforce the notion that inequality in the quality of breast cancer care was failing women. "Many of the women I work with are afraid," she said. "They do not trust the health care system. Many of the clinics and hospitals they go to do not provide the best care, or they simply give them the wrong Hospitals

with American College of Surgeons Approved Cancer Programs African American Community Areas with Elevated Breast Cancer Mortality In Chicago's African American neighborhoods with high mortality for female breast cancer, there are few hospitals with American College of Surgeons-approved cancer programs. Consequently, black women with breast cancer concerns have to either travel for care or receive care at nonapproved cancer treatment sites. This map depicts how health inequality is structured into the geography of a region. Source: <http://link.springer.com/article/10.1007/s10552-009-9419-7>. information. It's hard to overcome the mistrust. For women in the southland—Ford Heights, Chicago Heights, Harvey, poor areas on the South Side—access to mammography screening sites is really poor," says Akpan. "Women are falling through the gap—they don't know where to go."²⁶ When we traveled around Chicago and other cities, showed audiences of black women the mortality curves illustrating the black breast cancer death gap, and gave our explanations, they cried. We had validated something they knew to be true: the systems that served them were often inadequate. They cried because our data told them that the breast cancer death gap was a system problem and not a problem within black women. Their reactions galvanized us to focus on fixing the system. Because the mortality gap was structural, we needed hospitals to work together to improve care for black women. We identified hospitals with undertrained mammography technicians and radiologists and arranged free continuing-education courses. We met with CEOs to share their hospital's quality data and make recommendations for improvement. But this was not going to improve care fast enough. If a small inner-city hospital lacked the expertise to provide comprehensive breast cancer care, no amount of quality improvement would remedy it. But what if we could move women from poor institutions to good ones? Navigating to Quality We hired health "navigators." These were community health workers and nurses who could direct women to high-quality hospitals for screening and treatment. We solicited breast cancer services from all the region's top hospitals. Most obliged. The navigators guide their clients into care at the city's highest-quality medical centers even when they are two hours and two bus transfers away. Sometimes the navigators battle with the local doctors to wrest the patient into better care. Gerri Murrah is typical of the patients navigated. She was 60 and developed a sore lump in her breast in 2015. Not having a primary-care physician, she had gone to her local emergency room. The doctor didn't even consider cancer; Gerri was given antibiotics and sent home. Luckily, Murrah knew something was wrong and went to a different clinic and requested a mammogram. The results were suspicious. Murrah was assigned to a surgeon at a neighborhood hospital. This surgeon, not a breast specialist, made two bungles: Instead of doing a needle biopsy, he surgically removed the lump—a painful and unnecessary procedure. Then, without informing Murrah of the stage of her breast cancer (stage III), he recommended an unneeded mastectomy. When Deshauna Dickens, one of the task force navigators, finally connected with Murrah, she referred Murrah to the University of Chicago Hospital for a second opinion. There, Murrah learned she had other options that would preserve her breast. "Deshauna came in just in time to stop me from having my breast cut off," she says, in an O, the Oprah Magazine interview.²⁷ There are setbacks. Not all women respond. Not all institutions have the will to better their conditions. Some facilities were deplorable, such as the mammography facility in the Washington Park neighborhood's Provident Hospital, which the task force staff visited in 2014. The room that was used to develop mammography films had a sewer manhole cover in the middle of the floor and was suffused with noxious sewer fumes. The path to improve quality and reduce mortality can be slow and painful. The Breast Cancer Quality Consortium Yet progress has been made. The grassroots team persuaded 160 health care providers across the state, including every Chicago hospital, to share their data, such as tumor detection rates and follow-up rates. Slow improvements in quality were made even in the poorly performing hospitals. In 2013, after seven years of work, the black-white breast cancer death gap in Chicago had narrowed by 35 percent.²⁸ While the exact reasons for the improvement in the mortality gap are not easy to tease out, in no other metropolitan area of the United States has that death gap been reduced. The reduction in black breast-cancer deaths in Chicago shows that mortality inequities caused by structural violence are fixable. Focused and deliberate work directed at equalizing the health care system can save lives. Racial disparity can be reduced—and possibly eliminated. "We don't need a magic bullet to fix this," says Dr. Patricia Ganz, a member of the Breast Cancer Research Foundation Scientific Advisory Board and professor of medicine and public health at UCLA. "We just need to give black women the same standard of care."²⁹ Implicit Bias Contributes to Unequal Care While the story of the Chicago breast cancer death gap has had early success, in too many areas and on too many levels we are still dealing with the most basic inequities and prejudices. Bias, even if unconscious, affects individual physicians and their treatment decisions. This is unsettling but true. While most doctors do not exhibit explicit racial bias, such as refusing to treat certain patients because of their race, on tests of implicit bias they, too, show unconscious preferences for whites over dark-skinned faces. The Implicit Association Test is a widely used test of social cognition. More than 70 percent of the millions of Americans who have taken it exhibit a subconscious preference for whites over blacks.³⁰ Physicians score similarly. An ingenious 1999 experiment showed how unconscious bias affects clinical decision making. Thousands of doctors were asked to test their clinical acumen by reviewing the medical history given by a performer who acted out the symptoms of a potential cardiac syndrome on film.³¹ There were eight elderly patients. Four were men: two white and two black. Four were women: two white and two black. Physicians were asked to recommend a cardiac workup based on the clinical information the patients relayed. In addition, physicians were told whether the patient was insured or uninsured. The results were not surprising. Based on the gender, race, and insurance status of the patient, doctors recommended entirely different medical workups. Men of both races were more likely to be referred for angiograms to evaluate symptoms of chest pain. But blacks of both genders were less likely than the whites to be referred for the full cardiac workup. Those who were noted to be insured were more likely to be referred for a full workup as well. While this was an experiment and not real clinical care, unconscious bias in health care delivery seems to be a real phenomenon. In an eye-opening 2002 report on health care disparities, the Institute of Medicine found "strong but circumstantial evidence for the role of bias, stereotyping, and prejudice" in perpetuating racial health disparities.³² Some research suggests that there is a direct relationship among physicians' implicit bias, mistrust on the part of black patients, and clinical outcomes.³³ In a prospective study of older adults, patients who experienced discrimination in health care more than once yearly were twice as likely to have a disability four years later than cohort members who suffered no discrimination.³⁴ What needs to be done to address implicit bias in medicine?

Awareness is a start. Mandatory bias testing and cultural intelligence training have been proposed. But it requires day-to-day interactions between people of different backgrounds to break the implicit boundaries that prevent deeper understanding.³⁵ And that's necessary, but fair. But bias is only a piece of the story. Having No Insurance Is Bad for Your Health Another major factor driving inequitable care is lack of health insurance. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether. Twenty-five percent of adults without coverage say that they went without care in the past year because of its cost, compared to 4 percent of adults with private insurance coverage. Moreover, 55 percent of uninsured adults do not have a regular place to go when they are sick or need medical advice.³⁶ When uninsured patients get injured or develop a chronic disease that requires follow up, they are less likely than those with coverage to actually obtain all the services that are recommended.³⁷ Blacks and Latinos are more likely to be uninsured than whites, which only increases the burdens of health care inequity borne in neighborhoods of concentrated

poverty. Prior to the Affordable Care Act, an estimated 45,000 residents died each year due to a lack of insurance, or one person every twelve minutes. If being uninsured was a cause of death, it would be the tenth most common one in the United States.³⁸ The next chapter will deal further with the issue of health insurance. Apartheid Hospitals

Once people do get insurance, there is no guarantee they will get good treatment. As Nobel Prize winner Angus Deaton has noted, "Hospitals in the United States are run on something close to an apartheid basis with few white patients in the hospitals that treat mostly African Americans and vice versa."³⁹ Hospitals in which the majority of patients served are minorities have higher mortality rates across the board, whether from trauma, cardiac surgery, or general surgery procedures. In fact, as the percentage of minority patients served increases at an institution, so do the mortality rates across many conditions. There seems to be a direct correlation between the proportion of minority patients served by a hospital and death rates.⁴⁰ Take trauma care as an example. Trauma centers that serve mostly minority patients have higher mortality rates than those that serve mostly white patients. There is a gradation of trauma mortality based on the percentage of minority patients served by the trauma center. Those trauma hospitals with fewer than 25 percent minority patients have 60 percent better trauma survival rates than trauma hospitals with more than 50 percent minority patients. Hospitals with 25-50 percent minority patients have trauma mortalities in between the two.⁴¹ Why would this be? Trauma centers require specific levels of physician and other staff coverage, and they require periodic rigorous certification. Shouldn't this attention and regulation lead to better care, regardless of race and ethnicity? There are only two possibilities. One is that trauma severity or high-risk conditions are more prevalent among patients in institutions that serve mostly minorities. However, even when severity of illness is controlled for, minority trauma centers have 37 percent higher mortality rates than those serving mostly whites. The other possibility is that the care is actually unequal. I have shown how this is true for breast cancer care. It seems to be true for many conditions. **What hospital you attend is literally a matter of life and death. In general, hospitals and clinics where many minority patients receive care are lower quality than those that serve white populations, whether for medical or surgical conditions.**⁴² Further, **hospitals treating a higher proportion of black patients have higher mortality rates for many surgical procedures.** In addition, **these hospitals have higher mortality rates independent of race:**

both black patients and white patients have higher mortality in hospitals with mostly black patients than their racial counterparts in other centers.⁴³ The federal Center for Medicare and Medicaid Services recently created a national star ranking system for hospitals, to allow consumers a means to assess hospital quality. A hospital can be ranked from five stars to one star, with five stars denoting a very high quality hospital with lower mortality and one star being a low-quality hospital with high mortality.⁴⁴ In practice, **star rankings vary by the whiteness of the hospital's clientele.** Five- and four-star hospitals in America serve patient populations that are predominantly white. One- and two-star hospitals in America serve predominantly minority patients and very few whites. **This is true for care at clinics as well as hospitals.**

The doctors who work at clinics that care for predominantly black and other minority populations are less likely to be board certified, have less access to specialty consultation, and work in more chaotic conditions. It is not a matter of the patients' race or ethnicity. Hospitals and clinics in poor neighborhoods, those that serve uninsured populations or those on Medicaid, often do not have enough resources to provide the very best care.⁴⁵ What seems at first blush to be a racial disparity is actually a consequence of structural violence and institutionalized racism. Just follow the money. Let's compare the cash situations at two Chicago hospitals, both trauma centers. During my decade at Mount Sinai Hospital, located in a low-income black neighborhood, 20 percent of the patients had no insurance. Another 60 percent had Medicaid. The patient population served is virtually 100 percent black and Latino. If a white person happens to be hit by a car down the street from Sinai, then they might be brought there. Otherwise a white patient, or anyone who is well insured, would rarely set foot inside Sinai. Then there's Northwestern Memorial Hospital. One of the top hospitals in the United States, on the US News and World Report Honor Roll, it towers over Lake Michigan about five miles from Sinai, in Chicago's predominantly white Streeterville neighborhood. It has an A bond rating, and about 500 days of cash brimming in its accounts. This translates to \$2 billion in bank reserves. Most of Northwestern's largely white patient population has private insurance. A small number are uninsured. During my time at Sinai, there were often only a few days of cash on hand. Sinai had no bond rating—meaning a bank would lend it money for capital investments. Just as Lawndale had been redlined seventy years prior, Sinai and other hospitals that serve poor communities are redlined by the banking industry today, limited in their ability to borrow. Sinai has been an anchor in the Lawndale neighborhood since 1919, and it takes care of everyone who comes to its doors, regardless of ability to pay. The price of this noble mission is a hospital's equivalent to a vow of poverty. From a banker's perspective Sinai is a bad investment. Compare Northwestern and Mount Sinai's spending on capital in 2012. Capital dollars reflect the amount of money that a hospital has to spend on patients, doctors, equipment, and upgrades. Northwestern spent \$273 million on buildings and equipment. Sinai spent just \$6 million.⁴⁶ The failure of capital markets to support Sinai contributed to its chronic struggles to maintain service quality. If we really want to achieve equity in health care outcomes, then we have to invest more into the institutions serving those who need care the most, like Sinai. This means redistributing capital dollars based on need from Northwestern and its neighborhoods to invest in Sinai and its Lawndale neighborhood. This is just the opposite of how the American health care system works. In America we have arranged it so those who need it the most (often black people and other minorities) get less, while those with the most (white and affluent people) get the best care and facilities available in the world. It is no surprise that life expectancy in Northwestern's neighborhood is 85 years. In Sinai's neighborhood it is 72 years.⁴⁷ Failure to Rescue When it comes to providing the highest quality of care, volume matters. The doctors and the nursing staff who are exposed to high volumes of particular kinds of cases have more time to hone their skills, and this leads to better outcomes. A surgeon who does liver transplants every week is better at them than one who does one per year. As for complex surgical conditions where high volumes of cases are crucial to achieve the best outcomes, nonwhite patients are more likely than whites to receive them at low-volume institutions. These patients are also less likely to be rescued if they deteriorate postoperatively. Procedural complication rates are exactly the same at high-mortality and low-mortality hospitals. So what is the reason for the death gap? The answer is culling failure to rescue. When a sick patient gets a complication, the doctors and nurses have to recognize and treat it—that is, rescue the patient from dying. Hospitals with well-developed systems to recognize complications and rescue patients have lower mortality.⁴⁸ While all the components of rescue have not been identified, adequate nurse staffing and training is critical. The hospitals with the least capability to rescue—due to nursing shortages, lack of training opportunities for staff, or other factors—serve significantly more minority patients and suffer higher mortality rates.⁴⁹ Truth or Consequences Cardiac surgery at Mount Sinai Hospital is an example of a low-volume and high-mortality program. Its struggles are instructive for understanding the day-to-day decisions in a poor hospital and how they lead to health inequities. When I worked there, the heart surgery program was small—about fifty cases each year. Programs this small have trouble maintaining quality because there is not enough repetition for all the staff who need to be in top form. In addition, because the capital investments required to maintain the service were so high, Sinai managers thought the limited capital we had should be invested elsewhere. So we closed the program and partnered with a nearby, higher-volume academic medical center (University of Illinois) to take our patients. It made sense. The neighborhood did not need a small, poorly functioning heart-surgery program. Then one day we had a patient in the cardiac-care unit with three blocked coronary arteries. He needed emergency bypass surgery. Our cardiologists inserted a special pump into his aorta to boost to his failing heart until lifesaving cardiac surgery could be performed. Time was critical. But the patient was uninsured, and the University of Illinois refused the patient. In desperation I phoned the chief of cardiology there. He recommended that the patient be discharged from Sinai and instructed to walk into the University of Illinois emergency room. Then, he said they would be required to treat him. I was shocked. Not only was this immoral, but it was medical malpractice. The patient was hooked to life support, teetering on the edge of death with an artificial heart pump attached to a blood vessel in his groin. Without surgery soon he would surely die. It took a call from our CEO to U of I's CEO to get this patient transferred. After this event, against their better judgment, our cardiologists urged our CEO to restart cardiac surgery at Mount Sinai. Despite the low volumes, inability to guarantee quality, and high capital costs, it became a necessary investment. These are the choices faced by safety-net hospitals in communities of concentrated disadvantage. Provide nothing and let patients die from neglect; or provide the best care you can, at risk of higher than desired mortality, and hope to pull most patients through. More broadly, a 2014 study evaluated cardiac-surgery mortality in patients insured by Medicare. Nonwhite patients succumbed at a 33 percent higher rate than whites (after risk factors were controlled for). Thirty-five percent of

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the death gap was due to deficiencies in hospital quality. The highest-mortality hospitals were those that served predominantly minority populations. Both white and black patients who received their heart surgery at predominantly minority hospitals had higher mortality rates, suggesting structural factors were responsible. When we speak of institutionalized racism as a structural cause of premature death, it is not the virulent type of racism that we associate with opposition to the civil rights movement of the 1960s. It's a more banal but deadly form of brutality woven into the tapestries of our institutions and thus harder to eradicate. I was not shocked by the study's findings.⁵⁰¹ knew that race itself—as a social marker—was not the reason for the cardiac mortality gap at predominantly minority hospitals; it was our tolerance for inequality in quality across our health care system. This becomes even more obvious when we contrast these findings with the outcomes in the Veterans Administration system, where care is structured the same way nationwide. In the VA system there is no equivalent racial heart-disease death gap.⁵¹ Inequality in Quality and Unequal Treatment It is not only in majority minority hospitals that black health-care inequities exist.

When black and brown patients receive medical care in any setting, they are more likely than white patients to receive unequal care.

This was documented in the Institute of Medicine's shocking Unequal Treatment report, which synthesized hundreds of studies of age, sex, and racial differences in medical diagnoses, treatments, and health care outcomes. The report concluded that for almost every disease studied, black Americans received less effective care than white Americans.

These disparities prevailed even among groups with identical socioeconomic or insurance status. Minority patients received fewer recommended treatments for diseases ranging from AIDS to cancer to heart disease.⁵² How much of the treatment gap is related to implicit bias, patient mistrust, physician practice style, or systematic organizational dysfunction is not known, but these gaps have persisted over the decade and more since the Institute of Medicine report.⁵³ Each year since 2003, the Agency for Health Care Quality and Research has tracked progress on health care inequity across America, analyzing more than 250 quality measures across a broad array of settings and services. In the 2014 report, the agency reported no overall improvement in racial health disparities from prior years. Not one iota. The American Hospital Association Pledge In 2015, in response to years of intractable health care inequities, the American Hospital Association called upon CEOs of hospitals across America to sign a pledge to measure health inequities within their own institutions and to fix them. The Equity of Care Campaign to End Healthcare Disparities focus is on four areas. First, hospitals are to choose a quality measure that is important to their community. Next, they are to develop a plan to address a disparity, whether by race, ethnicity, or language preference. Third, hospitals are asked to provide cultural competency training for all staff or finalize a plan to do so. Finally, hospital operations teams are asked to initiate a dialogue with the board and leadership team about this disparity work.⁵⁴ After over a century of documented health-care disparities, this step is important. But it is hardly enough.

The nation's hospitals have been organized for the most part to make money by attracting the best clientele with the best insurance policies. For most hospitals this means avoiding poor and minority neighborhoods. Those frayed and capital-poor hospitals that have made it their mission to care for poor and uninsured often struggle in poverty like their clients. Just as the neighborhoods of concentrated disadvantage were created by white and industrial flight and the expansion of neighborhoods of concentrated advantage, a similar phenomenon has occurred in health care. The nation's wealthiest health care systems for the most part have avoided serving the residents of concentrated disadvantage by placing offices and hospitals only in white communities of advantage. So pledges are well and good, but without larger structural changes that level the insurance and capital decisions that underpin the health care system, health care equity will continue to be elusive. Only with national health insurance reform that begins with the idea of health as a human right could these structural issues be resolved.

The Affordable Care Act, the most recent response to the need for health care reform, has tried to address these issues. However, as we will see, it has been an inadequate solution so far.

HEALTH INSURANCE IN AMERICA You guys are evil. Canada's the best country in the world. We go to the doctor and we don't have to worry about paying him, but here your whole life you're broke because of medical bills.^{1 J U S T I N B I E B E R} It will not do to note that under the Affordable Care Act almost 90 percent of Americans currently have some form of health insurance, any more than it would do for a hotel to note that 90 percent of the time the roof over your bed does not leak when it rains.² Of all possible ways to remedy structural violence in America, the creation of an equitable universal health-care system based on the idea that health care is a right, not a commodity, ranks high.

While the health care law was a reform of the old system that saw fifty million Americans uninsured, the Affordable Care Act perpetuates health care inequity and fragmentation by its very design. Yet if Republican calls to repeal the law are heeded, we will be back to square one. And bad will revert to worse. I was not surprised that the solution for universal health care in the United States would be to prop up the existing costly, inequitable, and inefficient insurance system. In 2003 my wife and I cosponsored a fundraiser in Chicago for the then little-known Illinois state senator Barack Obama, who was running for the US Senate. In the living room of a modest single-family home in the neatly manicured South Shore neighborhood of Chicago, I asked the future president his position on national health-care reform. His words presaged what came to be known as "Obamacare." "I'm a proponent of a single-payer system," he responded. But he explained that the political power held by the health insurance companies was so formidable that opposing them would be political suicide. He noted that the insurance industry had over 250,000 employees across the country and a lobbying apparatus that had to be reckoned with in any drive for universal health care. "Single payer will never get passed in the United States," he concluded. He was correct. Single payer did not even get a hearing. The Affordable Care Act was a modest reform of the existing tiered healthinsurance system, which treats health care as a commodity, not a human right. The coverage provisions in the Affordable Care Act built on and attempted to fill in the gaps in a piecemeal system that had left many without affordable coverage. There have not been

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impressive gains since the passage of health reform.³ A net of twenty million more people gained health insurance coverage between 2013 and 2015. Medicaid has expanded in thirty-two states and the District of Columbia, providing new access to coverage to millions of previously uninsurable Americans.⁴ The Affordable Care Act has been successful in reducing the number of uninsured, but about 30 million Americans remain uninsured.⁵ Most important, the Affordable Care Act fails two critical parameters of health justice: it is neither universal nor equitable.

Elegant, Equitable, and Not to Be The most elegant, comprehensive, fairest, and lowest-cost solution to the health care crisis would have been to expand and improve the Medicare insurance plan to cover all Americans.⁶ Medicare, enacted in 1965 as a single governmental payer system to provide health insurance for Americans 65 and older, has been well liked since its inception. Before Medicare, 48 percent of such Americans had no insurance; now only 2 percent are uninsured. In addition, before Medicare 56 percent of senior Americans paid out-of-pocket health care expenses, compared to 13 percent now.⁷ Satisfaction with coverage is substantially higher among Medicare recipients than for those who have private insurance. Only 8 percent of Medicare enrollees report their experience as fair or poor, compared to 20 percent of those with typical employer-based health insurance coverage and 33 percent of those who purchased private insurance directly.⁸ Moreover, the costs of administering the program are substantially lower than those of private insurance companies—only about 2 percent of the total cost for Medicare, compared to 12 percent for the least expensive insurance company's overhead charges.⁹ Most important, experts estimate that since its inception Medicare has added five years to the life expectancy of older Americans.¹⁰ Polls have shown that universal government-sponsored health coverage is preferred by half of Americans.¹¹ And an improved Medicare would be an entitlement available to all Americans, with the exact same benefits for the wealthy and the poor.

Medicare for all would achieve the goal of universal access to health care. As an entitlement for all US citizens (and extended to noncitizen residents), access to health care would be a right. This would contribute to the improvement of the life expectancy gap between rich and poor. Plus it would save an estimated \$400 billion yearly by eliminating administrative waste.¹² So if one wanted to solve the problem of the uninsured and reduce the death gaps between rich and poor, expansion of Medicare with other enhancements would have been the most logical approach. This is not a radical idea. Thirty advanced industrialized nations have forms of universal health care.¹³ Canada has a "Medicare for All" health insurance with easier access to care, lower costs, and better health outcomes (including life expectancy) than those of the United States. The evidence is compelling. While health inequity has not been eliminated in Canada, the differences between poor and rich are not as striking as they are in the United States.¹⁴ In Canada, men in the poorest urban neighborhoods experienced the biggest declines in mortality from heart disease from 1971 to 1996.¹⁵ Life expectancy gaps between income groups declined during that period as well. Poor Canadians with cancer had better survival than poor people from Detroit, an outcome The Poison Pill: Health Insurance in America * 135 136 * CHAPTER TEN attributed to the Canadian system.¹⁶ Of all the major Western economic powers, the United States is the only one without a universal health care system in which health care is considered a human right.¹⁷ Rather than treating access to health insurance as a universal right, the language of the Affordable Care Act endorsed the idea that health care is a mandate.¹⁸ The difference between health care as a right and health care as a mandate is critical, as these conceptions lead to very divergent solutions. If health care is a right, universal health care is an entitlement that should be the same for all citizens. If health care is a mandate, however, then there is no such entitlement, and health care is a commodity to be bought and sold. The Affordable Care Act established the mandate as a core component of health care coverage, perpetuating the complex system of multiple payers, limited access, variability in quality of care, high costs, and large rich-poor life expectancy gaps. Obamacare and Beyond The 2010 Affordable Care Act remains the most significant overhaul of the American health care system since the passage of Medicare in 1965, expanding insurance coverage to millions. The law survived multiple attempts by Congress and two Supreme Court challenges that aimed to gut its major provisions.¹⁹ As a reform of the current for-profit insurance marketplace, the Affordable Care Act addressed two major gaps in the existing system. First, it allowed young adults to stay on their parents' health insurance until the age of twenty-six—a popular provision that benefits almost eight million Americans.²⁰ The second major reform prevented insurers from denying coverage to people with preexisting medical conditions. Medicaid was expanded to include millions of previously uninsurable individuals who had been excluded from the health care system. Uninsured rates among whites, blacks, and Hispanics dropped, narrowing though not eliminating racial and ethnic insurance coverage gaps.²¹ At the same time, the Affordable Care Act incorporated the worst aspects of our fragmented for-profit health insurance system. The tiered system of insurance—where the coverage options for the poor are markedly different from those for the rich—has further hardwired inequity into the law.

In 2004 there were fifty million people without health insurance in the United States. That year the Institute of Medicine published a report, "Insuring America's Health," that outlined the principles against which any health reform legislation would have to be measured.²² The institute identified the ideal system as having "universal, continuous insurance coverage that is affordable and sustainable for individuals, families, and society, and should enhance well-being through care that is effective, efficient, safe, timely, patient-centered, and equitable." Eleven years later, none of these standards was being met. Even after the passage of the Affordable Care Act, there are around thirty million Americans without insurance and an equal number of underinsured who have health insurance policies but with deductibles and copayments that are high enough to deter care.²³ How did the United States end up with a more fragmented, more costly, and more confusing health care system? Simply stated, collusion between members of Congress and entrenched corporate health insurance and Big Pharma interests precluded a more equitable and lower-cost solution. What Americans got with the Affordable Care Act was complicated insurance marketplaces in every state with a complex array of confusing private insurance products. The health reform process exposed, in the words of the British medical journal The Lancet, "how corporate influence renders the US Government incapable of making policy on the basis of evidence and the public interest."²⁴ When the moment arrived to consider having a Medicare-like "public option" on the state exchanges to compete with private insurance companies, Senator Joseph Lieberman of Connecticut, the deciding Senate vote, deep-sixed the idea by threatening a filibuster.²⁵ The capital of Connecticut is Hartford, the home of Aetna, one of the big five health insurance companies. Skin in the Game There are

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three major structural flaws in the Affordable Care Act, all of which could be solved by a single-payer system. The first flaw is The Poison Pill: Health Insurance in America * 137 138 * CHAPTER TEN that the insurance expansion is neither universal nor equitable. For example, because mandatory Medicaid expansion was blocked by the Supreme Court, nineteen states have left millions of poor people uninsured.²⁶ These states account for over half of poor uninsured blacks, single mothers, and the country's uninsured working poor. For poor people in these states, it is as if Obamacare was never enacted. Note that for the most part these states that have refused to expand Medicaid are the former Confederate slaveholding states, accentuating the legacy of structural racism. Access to specialty care for those who receive Medicaid coverage is limited compared to access for patients with private insurance.²⁷ More than one-third of US doctors refuse to take Medicaid—another structural barrier.²⁸ The second flaw is that premiums, copays, and deductibles for private health insurance and products on the marketplaces are prohibitively high for many people, especially the working poor. In 2015 average annual premiums for employer-sponsored health insurance were \$6,251 for single coverage and \$17,545 for family coverage. Between 2014 and 2015, premiums increased by 4 percent, while during the same period workers' wages increased 1.9 percent. Premiums for family coverage increased 27 percent during the last five years, while cost sharing has skyrocketed.²⁹ The average individual deductible across the marketplace plans in 2016 was \$5,765 for bronze plans. After the deductible is paid, an individual with such a plan will face 40 percent copays for services.³⁰ Insurance companies have reacted to their rising costs by creating narrow networks of providers and hospitals.³¹ This limits choice of patients by restricting the doctors and hospitals whose services they can use. At the heart of the Affordable Care Act are subsidies for the working poor to pay for health insurance premiums.³² The goal was to keep these premiums within reach of most Americans. It was a sweet deal for the insurance companies. The insurance companies are guaranteed to get their premiums; the federal government poured billions of dollars into their coffers. In exchange, an individual gets an insurance card. But with that card came unprecedented out-of-pocket expenses that kicked in before the insurance company paid one cent.³³ The belief is that without "skin in the game," the newly insured will overuse the system. As a result, coinsurance and deductibles that many Americans now are forced to pay have skyrocketed across the insurance markets. Yet every study ever done on the impact of copays and deductibles (even for middle-class people) is that they cause individuals to delay medical care.³⁴ Under a single-payer health care system there would be no copays or deductibles. Obamacare Bullshit The third flaw of the Affordable Care Act was that long-term doctor-patient relationships have been disrupted by insurance restrictions. President Obama said, "No matter how we reform health care, I intend to keep this promise: if you like your doctor, you'll be able to keep your doctor; if you like your health care plan, you'll be able to keep your health care plan."³⁵ This turned out to be untrue. Windora Bradley, a year before her stroke, struggled to pay her health insurance premiums. Faced with the dilemma to buy food or go without medications, she chose to go without medications. At one of her office visits, she let loose. "I'm tired about this Obamacare bullshit," she shook her head, frowning as her jowls quivered. "I worked for thirty-five years. Those people on welfare who never worked are getting free health care. I am paying \$700 each month and there is not enough left for medicines and food. That's not right. That's why I call it Obamacare bullshit." Windora lived on a pension of about \$1,000 per month. Most went for the premiums on her health insurance, which she still received through the Chicago Board of Education. She scrimped and saved to pay for her medications for her diabetes, hypertension, asthma, and vascular disease. Her situation is common among the working poor. Windora was ultimately able to get insurance on the marketplace that reduced her premium costs but not her out-of-pocket expenses. At first she purchased a Blue Cross insurance plan that she was told my hospital accepted, but this proved incorrect. She then had to purchase a more expensive plan to stay with me. Meanwhile her two sisters, who The Poison Pill: Health Insurance in America * 139 140 * CHAPTER TEN had also been my patients for over thirty years, had to switch doctors because my group did not accept the insurance they enrolled in. A number of my long-term patients found themselves in this dilemma. In 2015, after her stroke, Blue Cross dropped my hospital and many others from the plan Windora had just purchased. There was only one plan, from United Health Care, in all of Cook County that included my hospital and me in the network. The week after Windora signed up for it, United Health Care let it be known that it was considering withdrawing from all the exchanges in 2017.³⁶ In three years of the Affordable Care Act, Windora had purchased three different insurance policies just to retain me as her physician. In the fall of 2016, United Health Care announced it would drop my hospital from its network, and Windora, now wheelchair bound and speechless, is forced to find another doctor (to say nothing of her many specialists) after thirty-six years. For someone like Windora with complex medical and social obstacles, keeping a team of providers who are familiar with her medical travails is essential to getting good care. For me, her longtime doctor, it is a gut-wrenching experience. The fact is that Obamacare, despite its modest benefits, does not remedy American health care inequity. It will never achieve universal coverage. Eleven million noncitizen residents will never be eligible for its benefits. Thirty million people will remain uninsured. While insurance coverage has increased for all races, there is still a large racial and ethnic gap in insurance coverage, which will perpetuate health disparities. For those with health insurance, spiraling copays and deductibles have made access to care more difficult. Finally, by allowing a dizzying array of for-profit insurance carriers with high administrative overhead expenses, the Affordable Care Act as currently configured will not control costs. In 2016, the third year of Obamacare, insurance companies asked for double-digit increases in premium prices, as they claimed costs of delivery had outstripped the revenues. Meanwhile, health insurance stocks are trading at all-time highs, while patients like Windora Bradley face rocketing expenses and uncertainty about the future.³⁷ The Poison Pill: Health Insurance in America * 141 A Call for Single Payer I speak for many of my health care colleagues across the nation when I say that

the Affordable Care Act is a disappointment. In contrast, an improved and expanded Medicare for All would achieve truly universal care, affordability, equity, and effective cost control. It would put the interests of our patients—and our nation's health—first. By replacing multiple private insurers with a single nonprofit agency like Medicare that pays all medical bills, the United States would save approximately \$400 billion annually. Administrative bloat in our current private-insurance-based system would be slashed. That waste would be redirected to clinical care. Copays, coinsurance, and deductibles would be eliminated. A single streamlined system would be able to rein in costs for medications and other supplies through the system's strong bargaining clout—clout directed to benefit health, not profits. Finally, it would create an equitable system of care that would provide equal access to rich, poor, black, and white. As a result, life expectancy gaps between rich and poor would narrow. Hospitals that serve poor communities would have access to capital investment based on need. It has been done in other countries, and it can be done in the United States. Single-payer health care stands in stark contrast to the ACA's incremental reform. Yet it is important to remember that enactment of a single-payer system requires the defeat of deeply vested, deep-pocketed ideological opponents, health insurance conglomerates, and a thick alliance of health care constituencies along with other interest groups. The Affordable Care Act, passed by a Democratic majority and signed by a Democratic president, was a weak compromise that left the foundations of our flawed \$2.9 trillion health care system intact. It will be some time before political conditions are again right to tackle an improved Medicare for All. So why, given these hurdles, do I (and many other health care providers) persist? I persist because I have watched too many patients suffer and die because they lacked health insurance or had the wrong insurance card. I persist because I have witnessed the racial and ethnic death gaps enabled by our current health insurance arrangements. I persist because simple fairness dictates that health care is a fundamental human right. I persist because of patients like Win142 * CHAPTER TEN dora and Sarai, who deserve better. For those who counter that single payer is too expensive or politically unfeasible, we persist because the American ideal of "life and liberty" cannot be achieved without an equitable and universal health care system. Winston Churchill reportedly said, "You can always count on the Americans to do the right thing... after they have

tried everything else.”³⁸ We have tried everything else. I look forward to being part of a single-payer health care system that values the health of individuals, families, and communities as a common good—where health care is valued as a human right. Someday.

Medical research reforms improve access and distribution of treatments while preventing racist malpractice.

Harriet A. Washington ⁷, Writer, Washington was Health and Science editor of the Rochester Democrat and Chronicle. In 1990, she was awarded the New Horizons Traveling Fellowship by the Council for the Advancement of Science Writing.^[4] She subsequently worked as a Page One editor at USA Today newspaper, before winning a fellowship from the Harvard School of Public Health.^[5] In 1997, she won a John S. Knight Fellowship at Stanford University, and in 2002 was named a Research Fellow in Medical Ethics at Harvard Medical School.^[6], “Medical Apartheid, A dark History of Medical Experimentation on Black Americans from Colonial Times to the Present,” Epilogue, pp 423-442.

EPILOGUE Medical Research with Blacks Today The voluntary consent of the human subject is absolutely essential. —THE NUREMBERG CODE In this book, I have traced the long, unhappy history of medical research with black Americans. I have detailed how blacks have been convenient, powerless, maligned, and abused subjects of profitable medical research and also how their treatment has changed over the years. Slaves were physically forced into painful medical bondage, their bodies were forced onto the stage of medical experiments to lend credence to claims of black inferiority and difference, and black bodies were even conscripted for anatomical dissection after death. Blacks were made subjects of experimentation that served to denigrate their intelligence or to provide distorted justifications for their enslavement. The reproductive rights of blacks also have been subjugated via fraudulent research up to the present day. Groups of vulnerable blacks, including children, soldiers and prisoners, have been consistently targeted. Both the federal government and private corporations have devised large-scale research abuses that range from radiation experiments to biological-weapons development. This medical ill-use has not strictly paralleled scientific knowledge: Rather, it has mirrored the larger American cultural beliefs as well as politics and economic trends. Once, black Americans enjoyed the sparsest of legal and social protections, nearly universal abject poverty, and few health-care options. But this social and legal landscape has changed dramatically, and so have research practices. Where We Are Today Today, the worst abuses are mostly memories, although some forms of abusive research persist, and a few new issues have arisen. However, today's offenses pale beside those our forebears survived. Today, much medical research is more than safe for African Americans; it is necessary. This may seem a strange message for a book that has described so many racial research abuses, but this volume's frankness is an essential prerequisite for asking African Americans to consider participating in medical research. No one can dismiss blacks' historically grounded fear of research and retain any credibility. We must acknowledge the past in order to regain trust and to seize the future. But medical abuse is more than historical fact. Although less rife, it remains a contemporary reality, and an ever-present possibility. The challenge is to prepare the way for a new openness to medical research on the part of African Americans while maximizing their protections from abuse. I do not see how this can be accomplished without candor, because the traditional strategy of ostrichlike denial merely heightens mistrust. To gain trust, we must first acknowledge the flagrant abuses of the past and the subtler ones of the present, yet much of the popular argument around medical experimentation and African Americans is dictated by culture and politics, not historical fact. The scientific camp includes most physicians, medical researchers, and others of all racial groups who pride themselves upon their educational sophistication. They tend to deny all present research dangers and most past ones, dismissing fears as emanating from those who are uneducated about the legal protections governing research or so credulous as to believe unsubstantiated rumors about the medical targeting of blacks. Mainstream medical scientists, journals, and even some news media fail to evaluate these fears in the light of historical and scientific fact and tend instead to dismiss all such doubts and fears as antiscience. The potentially damping effects on medical research, not the facts, become the focus of most discussions of troubled experiments. Like the medical school professor whose horror at my choice of topics I described in the introduction, many claim that any acknowledgment of abuse will drive African Americans from sorely needed medical care. However, a steady course of lies and exploitation has already done this. A 2002 American Journal of Law and Medicine article estimated that as many as twenty million Americans have enrolled in formal biomedical studies—but fewer than 1 percent are African American.¹ Yet the focus on African American fears is misplaced. A January 2006 Public Library of Science study entitled “Are Racial and Ethnic Minorities Less Willing to Participate in Health Research?” examined the consent rates of twenty research studies that reported consent rates by race or ethnicity for more than 70,000 individuals. It found only slightly lower consent rates for blacks compared to (non-Hispanic) whites. The investigations ranged from interviews to drug treatment to surgical trials. Yet blacks are significantly less likely to be included in clinical trials, which suggests that some factor other than consent is implicated. Studies such as those mentioned in chapter 11 already show that black children are more likely to be used in nontherapeutic, harmful studies than in therapeutic investigations. Future research may document that this is true for black adults as well. In short, many scholars such as Tuskegee Bioethics Center director Dr.

Vanessa Northington Gamble aver that the true focus should not be on the aversion of black subjects but rather on the untrustworthiness of American medical research when it comes to studies involving blacks. This book certainly documents this ethical deficiency. Although the focus of this book is clearly on experimental abuses of a vulnerable population, I do not want to leave the impression that I am advising people to avoid potentially beneficial medical experimentation. Quite the contrary. **African Americans desperately need the medical advantages and revelations that only ethical, essentially therapeutic research initiatives can give them.** The reticence of African Americans is the reasonable and understandable result of a horrendous history, but it lags behind progress. African American absence from research reflects the realities of yesterday, not today. More to the point, this aversion is a reaction black Americans can ill afford. For this book to have the most value, I ask readers to hold two seemingly contradictory but actually complementary facts in mind. The first is that **African Americans must welcome and embark upon medical research as a bridge to fording the gulf that yawns between the health profiles of sickly enfranchised blacks and those of healthy, long-lived whites.** The second fact is that African Americans must remain wary of research abuses. They are rarer, but the potential for exploitation and abuse still looms. **Physicians, patients, and ethicists must also understand that acknowledging abuse and encouraging African Americans to participate in medical research are compatible goals.** History and today's deplorable African American health profile tell us clearly that **black Americans need both more research and more vigilance.** The worst abuses no longer occur and others are becoming far rarer, in part because the media exposure of racial research scandals has led to **public condemnation.** This, in turn, has helped to support the enactment of **stiffer laws carrying real penalties** rather than yesterday's toothless codes, such as that written at Nuremberg. **This matrix of legislation is not perfect, but it reduces the unabashed use of African Americans as duped or unwitting research subjects.** **Sociopolitical changes have also helped in this regard.** There are no more "separate but equal" hospitals to provide powerless research fodder. There are no more nakedly vulnerable black people without the protection of the law; there are no more hospitals devoid of those black physicians who can protest racial dichotomies in patient treatment. Black physicians, researchers, and journalists now join the white professionals of conscience who have brought such abuses to attention and to a stop. The news media may not always discern and detail the patterns underlying problems with new therapies, but they do regularly expose research abuses. **Government has shown itself more likely to close down entire university research programs** under the aegis of the FDA when embarrassed by federally sponsored abuse. Closure is a fate that has been suffered by even premier universities, from Duke to Johns Hopkins. Most universities have heeded the message. **All this amounts to a limited but real success story.** **African Americans are no longer the primary targets of research, exploitation, and abuse.** Research ethics and policies have evolved to the point where the worst abuses of blacks are but a bad memory. That's the good news.

Africa:
Continent of Subjects The bad news is that the racial mythology, the medical exploitation of black bodies for profit, and even the instances of medical sadism that threatened African Americans in the past have been exported to Africa. The recent history of medical research in Africa parallels closely that of African Americans in the United States a century ago. Colonialism and its residual racial and class separations have isolated blacks in hospitals or hospital wards away from whites, just as segregated hospitals once provided exclusively black subjects for white doctors. Laws that offered few or no protections for abused blacks have emboldened unscrupulous physicians and researchers who put curiosity and profits above the rights and welfare of their black patients. Western physicians, scientists, and pharmaceutical companies need large pools of people for Phase I trials, and they have swarmed Africa as they once flocked to prisons. U.S. researchers who can no longer conduct trials at home without intense scrutiny from the FDA and the news media have moved their operations to sub-Saharan Africa to exploit the public-health vacuum that once condemned black Americans. "To get around consent forms and a skeptical public, many researchers are turning their attention to African and other developing countries," Robert F. Murray, Jr., M.D., chief of the Division of Medical Genetics at Howard University, has observed. "I would say the greatest chance for injury is in the Third World, where people don't even know research is going on and don't have a clue." The long history of how Western investigators have taken their more questionable research initiatives to Africa is well documented in works such as Dr. Wolfgang U. Eckart's *Medizin und Kolonialimperialismus*. In it, Eckart details how, in a giddy dress rehearsal for Dachau, nineteenth-century German scientists conducted genocidal experiments on Africans, especially the Herero of Namibia.² The United States, like Europe, has long used its nonwhite colonies and territories as its laboratories. For example, Richard Strong, M.D., used prisoners in the Philippines to conduct deadly malarial experiments, and chapter 8 relates how Brazilian, Mexican, and Puerto Rican women have more recently been used for birth-control trials that maimed and killed many.³ Warwick Anderson, M.D., documents how colonizing nations, including the United States, have used often-mythical racial differences, including the purported infectious-disease immunities of Africans, to further colonial aims and to justify the use of natives as workers in dangerous environments—just as U.S. slave owners once did. In much of Africa, Asia, and South America, a wide understanding has reigned that ethical rules governing medical experimentation were not "for natives." Henry Louis Gates, chairman of African American Studies at Harvard University, recalls encountering such persistent racial myths during his undergraduate studies. "It was premised at Yale and took a year off to work at a mission hospital in Tanzania, where the doctors were all Australians. I was only twenty-one years old and I gave anesthesia to patients. I was shocked by the fact that when patients were writhing in pain, the doctors would say, 'They don't experience pain the same way we do.' I was totally disgusted. I complained loudly and called them all racists, of course. But this illustrates how it is always easier to distance oneself from the pain of 'the other.' The use of poor people of color abroad by American scientists today enables researchers to escape both the strictest scrutiny of institutional review boards and the gaze of the FDA," says Murray, who issued a prescient warning in 1994: "People are going overseas trying to do research in Africa. They are saying, 'We don't have to go through all that IRB stuff to study AIDS, sickle cell and other diseases. This sort of questionable research is now going on in Africa and Third World countries because there are plentiful patients and the scientists are not subject to the same restrictions they are now subjected to here.'" The Third World has become the laboratory of the West, and Africans have become the subjects of novel dangerous therapeutics. In 2002, the hormones of "Bushmen" were mined for potential weight-loss therapies.⁴ A human growth factor was tested on Pygmies before being used on Western children.⁵ And Depo-Provera, although a carcinogen, was tested on Zimbabwean women before it was introduced into the United States as a reproductive injection. American firms tested artificial blood on unsuspecting black South African hospital patients, at the cost of at least twenty deaths. Harvard tested HIV therapies through research that would have violated ethical requirements for Americans. Some of the research on Africans by Western scientists has been more subtle but equally troubling from an ethical perspective. For example, trypanosomiasis, or sleeping sickness, kills as many as half those it infects in the Central African regions of Uganda, the Democratic Republic of Congo, Sudan, Ethiopia, Malawi, and Tanzania. Melarsoprol, the only effective treatment, is a very toxic compound of arsenic and antifreeze that kills one in five people who take it. By 1995, the pharmaceutical firm Avantis had completed research demonstrating that its drug eflornithine was effective against sleeping sickness, although not against cancer, as the firm had hoped. But the company decided to abandon its use against trypanosomiasis, due to high production costs and low profits. It began seeking other profitable uses for the drug, and U.S. researchers soon found one: Eflornithine effectively banished facial hirsutism in women. Avantis and later Bristol-Myers Squibb began marketing the drug as Vanican, because many American women were able to part with fifty dollars a month to keep their faces free of hair, while few Africans were able to pay fifty dollars monthly to save their lives. It is completely understandable that the firm would its resources upon the profitable depilatory use of their medication, but it is disappointing that it chose not to make the drug available cheaply to Africans in order to vanquish sleeping sickness. Doctors Without Borders forged a coalition, which included Bristol-Myers Squibb, Bayer, and the Bill and Melinda Gates Foundation, to provide drugs to Africans through 2006, but although sleeping sickness threatens sixty million people, only 7 percent of these have access to adequate medical treatment.⁶ Medications considered far too dangerous or too hopelessly tainted for testing in the West have been introduced into clinical trials with unsuspecting African patients. Within the past decade, even the infamously teratogenic drug thalidomide has been tried on Africans as a treatment for leprosy—forty years after it produced twelve thousand horribly deformed babies around the world. FDA researcher Frances O. Kelsey, M.D., refused to approve thalidomide as a treatment for morning sickness in the 1950s because she determined that clinical trials did not demonstrate its safety; her caution saved most American infants the fate suffered by English and European whose mothers took the drug. (Only those U.S. babies whose mothers received thalidomide samples from their physicians were affected.)⁷ But Third World women subjects of thalidomide trials for leprosy and AIDS were not warned of the horrific birth defects the drug can cause. African experimental subjects, like the slaves of antebellum America, are legally vulnerable, relatively powerless, and racially distinct. Like black Americans after the Civil War, Africans' poorer health and vanished healthcare infrastructure make it easier to pass off nontherapeutic research as medical therapy or to impose participation in research as a condition for therapy. The U.S. physician-researchers who depend upon Africa in search of subjects frequently characterize their work as therapy, offering experimental solutions for medical disasters. When physicians offer African the same therapies they offer Westerners, they can lay claim to unalloyed beneficence. But the Western standard of care is not being offered; usually poor black Africans with no access to medical attention are offered treatments that are new or untried. Sometimes U.S. researchers appear in the midst of an epidemic against which the stricken Africans have no medication and offer experimental treatment. During the height of a 1996 meningococcal meningitis epidemic, for example, scientists offered Pfizer's experimental drug Trovan (rifaxin) to terrified parents in Kano, Nigeria. Nigerians desperate for medical attention grasped at Trovan's straw. By the time the experiment ended, two hundred children were left severely disabled and eleven were dead. In 2001, at least 211 Nigerian parents sued New York-based Pfizer, Inc., alleging that non-FDA-approved experiments had killed or injured their children; that Pfizer failed to obtain the requisite approval from local leaders; and that the pharmaceutical giant failed to administer standard therapies with proven efficacy, such as Pfizer's own ceftriaxone to those children who continued to deteriorate after being given Trovan. Peter Ebigo of Chilights Africa told Inter Press Service, "Our leaders must not allow Nigerians to be used as guinea pigs by any company to make money." Pfizer counters that it treated ninety children with Trovan and ninety-seven with ceftriaxone, and that it obtained all the necessary approvals. However, Dr. Sadig Walli, chief medical director of the Aminu Kano Teaching Hospital, says the hospital's medical ethics committee never gave Pfizer the required approval to use the drug at the infectious-disease hospital in Kano. "Pfizer did not do that; I am not sure if they had the consent of the people used as guinea pigs, because that means informed consent in medical parlance. Such consent has to do with the patients being told the good as well as the side effects of the drugs to be administered," said Dr. Walli. But documenting Trovan's effects on these patients for the lawsuit would prove tricky: The medical records of 350 meningitis patients treated between April and June 1996 have disappeared from the hospital.⁸ The dearth of health care in much of Africa and the Third World makes its people vulnerable to experimental abuse. One cannot generalize about a continent as large and diverse as Africa. There are wealthy countries as well as poor ones, and a few health-savvy nations, such as Cameroon, could teach us a thing or two about providing health care to all our citizens. But much of sub-Saharan Africa has been devastated by colonial rape and depletion. These have left poor health, a ravaged health-care infrastructure, and few physicians in their wake. A mere 750,000 health workers care for the continent's 682 million people. The Organisation for Economic Co-operation and Development estimates that this represents a health-care force that is as much as fifteen times lower than in OECD countries. Only 1.3 percent of the world's health workers practice in sub-Saharan Africa, but the region harbors fully 25 percent of the world's disease. A bare minimum of 2.5 health workers is needed for every one thousand people, but only six African countries meet this standard. Instead, the average in sub-Saharan Africa is 0.8 health workers per one thousand people—less than one-third the minimal standard. To achieve the minimum health-care staffing level will require an infusion of one million health workers into the continent. Safe devices are as scarce as doctors. Reused SUDS (single-use devices) and sterilized needles help to spread AIDS and other infectious illnesses throughout Africa. The medically damaging injection practices and use of ethically suspect research has fostered a loss of trust in vaccines in Nigeria. Much of the news coverage focuses upon the contentions by suspicious Africans that the administration of Western vaccines spreads HIV and causes sterility.¹⁰ But no matter whether these fears are correct or imaginary, the practical result is unambiguous: suspicious patients avoid care, and this iatrophobia means that "conquered" diseases such as polio are seeing a resurgence on the continent. A burgeoning research culture is thriving in the midst of this desultory public-health activity and therapeutic vacuum. While the continent's wounds go unbound, research is big business in Africa. Seventy billion dollars is spent each year on medical research, but only 10 percent is devoted to diseases that cause 90 percent of the global health burden.¹¹ This dichotomy provides an incubator for research abuses. Surrounded by pain, death, and infection, desperate, medically ignorant Africans are confronted with a Hobson's choice: experimental medicine or no medicine at all. Western researchers who conduct investigations in the Third World are supposed to elicit the approval of their home medical institutions. For example, most university policies align with FDA regulations that require treatments given to the control-group members must be the standard of care for the treatment of the illness. Thus if one wanted to test Trovan in Connecticut, the protocol or research plan would stipulate that researchers must give the control group the best drugs known to treat meningitis, a drug such as ceftriaxone. Under some conditions, generally when no effective treatment for a condition exists, control-group members receive a placebo, an inert substance or a sham technique that does not offer any intrinsic therapeutic value but allows scientists to compare results between a treated and an untreated group. But placebo studies, which are falling out of favor in the West, are completely inappropriate for serious diseases for which effective treatments exist. You cannot ethically justify withholding, for example, an efficacious drug such as AZT from HIV-positive people or people at high risk of contracting HIV just to determine whether protease inhibitors work better than nothing. You must give the tested group protease inhibitors and the control group either AZT or the best-known standard therapy. Tossing the people in the control group placebos, vitamins, or antibiotics would doom the control group and so would be an unacceptable ethical breach—at least in the West. However, American IRBs treat Africans as second-class subjects and employ different standards for evaluating study designs in Africa than those used in the United States. Requiring evidence that the drug being administered meets or exceeds the standard of medical care is de rigueur for Western trials, while university IRBs now employ an ethical slight of hand to stipulate that the tested drug must meet or exceed

the standard of care in the country where the study is being evaluated. In impoverished, medically underserved sub-Saharan African countries, that standard of care has historically tended to be nothing. Americans who conduct research in African venues are supposed to seek the consent of their subjects. But this has never been a popular move, as the exaggerated 1964 complaint of Dr. Francis D. Moore, a Harvard surgeon whose photograph had graced the cover of Time a year earlier, illustrates. Several years ago an individual from this country went to Nigeria to try out a new measles vaccine on a lot of small children. Now how exactly are you going to explain to a black African jungle mother the fact that measles vaccine occasionally produces encephalitis but that more important than that it might sensitize the child for the rest of his life to some other protein in the vaccine? We now know that any sort of immune response excites cross reactions. For example, if a person develops a heightened immune reaction to some specific antigen such as typhoid he will be found to have other high titers against non-specific antigens at the same time. In fact, there is a suspicion [sic] that some of the so-called autoimmune diseases are aroused by exposure of the reticulendothelial system to completely different antigens. The possibility therefore arises that measles vaccines applied to thousands and thousands of children might excite in some of them such diseases as thyroïditis and ulcerative colitis. Can you imagine trying to explain that to a jungle mother? ... One of the greatest assets of a good doctor is the ability to look a patient in the eye and have the patient go along with him on a hazardous course of treatment.... The same quality is exhibited by a medical experimenter when he looks at [a] patient and says that he thinks everything is all right. 12 Moore avoided the troublesome task of individual disclosure and consent, and so do many researchers in Africa, today, who do not want to take the time to translate their proposal into the local language and culture. They do not want to explain to hundreds or thousands of subjects such risks as iatrogenic encephalitis and sensitization—concerns that would have been as murky to a Connecticut homemaker in 1964 as they were to Moore's "jungle mother." These scientists do not want to risk having the subjects reject the experiment once they understand the possible health costs. Neither do they especially want to explain why they are testing a new therapeutic approach to HIV thousands of miles away from the millions of cases in their own country. Moore doesn't mention this sort of question in his tirade against informed consent, but I suspect that it is the more difficult of the questions his jungle mother might put to him today. The Erosion of Consent Underlies the disastrous Thalidomide research trend; medical research with black Americans has lost so much of its historically abusive nature that black Americans should embrace new medical research—after judicious inquiries of their own into any study they are considering. But there are still issues that must be addressed, and until these problems are rectified, black Americans must embrace medical research warily. These issues include the recent erosion of informed consent; the need for better-quality research into black health issues; the overemphasis upon genetic research in nongenetic issues; and the government's distortion of research with black Americans to further political and ideological ends. *"It is the most fundamental tenet of medical ethics and human dignity that the subjects volunteer for the experiment after being informed of its nature and hazards.* This is the clear dividing line between criminal and what may be noncriminal. If the experimental subject cannot be said to have volunteered, then the inquiry need proceed no further." So testifies Andrew Lyd, M.D., chief witness for the prosecution in the Nuremberg doctors' trial. The Nuremberg Code was instituted in August 1947, by Americans judging twenty-three physicians and scientists, to ensure that the horrors of abusive medical experimentation never again be visited upon the world. Its very first line is unambiguous: "The consent of the subject is absolutely essential." But American research culture increasingly disagrees. In October 1996, 13 the Department of Health and Human Services passed 21 CFR 803.4, a regulation that robbed seriously ill emergency room patients of the right to informed consent. This allows researchers to legally enroll such patients in medical-research studies and test experimental treatments on them without their consent. 14 The emergency room deaths began the very next year. On April 1, 1997, when the Occupational Health and Hygiene Plan (OHH) suspended a U.S. clinical trial that had enrolled unwitting patients in a clinical trial of aspirin-cross-linked hemoglobin (DCHb) for treating shock. So many more people who received the experimental treatment died than those receiving standard care that the trial had to be stopped early. These people had never given their consent to participate in the study that killed them. Yet today the practice of experimenting with nonconsenting emergency room patients continues. For example, when they need a blood transfusion, unconscious patients brought into some emergency rooms are as likely to be given an artificial substitute as blood—without their knowledge. Also, the Abco Corp. company proposes to implant their complication-ridden model of a self-contained artificial heart into a wide variety of heart-attack patients who are brought into emergency rooms if they meet certain (rather wide) research criteria—again without their permission or knowledge. And informed consent is also being attacked more insidiously—in assaults upon existing laws. 15 Various ethicists who are experts in human medical experimentation, such as Jay Katz, M.D., and George Annas, J.D., argue that the vague language of federal regulations governing human medical experimentation is being interpreted in a manner that minimizes protection. At the same time, they point out addenda to these regulations that further curtail patient protection and patient autonomy while extending the types and number of people who become subjects. The notion of consent is often interpreted as a parental surrogacy or a compromise between the needs of researchers for subjects and a smudge on a patient's autonomy. Or it is set behind the mask of futility—in such scenarios, it is argued, the patient is incompetent and cannot agree or disagree to partaking of a possibly life-saving experimental treatment, so his doctors should decide for him. In such cases, "research" is conflated with "treatment" to justify removing informed consent from the equation. But these scenarios are false and misleading. It is not necessary to waive informed consent in order to provide the unconscious with treatment; Laws already exist that permit doctors to offer the best-available treatment to patients who are comatose, unconscious, underage, or in other ways unable to consent to treatment. But these laws do not extend to experimentation, and rightly so. Treatment focuses upon the patient's needs; experimentation focuses upon the researchers' needs, no matter how much those researchers may invoke possible side effects or benefits for patients. In fact, these studies are typically randomized, which means that the computer, not the doctor, determines what experimental therapy will be administered. This may not be the best treatment for the patient, nor the therapy the patient would choose. Once one loses the right to be told what one is about to undergo, to agree or to refuse participation, research policy gains momentum on a very slippery slope. This book documents the depths to which researchers have stooped to bypass the consent of the subject. In fact, African Americans first became favored subjects because during the antebellum period they did not enjoy legal protections and researchers did not need their consent. This vulnerability also persists today in other settings where blacks are overrepresented, such as military ground troops. In 1990, the Department of Defense (DOD) sought and obtained from the Food and Drug Administration a waiver of the informed-consent provisions that give other Americans the right to say no to experimental medications. The DOD forced them to accept experimental drugs, including pyridostigmine bromide, a putative prophylactic against nerve gas attack; and the pentavalent botulinum toxin vaccine for botulism. In 1998, with FDA permission, the DOD Anthrax Vaccination Immunization Program (AVIP) also began immunizing 24.4 million soldiers against the potential threat of airborne anthrax. At least 900,000 troops have been immunized to date. But, citing devastating side effects and deaths that have been validated by amendments to the medication warning labels, hundreds of soldiers have refused to comply, at least one hundred of whom have been court-martialed, and many have been forced to leave the military. One of these was Jemeika Barber, who while stationed in Colorado was ordered to accept an anthrax vaccination in preparation for a transfer to Korea. She disputed that order on the grounds that the vaccination may not be safe for females of childbearing age. Black soldiers such as Barber are twice as common in ground troops as are American society, and so are especially vulnerable to measures such as forced vaccinations. 16 In late 2003, Judge Emmett G. Sullivan of the United States District Court in Washington, D.C., noted that the Supreme Court had ruled that U.S. combat troops could no longer be compelled to take the experimental anthrax vaccinations. The FDA responded by rapidly elevating the anthrax vaccine from a questionable investigational drug to an approved therapeutic, allowing the DOD to sidestep the intent of the law and restore the soldiers to a state of investigative servitude—"investigative" because the data collection and evaluation of the anthrax vaccine risks, including death, will continue among soldiers. Fortunately, in 2004, Judge Sullivan ordered the DOD to stop forcing anthrax vaccines on U.S. military personnel. Barber's lawsuit against the army continues. Today, African American are at greater risks than whites to being conscripted into such research without giving their consent, because blacks are more likely than whites to receive their health care from emergency rooms. However, this coin of research vulnerability has an obverse: We also need more and better research into black health care. Such high-quality research has begun to emerge, but, as chapter 14 points out, it has also taken some wrong turns. For example, research into black ailments and medications, such as that conducted in support of the black heart-failure drug BiDil, is sometimes sloppy and illogical, and in other cases it is based on the thinnest of premises. The long history of flawed science in the practice of preconceived notions is being supplemented by new, insufficiently rigorous research that is based on racial theories of disease. Adopting these unquestionably while ignoring important environmental disease factors not only imperils black health; it also reinforce the idea of blacks as possessing dramatic physiologic differences. The inclusion of blacks in quality American medical research is also important for everyone. Why? Many arguments cite the dollar savings or the reduction in disease exposure to the larger society that will emanate from better health among African Americans. However, I am often uncomfortable with arguments that focus solely on utility, especially when it comes to medicine and health. Such benefits can be elusive or hard to quantify. I believe that caring for people and maximizing their chances at health and happiness are goals that we should pursue for their own sake, because they are the right thing to do. They elevate us spiritually and socially, and reaffirm our cohesion and our

there's no denying that increasing the ethical, reasonably safe research available to Africans

Americans will benefit everyone else. This book has repeatedly demonstrated how the poor health profile spawned by experimental abuse has not only harmed blacks but has spilled over to harm their white compatriots. Pathogens, for instance, are notoriously democratic. Had African Americans not been excluded from early AZT therapy on the basis of flawed HIV treatment clinical trials (that largely excluded them), would the number of HIV-infected African Americans be lower today? Would the number of all domestic AIDS cases be lower, considering that black Americans today constitute half of all the HIV-infected? It's too late to

today? Would the number of all domestic AIDS cases be lower, considering that black Americans today constitute half of all the HIV-infected? It's too late to know now, but not too late to do better racial recruitment for the next HIV clinical trials. The fallout extends beyond infectious disease. For example, Donna Christian-Christensen, M.D., who represents the U.S. Virgin Islands in Congress, has observed that the percentage of black Americans who are insured is lower than that of white Americans, and the cost of caring for these uninsured people raises the rates and health-care costs of all Americans. She said, "We're getting to the hospital late, using much more expensive care: We're really driving up the costs of health care." In fact, a decade ago, research by Harvard School of Public Health professors Ichiro Kawachi, M.D., and Deborah Prothrow-Stith, M.D., explained this public-health phenomenon in detail and even quantified it, emerging with what was popularly referred to as the "Robin Hood Index." The shorthand is that public health suffers more in the nations with the greatest inequities in wealth, and that the middle class suffers nearly as much as the poor from inequities. In the United States, which has, for example, one of the world's greatest disparities in income between the haves and have-nots, we have not only the greatest health disparities but the greatest health-cost burdens for the mostly white middle class. In short, whites should care about quality medical research for African Americans because its dearth has generated needless pain, suffering, anger, and costs that continue to permeate the fabric of our entire nation: It is not only a racial tragedy but also an American tragedy. For their part, African Americans cannot afford passivity. Seneca said, "It is part of the cure to wish to be cured." When it comes to medical research, that wish must be awakened in African Americans. African Americans should not shun lifesaving research; indeed, they cannot afford to do so. Instead, they must carefully scrutinize research initiatives before becoming subjects. But we must do more: We must also address the dearth of therapeutic research in areas that affect the health of African American most dramatically. **What**

changes are necessary to achieve this? REPAIR THE SYSTEM OF INSTITUTIONAL REVIEW BOARDS (IRBs) judge the scientific and ethical acceptability of proposed studies on human subjects. However, a string of abusive experiments have revealed that the nation's five thousand IRBs have failed to perform their role of protecting the public, and African Americans in particular. In June 1998, a Department of Health and Human Services (HHS) report concluded that IRB staff are inadequately trained, subject to conflicts of interest, and overwhelmed by too many cases.¹⁷ The Office of Protection from Research Risks (OPRR) requires IRBs to have a **minimum of five members**, at least one of whom must have primarily scientific interests, another of whom must have primarily nonscientific interests, and another of whom must be otherwise unaffiliated with the IRB's institution. But most IRB members are scientists affiliated with the organization in question, and even the lay members tend to have loyalties to the home institution. I propose that each IRB be composed of **equal numbers of scientists and of peers of the group who will be asked to participate as subjects**. Some may object that laypeople will be unable to understand enough about scientific experiments to judge their suitability and value, but as a medical communicator, I doubt this. I know many skilled and motivated scientists who routinely convey complex information to many people, although to do so may require some preparation and effort. Moreover, if a project cannot be explained to laypersons in an IRB meeting, how does a researcher propose to explain it to the **potential subjects**, as he [they] must do by law? I also propose that each IRB include a **medical ethicist** and, if possible, a **medical historian**. STOP THE EROSION OF CONSENT Ban exceptions to informed consent. Recognize the

right of every patient to say yes or no as an absolute value and cease designating groups such as soldiers, unconscious emergency room patients, and Third World experimental subjects as appropriate subjects without their input.

When physicians are faced with a patient who is unable to consent because of his or her medical condition, and whose condition requires treatment before a family member or other proxy can be consulted, I propose that the patient be treated as if the physician had no research protocol to worry about.

Treat him or her, but don't enroll that patient in a study. Instead, use the best-known treatment for that particular individual.

INSTITUTE A COORDINATED

SYSTEM OF MANDATORY SUBJECT EDUCATION The NIH and the Office of Research Integrity require that every practicing medical researcher receive education in the ethical and practical conduct of biomedical research.

I took such a course at Harvard Medical School in 2004 and found it factually invaluable and culturally revealing. I propose that prospective research subjects be given the same advantage. Every institution that receives government funds to perform research should be required to hold approximately three classes that equip subjects with information about how research is conducted, what risks and benefits are inherent in different types of research, what their legal rights and moral responsibilities are, what sort of questions they should ask, and how they can maximize their chances of getting the desired result from the clinical trial they enter. Except for seriously ill or otherwise-incapacitated patients, only people who have completed this course should

be eligible to participate in governmentfunded clinical trials, and only they should be permitted to serve on IRBs.

EMBRACE A SINGLE STANDARD OF RESEARCH ETHICS We cannot retain moral credibility if we champion human rights in medical research at home and ignore them abroad. Researchers should be made to follow informed-consent strictures abroad that are as restrictive as those governing their research on American shores.

Pharmaceutical companies should be forced to make lifesaving drugs available to people in poor countries, even when this means sacrificing their obese profits for the benefit of human welfare. Because the federal government sponsors much of the research that enables pharmaceutical companies to develop vital medications, the federal government should take advantage

of its legal right either to force manufacturers to lower their prices or to suspend patent enforcement in poor countries. However,

more important than any of the above recommendations is the need for African Americans to set their own research agendas. Black patients must take ownership of medical-research issues,

as they have done with so many other complex health issues, from AIDS to

environmental racism. Already, expert medical organizations have taken leadership roles. The National Center for Bioethics in Research and Health Care at Tuskegee University provides not only a center for scholars but also a venue for

muchneeded lay education on medical research. The National Medical Association has also spearheaded patient education through its Project IMPACT, which has helped black Americans to navigate clinical trials safely by providing brochures, Web sites, and access to experts. African American and other health organizations must continue and expand the work of these pivotal groups, and much of this can be done close to home, through church health fairs, social organizations, and community activism. I challenge African Americans to bring medical-research education to the fore of the American health agenda. I challenge you, the reader, to familiarize yourself with the informational documents on this book's Web site and elsewhere, to join an IRB, to ask the hard questions of physicians who are recruiting in your community, and to join appropriate clinical trials once you have satisfied yourself that they are worthwhile and relatively safe.

I challenge African Americans to effect a transformation of our attitudes toward medical research and to demand our place at the table to enjoy the rich bounty of the American medical system in the form of longer, healthier lives.

Expanding the medical workforce to be more representative of the communities it serves enables better care and policy design through shared experience.

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Racial/ethnic disparities in health have been well described, with data showing that members of minority groups suffer disproportionately from cardiovascular disease, diabetes, asthma, and cancer, among other conditions.'

The causes of these disparities are multi-factorial, and perhaps the largest contributors are those related to social determinants of health external to the health care delivery system. For example, members of minority communities tend to be more socio- economically disadvantaged, to have lower levels of education, to work in jobs with higher rates of occupational hazards, and to live in areas with greater environmental hazards (such as air pollution)

than members of the majority population.²⁻⁶ Furthermore, minorities are overrepresented among the rolls of the uninsured, with Latinos, for example, representing 13% of the U.S. population but 25% of those Americans without health insurance.⁷ Lack of insurance takes a significant toll on these populations, with health effects including less access to preventive care than among people with insurance, high rates of emergency department use and avoidable hospitalizations, later-stage diagnosis of cancer, and the inability to obtain prescription medications.⁸⁻⁹

Even the prolonged impact of racism has been studied and linked to poor health outcomes among African Americans.¹⁰⁻¹¹ Racial/ethnic disparities in quality of care for those with access to the health care system are equally concerning. These disparities have been shown to exist in the utilization of cardiac diagnostic and therapeutic procedures,²⁻⁶ prescription of analgesia for pain control,⁷⁻⁹ surgical treatment of lung cancer,²⁰ referral to renal transplantation,²¹ treatment of pneumonia and congestive heart failure,²² and the utilization of specific services covered by Medicare (e.g., immunizations and mammograms).²³ The recent Institute of Medicine report Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care identified well over 175 studies documenting racial/ethnic disparities in the diagnosis and treatment of various conditions, even when analyses were controlled for socioeconomic status, insurance status, site of care, stage of disease, comorbidity, and age, among other potential confounders.²⁴ Among the many root causes of disparities that have been presented and explored, variations in patients' health beliefs, values, preferences, and behaviors have recently garnered attention.²⁹⁻³² These include variations in patient recognition of symptoms; thresholds for seeking care; the ability to communicate symptoms to a provider who understands their meaning; the ability to understand the prescribed management strategy; expectations of care (including preferences for or against diagnostic and therapeutic procedures); and adherence to preventive measures and medications.²⁸ These factors are thought to influence patient and physician decision-making and the interactions between patients and the health care delivery system, thus contributing to health disparities.²⁹⁻³²

As a result of these observations, the field of "cultural competence" in health care has emerged. A "culturally competent" health care system has been defined as one that acknowledges and incorporates-at all levels-the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs. A culturally competent system is also built on an awareness of the integration and interaction of health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes for different patient populations.³³ Furthermore, the field of cultural competence has recognized the inherent challenges in attempting to disentangle "social" factors (e.g., socioeconomic status, supports/stressors, environmental hazards) from "cultural" factors vis-a-vis their influence on the individual patient. As a result, understanding and addressing the "social context" has emerged as a critical component of cultural competence.³⁴ We will therefore refer to sociocultural barriers throughout this article to emphasize this connection, and will integrate this idea into our working definition of cultural competence. The movement toward cultural competence in health care has gained national attention and is now recognized by health policy makers, managed care

administrators, academicians, providers, and consumers as a strategy to eliminate racial/ethnic disparities in health and health care.³⁻³⁹ There is, however, an ongoing debate as to how to better define and operationalize this critical yet broad construct. A number of different terms have been proposed to better articulate and encapsulate its meaning. Cultural sensitivity, responsiveness, effectiveness, and humility each emphasizes certain aspects and together reveal a lack of consensus, as each has a unique definition. Models for operationalizing cultural competence have emphasized particular aspects of the health care delivery system, especially the provider-patient interaction. No one has yet reviewed the literature and developed a more comprehensive approach to thinking about and implementing cultural competence in health care at multiple levels and from multiple perspectives. We surveyed the medical and public health literature to seek answers to two questions:

(1) What are the major components of cultural competence? and (2) How do we incorporate culturally competent interventions into the delivery of health care? METHODS We set out to practically define cultural competence and develop a framework that links interventions to an overall approach to eliminating racial/ethnic disparities in health and health care. Our goals were to: * Identify sociocultural barriers to care for various racial/ethnic groups. We focused on specific social and cultural factors that form the basis for individual health beliefs, behaviors, values, and preferences and how they potentially mitigate a patient's ability to obtain quality care. (Limited English proficiency as a barrier is a simple example.) It should be noted that our goal is not to look at sociocultural factors from a deficit model, as there are many cultural factors that have been found to be "protective" for health, and the "healthy immigrant" effect, or "epidemiologic paradox" has been well established. Instead, our goal was to identify situations in which sociocultural factors are not incorporated into the U.S. health care delivery system and how that leads to poorer quality care-as these are points for intervention. * Explore at what level in the process of obtaining care these barriers occurred (health systems level, clinical encounter level, and so on). * Identify cultural competence interventions that address these specifically identified sociocultural barriers. * Link these interventions to a framework that can be applied to the elimination of racial/ethnic disparities in health and health care. We reviewed: * Academic literature: We searched the PubMed database (MEDLINE, PreMEDLINE, HealthSTAR) for 1977-2002 using the following keywords: socio-cultural barriers, cultural competence,

cross-cultural care, health disparities, racial/ethnic disparities, minority health, and multicultural health, both alone and in combination. From the original set of articles that we identified, we set up criteria for relevance to our project. We included in our review only those publications that specifically addressed sociocultural barriers to health care (and provided details about the level of the health care system at which they occurred); cultural competence interventions; and/or racial/ethnic disparities in health and health care. We defined a sociocultural barrier to care as a social or cultural quality, characteristic, or experience of a racial/ethnic group or individual that led to differential treatment and varying quality of care. * Government and foundation publications: We searched major government and foundation reports relevant to our work by reviewing websites of the Commonwealth Fund, the Kaiser Family Foundation, the Kellogg Foundation, the Robert Wood Johnson Foundation, the California Endowment, the Office of Minority Health, the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institutes of Health, the Agency for Healthcare Research and Quality, and other Department of Health and Human Services agencies. We collected data and references, for example, from Minority Health: A Chartbook, published by the Commonwealth Fund,⁴⁰ the Kaiser Family Foundation's report on Race, Ethnicity and Medical Care,⁴¹ the CDC's Diabetes Today project handbook,⁴² and the

American Medical Association's Cultural Competence Compendium RESULTS Sociocultural barriers to health care: a multilevel analysis We identified three major levels of health care at which sociocultural barriers occur that contribute to racial/ ethnic disparities in health and health care. While these are not perfectly distinct categories and there may be some overlap between them, they help to build a framework on which to understand the complex and important issue of cultural competence in health care. Organizational barriers.

Health care systems and structural processes of care are shaped by the leadership that designs them and the workforce that carries them out. From this organizational standpoint, one factor that impinges on both the availability and acceptability of health care for members of minority racial/ ethnic groups is the degree to which the nation's health care leadership and workforce reflect the racial/ethnic composition of the general population. Institutional leadership. Despite representing almost 28% of this nation's population,⁴⁴ African Americans, Latinos, and Native Americans make up only 3% of medical school faculty, fewer than 16% of public health school faculty, and only 17% of all city and county health officers.⁴⁰ Furthermore, fewer than 2% of individuals with senior leadership roles in health care management are non-white.⁴⁵ In the absence of strong quantitative data, a plethora of anecdotal evidence suggests that lack of diversity in the leadership and workforce of health care organizations results in structural policies, procedures, and delivery systems inappropriately designed or poorly suited to serve diverse patient populations.⁴¹⁷ Given their social and cultural understanding of the communities they serve, minority professionals are more likely than their white counterparts to organize health care delivery systems to meet the needs of minority populations.⁴⁷ Examples of barriers to care in the way systems are currently organized include: limited clinical hours of service that don't account for community work patterns, bureaucratic intake processes that create fear of deportation among the undocumented, and long waiting times to make appointments and/or at the time of visit.⁴⁸ In addition, under-representation of minorities on faculty at medical schools and schools of public health prevents a nuanced understanding of community needs from being shared through the critical avenues of role modeling and teaching. Ultimately, inadequate minority representation in governance, administrative, and clinical leadership roles causes health care systems to be disconnected from the minority communities they serve.⁴⁵ Health care workforce. Racial/ethnic diversity in the health care workforce has been well correlated with the delivery of quality care to diverse patient populations. For example, research has shown that, for minority patients, racial concordance between patient and physician is associated with greater patient satisfaction and higher self-rated quality of care.⁴⁹ Other work has established the preference of minority patients for minority physicians, independent of practice location or other geographic issues.⁵⁰ Spanish-speaking patients, for example, report more satisfaction with care from Spanish-speaking providers than from non-Spanish-speaking providers,⁵³ and African American patients report more satisfaction with care when their physician employs a participatory and inclusive style of decision making.⁵⁴ Although there are no head-to-head quality of care comparisons between patients of minority and non-minority physicians, in general, self-rated quality of care and patient satisfaction have been closely linked to certain health outcomes, such as blood pressure control.⁵⁵ Given this logical link, it is feasible to hypothesize that there are quality of care differences for minority patients dependent on the race/ ethnicity or culture of their providers. Other practical issues that link service delivery to diversity arise. Komaromy et al. showed that approximately 45% of African American physicians and 24% of Hispanic physicians in office-based practices in California care for patients with Medicaid as the primary insurer, compared with 18% of white physicians.⁵¹ Furthermore, in a national consumer survey, Saha et al. found that 25% of African American respondents and 23% of Hispanic respondents were cared for by either African American or Hispanic physicians, despite African American physicians making up 4% and Hispanic physicians 5% of the nation's physician pool.⁵² These studies demonstrate that minority physicians are more likely than their white counterparts to provide care to poor and minority patients and may provide more effective care to patients of their own ethnicity. However, African Americans, Hispanics, and Native Americans are drastically underrepresented in the health

professions.⁵⁸ **The prognosis for the future is not much brighter.** From 1996 to 1997, Mexican American medical school enrollment dropped by 8.7% (451 to 412) and enrollment of mainland Puerto Ricans dropped by 31% (141 to 97), while the enrollment of African Americans dropped by 3.7% (1,189 to 1,134), compared to a 1% drop in whites-from 10,556 to 10,450. In that same year, only 11% of all graduates were from underrepresented minority groups.⁵⁹ It is both impossible and inappropriate to try to match minority patients to concordant minority providers. Still, these data suggest that **there is justification for bolstering the ranks of minorities in the health care professions Structural barriers.** In a complicated health care system in which the rules are many and economic forces drive both structure and function, the **needs of vulnerable populations inevitably suffer.** Structural barriers arise when patients are faced with the challenge of obtaining health care from systems that are complex, underfunded, bureaucratic, or archaic in design. Whereas many structural barriers to care may equally impact people of low socioeconomic status, regardless of race/ethnicity, **several barriers are especially pertinent to minority populations:** * **Lack of interpreter services or culturally/linguistically appropriate health education materials** is associated with patient dissatisfaction, poor comprehension and compliance, and ineffective or lower quality care.⁶⁰ Doctor-patient communication without an interpreter when there is even a minimal language barrier is recognized as a major challenge to effective health care delivery.⁶⁰ Research in this area has shown that: + Spanish-speaking patients discharged from emergency rooms are less likely than their English-speaking counterparts to understand their diagnosis, prescribed medications, special instructions, and plans for follow-up care⁶³; less likely to be satisfied with their care or willing to return if they have a problem; more likely to report problems with their care⁶⁴; and less satisfied with the patient-provider relationship.⁶⁴ * **Physicians who have access to trained interpreters report a significantly higher quality of patient-physician communication** than physicians who use other methods, such as un-trained staff or family members.⁶⁵ + Hispanic patients with language-discordant physicians are more likely to omit medication, miss office appointments, and visit the emergency room for care than those with Spanish-speaking physicians.⁶⁷ * Bureaucratic intake processes and long waiting times for appointments have both been cited disproportionately by minority patients as major barriers to access to health care.⁶⁴⁶⁸ When patients have insurance but must undergo difficult intake processes to see a provider or when patients must wait exceedingly long to receive medical care, quality of care is compromised.⁷⁰ * Members of minority groups also face structural barriers with regard to referral to specialists and continuity of care. A large survey by the Commonwealth Fund found that 22% of Hispanics and 16% of African Americans, as compared to 8% of whites, reported a "major" problem accessing specialty care.⁴ Another study revealed that 46% of Hispanic and 39% of African American adults, compared with 26% of white adults, do not have a regular doctor.⁴ **Clinical barriers.** Clinical barriers have to do with the interaction between the health care provider and the patient or family. They occur when **sociocultural differences** between patient and provider **are not fully accepted**, appreciated, explored, or understood. Patients may have very different socioculturally based health beliefs; medical practices, including use of home remedies; attitudes toward medical care; and levels of trust in doctors and the health care system.⁷² As the country becomes more culturally diverse, health care providers of all ethnic backgrounds are dealing with a greater proportion of patients whose perspectives are different from those taught in the mainstream health care system. Research has shown that provider-patient communication is directly linked to patient satisfaction, adherence, and subsequently, health outcomes⁵⁵⁻⁵⁷⁷³⁷⁴ (see Figure). **Thus, when cultural and linguistic barriers in the clinical encounter negatively affect communication and trust, this leads to patient dissatisfaction, poor adherence** (to both medications and health promotion/disease prevention interventions), **and poorer health outcomes.**^{38,53,63,67,69,75,76} Moreover, when providers fail to take social and cultural factors into account, they may resort to stereotyping, which affects their behavior and decision-making.³² **In the worst cases, this may lead to biased or discriminatory treatment** of patients based on their race/ethnicity, culture, language proficiency, or social status.¹¹³² Defining cultural competence: a practical framework "**Cultural competence**" in health care entails: **understanding the importance of social and cultural influences on patients' health beliefs** and behaviors; **considering how these factors interact at multiple levels of the health care delivery system** (e.g., at the level of structural processes of care or clinical decision-making); **and, finally, devising interventions that take these issues into account** to assure **quality health care delivery to diverse patient populations.** Given the evidence of sociocultural barriers to care and the levels of health care delivery in which they occur, a **new framework for cultural competence** would include **organizational, structural, and clinical interventions**: * Organizational cultural competence interventions are **efforts to ensure that the leadership and workforce of a health care delivery system is diverse and representative** of its patient population- e.g., leadership and workforce diversity initiatives.⁷⁻ * **Structural cultural competence** interventions are initiatives to ensure that the structural processes of care within a health care delivery system **guarantee full access to quality health care for all of its patients**-e.g., **interpreter services, culturally and linguistically appropriate health education materials.**³³ * Clinical cultural competence interventions are efforts to enhance provider knowledge of the relationship between sociocultural factors and health beliefs and behaviors and to equip providers with the tools and skills to manage these factors appropriately with quality health care delivery as the gold standard-e.g., cross-cultural training.^{31,80}⁸² To date, there have been various cultural competence interventions at the organizational, structural, and clinical levels: Organizational cultural competence interventions. Organizational cultural competence **Interventions include** "diversity" and "**minority recruitment" initiatives** within the **Department of Health and Human Services, academic health centers, hospitals, and medical**

schools. As a result of minority under-representation in medicine, the Physician-Population Parity Model of the Association of American Medical Colleges (AAMC) was set forth in 1970. Its goal was that the percentage of minorities in our physician workforce would approximate the percentage of minorities within the general population of the U.S. Although progress was made, efforts fell short. In the 1990s, the AAMC initiated Project 3000 by 2000 with the stated goal of having 3,000 minority students enrolled in the entering medical school class by 2000. Despite strategies to achieve these goals, the AAMC fell quite short of its target, perhaps as a result of anti-affirmative action legislation in states such as California and Texas in the mid-1990s.⁵² Given our growing diversity, minority recruitment efforts in health care have been seen as critical to meeting the needs of our population.⁵²⁸³ There are successful models at many levels of the health care delivery system, including those sponsored by foundations (the Commonwealth Fund, the Robert Wood Johnson Foundation), professional organizations (including the AAMC), and government (HRSA). Describing these in more detail is outside the scope of this article. Ultimately, it is obvious that the organizational component of cultural competence is an important part of efforts to improve quality of care for all Americans. Structural cultural competence interventions. These initiatives have been the most studied, with research focusing, for example, on the impact of reducing language barriers on quality of care.⁸⁴ Some studies have also been done on culturally appropriate health education materials and their impact on patient knowledge and understanding of certain medical interventions.⁸⁵ There is an obvious and direct link between these structural barriers and quality of care, and this remains a fertile area for intervention. The federal government and managed care organizations, through various initiatives, have attempted to develop policy and regulatory efforts to ameliorate these barriers.³³⁸⁶

Cultural safety training demilitarizes clinical encounters--focus groups prove it's effective

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In actual practice, cultural competence in the US has been largely approached through sensitization of clinicians to the social predicaments of these ethnoracial blocs or through efforts at ethnic matching of patient and practitioner (Good, Willen, Hannah, Vickery, & Park, 2011). The cultural competence literature tends to treat culture as a matter of group membership (whether self-assigned or ascribed). This assumes that members of a group share certain cultural "traits," values, beliefs and attitudes that strongly influence or determine clinically relevant behaviour. Unfortunately, this approach tends to reify and essentialize cultures as consisting of more or less fixed sets of characteristics that can be described independently of any individual's life history or social context - hence the plethora of textbooks with chapters on specific ethnocultural groups. This is an old-fashioned view, now largely abandoned by anthropology. Contemporary anthropology emphasizes that culture is not a fixed, homogeneous, intrinsic characteristic of individuals or groups (Guarnaccia & Rodriguez, 1996). Instead, culture involves a flexible, ongoing process of transmitting and using knowledge that depends on dynamics both within communities and at the interface between ethnocultural communities and institutions of the larger society, like the health care system, as well as global networks (Modood, 2007; Phillips, 2007). As a result, cultures are often hybrid, mixed, and undergoing constant flux and change (Burke, 2009; Kraidy, 2005). Nevertheless, because culture provides the concepts through which individuals and communities interpret the world and construct their hierarchies of goals and values, cultural processes remain central to the ethics and pragmatics of health promotion and health delivery. An approach to cultural competence based on this more contemporary view of culture must consider how to meld recognition of, and respect for, the identity of individuals and communities with attention to the dynamic, contested, and often highly politicized nature of individuals' interactions with collectivities, both local and global. The cultural identity of an individual must be understood in terms of ongoing interactions within multiple networks or communities; similarly, the culture of an ethnic community can only be understood in terms of its interaction with the larger society. Each struggles to define, position, constrain and exploit the other. This view of culture foregrounds issues of power and the politics of identity and otherness (Modood, 2007). Recognition of cultural diversity coupled with analysis of the structural sources of inequality offers us the best way to understand and redress the inequities and injustices that are ignored, or even aggravated, by culturally-blind [culturally-ignorant] health care (Fraser & Honneth, 2003). Competence and epistemic communities "Competence" is the latest iteration of the emphasis on technical expertise in a scientifically-based medicine that was central to the professionalization of biomedicine and the reform of medical training following Flexner in the 1920s (Carraccio, Wolfsthal, Englander, Ferentz, & Martin, 2002). Science remains the touchstone of technically competent practice in current efforts to develop evidenced-based practice in the health professions (Whitley, Rousseau, Carpenter-Song, & Kirmayer, 2011). This has close parallels in the development of clinical psychology, with the notion of the

scientist-practitioner. Far from criticizing this central role for science, we should recognize it as an essential though unfinished project, but distinguish the unique value of scientific research and reasoning from “scientism” — the invocation of science as an article of faith or rhetorical flourish to foreclose critical analysis and debate. Certainly, clinical and professional competence are highly desirable qualities. Indeed, some version of competence (the ability to do things well, to achieve desired goals, and to act appropriately for the context) is widely desired and respected across very different traditions, professions and domains. Judgements of competence may not only reflect evidence on outcomes (which, of course, are hard for individuals to judge and prone to bias), but on the ability to act in ways that are viewed as (culturally) appropriate for the case in context. Emphasis on this attention to protocol, appropriateness and other forms of cultural authority is sometimes viewed as an alternative to the epistemology of science. Thus, traditional healing is said to work because “it has stood the test of time,” it fits with deeply held ontologies that explain illness and healing, it is authorized by social institutions that are among the pillars of collective identity, or simply because it is sacred and ineffable and, hence, beyond any critique. Whatever the merits of arguments that traditional medicine lies outside the epistemological frame of biomedicine, practitioners must still meet some shared criteria of safety and competence. There are inept practitioners and ineffective or inappropriate practices in every health care system or healing practice. Appeals to tradition do not vouchsafe the clinical efficacy or ethical integrity of any health practice or practitioner. Traditionally, healers were members of local communities so that their ethical conduct and effectiveness could be monitored by others close at hand. However, the modes of regulating practice that worked in small-scale societies will not suffice in the global agora, where every form of knowledge and medicine is commodified, and superficial appeals to cultural tradition are used to market treatments. Pluralistic health care systems raise complex ethical and pragmatic issues and simply decrying the hegemony of biomedicine does not take us very far toward resolving the problems created by a naïve embrace of anything labelled “non-Western” or “traditional” as being inherently good and beyond critical appraisal. Despite this caution, it is important to recognize that the institutionalization of competence within the mental health professions also serves political and economic processes of boundary marking, domination and legitimization. Professionals who are competent arrogate the right to designate others as less competent (or frankly incompetent) and to regulate and control the delivery of health services. The ingredients of competence, in terms of knowledge, skills and attitudes, may be quite distinct from the mechanisms by which competence is certified and maintained – and both the content and the process of defining competence in different medical systems deserve critical analysis.

We need to diversify our notion of competence itself, not to encourage the indiscriminate embrace of any treatment that is labelled traditional but to broaden our notions of efficacy and outcome to assess practitioners and treatments in diverse systems of healing and intervention.

Alternatives to cultural competence **While it is essential that professionals be technically competent and, in the case of clinicians, this competence includes interpersonal skills, ethical commitments, and the ability to effectively refine and use one's empathic capacity, an emphasis on professional competence in the domain of culture risks reifying** appropriating **rather than respecting and engaging the other's lifeworld.** For this reason, some have advocated alternative concepts through metaphors such as “cultural responsiveness” (Sue et al., 1991), “cultural humility” (Tervalon & Murray-Garcia, 1998), or “cultural safety” (Papps & Ramsden, 1996). **The notion of cultural safety was developed in the 1980s in New Zealand in response to Maori discontent with medical care** (Papps & Ramsden, 1996; Koptie, 2009). In contrast to the emphasis in cultural competence on practitioners' skills, **cultural safety “moves beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health care”** (National Aboriginal Health Organization, 2008, p. 3). In Canada, cultural safety has been recognized by the **National Aboriginal Health Organization (NAHO), other Aboriginal organizations and the Mental Health Commission of Canada, as a preferred approach to guide efforts to improve the cultural responsiveness and appropriateness of health care.** Nursing educators and practitioners have led the development of the concept of cultural safety in New Zealand and in Canada (Aboriginal Nurses Association of Canada, 2009; Smye, Josewski, & Kendall, 2010; Stout & Downey, 2006). **Cultural safety is a powerful means of conveying the idea that cultural factors critically influence the relationship between carer and patient.** Cultural safety focuses on the potential differences between health providers and patients that have an impact on care and aims to minimize any assault on the patient's cultural identity. Specifically, the objectives of cultural safety in nursing and midwifery training are to educate students to examine their own realities and attitudes they bring to clinical care, to educate them to be open-minded towards people who are different from themselves, to educate them not to blame the victims of historical and social processes for their current plight, and to produce a workforce of well-educated and self-aware health professionals who are culturally safe to practice as defined by the people they serve. (Crampton, Dowell, Parkin, & Thompson, 2003, p. 596) **Cultural safety in indigenous contexts means that professionals and institutions, whether indigenous or not, work to create a safe space for an encounter with patients that is sensitive and responsive to their social, political, linguistic, economic, and spiritual realities.** Culturally unsafe practices involve “any actions that diminish, demean or disempower the cultural identity and well-being of an individual” (Nursing Council of New Zealand, 2002, p. 7, cited in Polaschek, 1998). In Canada, the National Aboriginal Health Organization (NAHO, 2008; Brascoupe’ & Waters, 2009) has advocated principles of cultural safety that are grounded in recognizing the historical context of Aboriginal experience. **This includes recognizing the diversity of populations, understanding power issues** in health care worker-patient relationships, and raising awareness of cultural, social and historical issues in organizations and institutions. In the training of health care providers and professionals, cultural safety involves attention to issues of communication, power sharing and decision making, working toward understanding and addressing misunderstandings, and recognizing and respecting fundamental cultural beliefs.

Although there is overlap between concepts of cultural safety and cultural competence, the metaphors have **different connotations** and the constructs emphasize distinct approaches to social and cultural dimensions of care. Cultural safety does not emphasize developing “competence” through knowledge about the cultures with which professionals are working. Instead, cultural safety emphasizes recognizing the **social, historical, political and economic circumstances that create power differences and inequalities in health and the clinical encounter** (Anderson, Perry, et al., 2003; Anderson, Scrimshaw, et al., 2003). Cultural safety has some overlap with concepts such as “cultural sensitivity,” cultural responsiveness and “cultural humility” – that is, with a willingness and ability to listen and learn from patients. Openness, respect and attentiveness are pre-requisites for cultural safety but, by themselves, are not sufficient. “Sensitivity can be thought of as the first step towards learning about oneself within the context of one’s interaction or relationship with people of a different culture” (NAHO, 2008a, p. 27). **The self-reflexivity of practitioners and systems opens the door to reorganizing the delivery of services and the conduct of clinical work in ways that share power and control over health care but the details of how this is achieved must be worked out for specific contexts.** The concept of cultural safety has also received some criticism, both for its ambiguities and its narrow readings of the social determinants of health and the politics of the clinical encounter. Johnstone and Kanitsaki (2007) provide a critique from an Australian perspective. They note that cultural safety developed in the bicultural political context of New Zealand and it is not clear how well the construct applies to the multicultural context of Australia. There has been relatively little research on cultural safety and, in particular, the links between cultural safety and positive outcomes (in training or practice) have not been clearly demonstrated. As metaphor or model, cultural safety is not a transparent concept but, like cultural competence, requires unpacking and further specification in terms of its implications for training, health systems and clinical practice. Discussions of cultural safety tend to frame the clinical encounter as a situation fraught with risk and vulnerability, and locate all the power and potential for aggression and harm on the side of the clinician. As a result, cultural safety tends to approach culture in terms of vulnerabilities rather than strengths. By implying that the cultural “other” is vulnerable, cultural safety may also contribute to essentializing and stereotyping ethnocultural groups. To explore the significance of some of these criticisms, Johnstone and Kanitsaki (2007) conducted a focus group and key informant study of how practitioners, patients, consumers and ethnic minority organizations in Australia understand cultural safety. Providers interpreted cultural safety as not imposing their own cultural values on patients in areas that were of vital importance, or as exhibiting “racial respect” and explicitly anti-racist perspectives. The key threats to cultural safety identified by patients included: inability to communicate with service providers; poor attitudes by staff resulting in not being treated with respect (for example, patients being treated as if they were stupid, subjected to stereotypes and prejudice); not being able to have their families present; not being listened to; not being given clear explanations; being forced to comply with unfamiliar forms of care or treatment; being powerless or unable to take action to help themselves or their loved ones; overall inflexibility of the system; feeling isolated because no one around them shared their culture or language; not having access to appropriate interpreter services. It is these sorts of violations of clinical trust and power imbalances that attention to cultural safety is meant to remedy. A wide range of strategies have been proposed to counteract these barriers to work toward an open, collaborative and safe space in clinical services and systems (Brascoupe' & Waters, 2009). The framework of cultural safety can be used to critique health policy and practice (Josewksi, 2011).

Race-conscious CHNAs activate hospitals’ capacity to remedy social contributors to health outcomes.

Christopher J. King & Yanique Redwood 16. King is from the Health Systems Administration at the Georgetown University Medical Center, Redwood is from the Consumer Health Foundation. 2016. “The Health Care Institution, Population Health and Black Lives.” Journal of the National Medical Association, vol. 108, no. 2, pp. 131–136.

INTRODUCTION While some may assert we live in a post-racial era, a **body of scholarship corroborates the presence of structural racism in contemporary settings**.^{1e5} Most recently, a series of events have elevated social consciousness about the Black experience in America.⁶ Consequently, the **Black Lives Matter movement** gained momentum in 2012, serving as a “call to action and a response to the virulent anti-Black racism that permeates our society.⁷” The mission specifically focuses on addressing “ongoing and widespread devaluation of Black Lives and the social, political, and economical structures that result in

unequal opportunity.⁷ Such forms of injustice have a **profound effect** on communities of color and are manifested through **inequities in common correlates of health**, including access to quality education, healthy foods, livable wages, and affordable housing. Moreover, a **substantial body of evidence highlights the relationship between race, racism and health status**.^{8e12} Blacks are disproportionately burdened by poorer access and lower quality of care even when controlling for factors, such as income, education, and insurance.^{8,13} They also represent higher rates of **morbidity and premature mortality** when compared with white counterparts. Some of the starker differences can be found in hypertension, diabetes, and asthma rates, resulting in **higher frequencies of treatment for comorbidities and ambulatory care sensitive conditions**.^{14e19} Such racial disparities have a significant financial impact and are estimated to cost \$35 billion in excess health care expenditures and \$10 billion in illness-related lost productivity.²⁰ In response to these disparities, many health care institutions have demographically stratified and analyzed health outcome data and incorporated best practices to create interventions to reduce or eliminate disparities in care. However, **due to broader structural contexts, significant disparities persist**. We assert that **these trends will remain intractable until structural racism and its effects (bias, discrimination) are recognized as root causes of poor health**. This approach is especially relevant as health reform is incentivizing health care leaders to find new and more creative ways to promote wellness, reduce readmissions, and manage the health of populations. **By applying a racial equity lens** in how they are governed and operated, **hospitals, as anchor institutions, can advance their population health goals**.²¹ **Using health reform as a springboard**, we articulate why this approach is important and close with a conceptual framework to stimulate thought and organizational practices that **(1) promote racial equity within health care settings** and **(2) contribute to the advancement of historically marginalized communities of color**.

HEALTH EQUITY AND BLACK LIVES In light of the magnitude and long-term psychological impact of racism, coupled with a history of implicit and explicit injustices imposed on those of African descent, two definitions in the literature inform our interpretation of health equity within the context of Black Lives. In 2003, Braveman and Gruskin defined health equity as a goal of eliminating systemic disparities in health or in the major social determinants of health (i.e., education, housing, employment) between social groups who have different levels of underlying social advantage and disadvantage – that is, different positions in the social hierarchy.²² Camara Jones construes health equity as the assurance of the conditions for optimal health for all people, which requires valuing all individuals and populations equally, rectifying historical injustices, and addressing contemporary injustices by providing resources according to need.²³ Consequently, we assert that it is important for health care leaders to recognize institutionalized injustices in their own communities and carefully examine how they impact the health of the populations they serve. Note: The focus of this commentary is on Black Lives; we also use “minorities” and “communities of color” interchangeably based on contextual language.

INSTITUTIONALIZED RACISM AND ITS EFFECTS **In order to be effective in improving health through a racial equity lens, it is important to recognize how the health care institution is a subset of a larger ecosystem with vestiges of institutionalized racism**, stemming as far back as the 1600s.⁹ The legacy continues to influence how low income communities of color are structured and resourced.^{23,24} **Institutionalized racism is defined as “the structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by race**. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator.²³ **Despite the passage of prominent legislation** that makes explicit forms of racism illegal, **remnants of historically grounded policies and practices that perpetuate poor health in contemporary settings are evidenced through racial segregation and unequal distribution of resources**.^{24,25} The consequences of these injustices are multifactorial and **detrimental** to the well being of society, but for the purposes of this commentary, we focus on the relationship between institutionalized racism and health. More specifically, a growing body of evidence suggests racism as a social determinant of health.^{24,26} For example, chronic exposure to discrimination creates a physiological or hormonal response (survival stress) that may stimulate or exacerbate chronic disease conditions making it challenging to improve individual health.^{24,26e28} This recognition is especially important to providers as a newly insured cadre of persons enter systems of care many of whom have low income e encountering day-to-day psychosocial barriers that emanate from discriminatory policies and practices. **Within a historical context of medical care, persons of color have had a profoundly unique experience**. Countless numbers of Blacks **were medically exploited and subjected to inhumane and traumatic experiences**. While the **Tuskegee** experiment is widely referenced in the literature, it **is an isolated depiction of a more systemic, robust and pervasive agent** to advance medicine at the expense of Black Lives.²⁹ The legacy and trauma associated with the atrocities have deeply affected Black Americans’ perceptions about the health care system and how they consciously or subconsciously interact with providers.^{8,30} For example, scholars have found Blacks more likely than Whites to distrust the health care system and more likely to prefer racially concordant providers.^{30e35} Such distrust, coupled with underrepresented people of color in medicine,³⁶ impede patient engagement and may be culpable for late stage diagnoses and/or exacerbation of chronic disease conditions in persons of color.³⁰ In addition to distrust at the patient-level, providers are susceptible to decision-making based on implicit biases e attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.^{8,12,37e39} Documented occurrences of **racially driven decisionmaking in clinical settings**

have not been characterized as intentional but partially attributed to subconscious perceptions that emanate from exposure to high frequencies of negative portrayals of Black Lives at a societal level.^{40e42} Consequently, actions that stem from biases compromise quality of care through error, miscommunication, no referral or inappropriate referral to specialty care or medical procedures, and misdiagnosis of medical conditions.^{10,12,43,44} POPULATION HEALTH The gravity of these dynamics must be recognized within the context of population health a term that has progressively increased in the literature since 2010.⁴⁵ While the interpretation and its utility tend to vary depending on discipline or profession, health care institutions are likely to perceive population health as clinically managing the patients under the auspices of their care. However, health outcomes for these patients are heavily influenced by structural conditions and the quality of assets that are available across the life span. Therefore, we advocate for a more comprehensive interpretation. In 2003, Kindig and Stoddart defined the term as “the health outcomes of a group of individuals, including distribution of such outcomes within the group.”⁴⁶ They posit, “the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link the two.”⁴⁶ Young describes population health as a “framework for thinking about why some populations are healthier than others” including policy, research, and resource allocation.⁴⁷ By normalizing these interpretations through a racial equity lens, health care organizations have the potential to advance population health goals by improving the patient experience as well as the social conditions in which they live. CONCEPTUAL FRAMEWORK Hospitals are components of a larger ecosystem; they cannot take sole responsibility for addressing complex and intersectional inequities that perpetuate poor health in communities of color. However, as health care providers, they can be instrumental in eliminating racial disparities within clinical settings, and as anchor institutions, they can be socially impactful e using their business models to create opportunity and stimulate investments in historically marginalized communities. To incite a more strategic approach to population health improvement within the context of Black Lives, we offer a conceptual framework based on a bifurcated approach (Figure 1). Internal strategies focus on operational practices, including how clinical systems and services are organized and structured. External strategies focus on the community at-large, including how the health care institution, as an “anchor institution” supports or invests in upstream factors, resulting in equitable access to opportunity. While institutional capacity and community dynamics vary, we provide examples of strategies for both constructs, as well as their associated outcomes, and how the efforts stimulate systemic change. Internal strategies Since racial differences within clinical settings are substantiated in quantitative and qualitative research designs, we define internal process activities as practices and guidelines within the health care institution that promote consistency in the patient experience, regardless of race, as well as allocation of support resources according to need. To achieve this objective, the relationship between race, racism, and health⁴⁸ must first be understood, internalized and normalized by the organization’s governing board and employee population. Furthermore, a carefully structured approach is necessary to help the groups identify their own biases and how those biases translate into unconscious decision-making within governance and practice contexts. The Implicit Association Test (IAT) is a validated instrument that can provide structure around this approach. Developed in 1998, the IAT allows participants to assess bias or preference for specific demographic identities (race, gender, religion, etc.).⁴⁹ Since its development, it has been used in various settings to raise individual and collective awareness around unconscious bias and its impact on communities of color. Through a carefully guided process, the IAT opens the door for safe and constructive dialogue that can heighten institutional awareness e helping board and staff cognitively intercept biased defaults. The benefits are numerous and can inform core business areas, such as board recruitment processes and general hiring practices, marketing and planning approaches, as well as quality, safety and patient experience metrics. Some health systems are nationally recognized for governance and operational activities aimed at improving the patient experience, eliminating treatment disparities by race, and promoting economic advancement in communities of color. For example, Main Line Health is known for its approach to achieving board and staff diversity and the integration of social factors in clinical care.⁵⁰ Through its Health Disparities Solution Center, Massachusetts General Hospital aims to eliminate racial disparities in care through a series of workforce development and quality improvement initiatives.⁵¹ Georgetown University Medical Center’s Kid Mobile Clinic provides comprehensive pediatric care and spearheads advocacy initiatives to promote health in historically underserved Black communities in the District of Columbia. Henry Ford Health system’s “best in class” supplier diversity initiative has yielded more than 300 active minority and women-owned businesses in its supply chain management database.⁵² External strategies In the wake of health reform, the changing landscape is positioning hospitals with new opportunities to demonstrate their tax-exempt worthiness through community health improvement and community building activities.⁵³ The shift in resources presents a profound opportunity to identify racial inequities and invest in neighborhoods that have borne the brunt of decades of failed social policies and practices with racism at their core. Determining key health issues and the dynamics that contribute to those issues is the first step and the mandated triennial Community Health Needs Assessment (CHNA) for not-for-profit hospitals can be instrumental in facilitating the process. By conducting a race-conscious CHNA, hospitals will achieve better insight on how institutionalized racism impacts health outcomes in the communities they serve. Race conscious strategies may include designing quantitative and qualitative data collection measures aimed at assessing if or to what extent persons of color perceive or experience racism. Examining the history of the community or policies that have or continue to perpetuate differences in the distribution of resources will also be strategic. The process can also include assessment of community assets (institutional or organizational) for strategic partnerships since health care organizations are not likely to have the expertise nor the resources to assume a lead role within the racial equity space. Other CHNA strategies may include assessing the hospital’s own data and honing in on morbidity and mortality racial disparities at the neighborhood level. Findings offer clues for more targeted interventions and how resources can be more equitably distributed. Based on CHNA findings, hospitals must identify health priorities and work in partnership with the community to develop an implementation plan that addresses the issue. Some health systems have made considerable progress in shifting their approach to community benefit through bold, unconventional

tactics. Bon Secours Health System and its partners have invested in dilapidated row homes and converted them into 119 affordable apartments in West Baltimore.⁵⁴ University Hospitals, Cleveland Clinic and its partners have pooled resources to finance a wealth building initiative e the Evergreen Cooperatives, a network of employee-owned businesses that hire from systematically underserved neighborhoods.²¹ St. Joseph's Health System supports activities to build capacity at the grassroots level through community organizing, leadership development, and coalition building.²¹ MedStar Health and Seattle Children's Hospitals work with youth in communities of color e providing mentoring, job shadowing, and internships to promote healthy development and cultivate a pipeline to increase the number of underrepresented persons of color in health care.^{55,56} Goal Population health incentives are challenging health care institutions to value prevention and be more accountable to their communities. Moreover, it is clear that institutional racism and its effects (within the health care institution and beyond the health care institution) continue to have a negative impact on health outcomes of Black Americans and other persons of color. Therefore, we argue that a health care system's population health goals can be optimized by 1) employing internal strategies to improve the patient experience and reduce or eliminate racial disparities within health care settings; and 2) employing external strategies to improve the social, political, economical, and environmental conditions of communities of color. For accountability purposes, a racial equity dashboard based on internal and external process measures can be helpful in documenting and tracking the breadth of the institution's capacity to effect change. Collectively, these strategies will support systemic change that is critical for improving the quality of health care and advancing local and national population health goals.

AND spills over to future political gains by building organizing capacity

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In Bernie Sanders's wake, the socialist left has experienced a historic resurgence. The Democratic Socialists of America (DSA), which now counts over 25,000 members, is the largest socialist group in the United States since Students for a Democratic Society in the late 1960s. The challenge now is to hone its political vision and build a durable and democratic organizations that can affect real change. A focus on winning single-payer health care can help us do that. The growing demand for single payer rankles establishment Democrats, who insist that the Affordable Care Act — with its labyrinthine subsidies program meant to provide coverage without undermining the private insurance industry — is the best deal on offer, and to demand anything more is pie-in-the-sky and politically counterproductive. But with Obamacare given reprieve for the moment (albeit unsafe from future attacks), and our still-broken health care system on everyone's mind, socialists have an opportunity to organize ordinary people toward a better common goal: genuine universal coverage, managed and dispersed by democratic, transparent, and efficient institutions that are accountable to us, not corporate shareholders. California has the unique potential to become the first state to pass single payer. A grassroots movement for the cause, spearheaded by the California Nurses Association, goes back decades. This movement twice passed single-payer bills through both houses of the state legislature in the 2000s, but both were vetoed by then-Governor Arnold Schwarzenegger. Out of this legacy of popular action, 70 percent of California voters now support single payer in polls. To appeal to that active grassroots and public support, California Democrats have made single payer an official plank of their party platform. Democrats hold the Governor's seat and an exact two-thirds supermajority in both houses of the legislature, so the time has come to deliver on promises. We are two organizers with the East Bay chapter of DSA, which has made a strategic decision to focus on a single campaign: organizing around single-payer health care legislation, SB562, in California. The lessons from our campaign aren't universal (no one's are), but in explaining the strategic thinking behind our mass canvassing program and sharing the lessons we've learned from implementing it, we want to show how a focus on Medicare for All can increase socialist organizations' organizing capacity and build working-class power for long-term struggle. Zeroing in on Single Payer In recent months, socialists — many of them newcomers to the movement — have flocked to DSA, seeking opportunities to continue pushing for left political-economic reforms after the Sanders campaign. Both the national DSA organization and local chapters have begun a

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program of political education to introduce these members to socialist history, theory, and strategy — some for the first time in their lives. The East Bay chapter has been no exception: over five hundred people joined after Trump's election. At East Bay DSA's chapter elections in January — our first following the membership explosion — many candidates running for a leadership role pledged to focus our organizing on the California single-payer effort. The members who won election were nearly unanimous in their interest in pursuing this campaign. Based on that mandate, the leadership voted to officially join the campaign for Healthy California in February and started canvassing almost immediately. Two generations of our elected leadership have now committed to single payer as the core focus for our organizing work. Importantly, this hasn't prevented ongoing chapter actions on other issues: our direct action committee helped blockade an ICE office and held the line to protect an elderly renter from eviction; we were at the airport protests, the Women's Strike, and May Day; we have a housing caucus, a prison abolition caucus, and a socialist feminist caucus. But we've found that focusing the bulk of our organizing effort on single payer comes with major benefits: we concentrate and replicate our capacity for training members, we stress-test our organizing against the clear benchmarks of a single campaign, and we build internal unity and transparency by working together on a common cause. The **singular focus helps convey to our coalition partners and members alike that we're in this for the long haul, and we're in it to win.** As a result of our recent growth in both size and legitimacy, coalition partners have asked to table with us at events for increased visibility, and local candidates have sought our endorsement. **East Bay DSA's commitment to campaigning for SB562 is a tactic in service of a larger strategy to build good internal structures in our burgeoning group and effective organizing skills among a new generation of grassroots leftist activists.** We also seek to strengthen ties between socialists and the labor movement — in this case the women-led and substantially non-white nurses' union — and win reforms that will strengthen the power of the working class. The Ground Game Our focus on winning single payer has driven the evolution of our organizing process. Our canvassing strategy began with a focus on large canvasses that gathered members from across our entire chapter as well as non-members interested in joining in. Before these canvasses, a select team of canvass captains received training from the union and community organizers in the chapter. On the day of the large canvasses, these captains trained and facilitated practice sessions for teams of about a dozen people each. To date, five hundred people have received training from team captains, then pounded the pavement together to knock on doors. In a frightening national political moment, door-to-door organizing has been heartening for many members, showing us we're not as alone as we think. One of our members, who originally described herself as shy, remarked that her canvassing experiences with our chapter had convinced her there are only two kinds of people in the Bay Area: socialists, and people who aren't home. Across all of our canvassing, we've focused on empowering neighbors to see their experiences with medical fees and debt in terms of class conflict, explained the mechanics and upsides of single payer, and gathered thousands of pledges to support DSA and our coalition partners in the fight for public universal coverage. In the process, our organizers have also developed as leaders. In a testament to the skill- and commitment-building potential of this tactic, about half of the chapter's newly elected Local Council started out as single-payer canvassers. The large, chapter-wide canvasses provided a good way to kick start training across our membership but weren't well suited to build steady teams of organizers consistently working the same neighborhoods. To address this issue, our organizing tactic has shifted since May to focus on district canvasses, where our members develop dedicated teams for their own neighborhoods. The point is for socialist organizers to talk to their own neighbors and build lasting political relationships. We live in an atomized, alienating society where most of us don't know our neighbors' names, and don't see any reason to learn them. These district canvasses break our own members out of their isolation, while simultaneously building stronger community ties between our organization and existing neighborhood networks. In early July, one of our canvassers, after a particularly successful round of door-knocking, was invited to speak at a block party. The person then found themselves literally organizing their neighborhood. Another district canvasser was invited to give a talk for a second block party just last week. A third stage in the evolution of our organizing is just beginning. Our canvassing program has done well at training our members for the initial conversations with neighbors, but we've found we need more structure and shared skills for follow-up to keep our neighbors consistently involved. As our chapter grows, the most involved members have largely had their workload expand just as fast; this has made it clear that helping members develop into leaders needs to become a central part of our organizing system. To clarify who should take on our member development efforts, we passed new bylaws in April which created distinct positions (both elected and appointed) for internal organizers and external organizers. The internal organizers, who were elected in June, are now focused on developing a member steward system based on the model used in many unions and the New York City and Philadelphia DSA chapters. This will build a trained network of stewards among our membership, with each responsible for supporting and catalyzing a set of less-active members and interested neighbors to become regular participants. Strong local relationships like these are invaluable to socialist organizers and can be tapped in future campaigns for fights around housing justice or workers' rights. Democratic elites have all but abandoned field organizing, especially in down-ballot races, in favor of exorbitant, consultant-led media strategies. In many places, by training even a few dozen regular canvassers through the single-payer cause, socialists can quickly develop one of the strongest ground games in town. By building ongoing relationships with our neighbors, this emphasis on field organizing will put us in a position to be helpful, in-demand allies for local unions and other Left campaigns, and lay the foundation for real impacts on electoral politics. And while we should only organize for what we are committed to winning, we should also organize so that, whether we win or lose one round in a fight, we are building the skills and relationships for power in the long term. The focused campaign gives us an opportunity to troubleshoot our organizational structure and its challenges, which makes our chapter increasingly resilient, responsive, and effective, and will serve us well beyond the fight for single payer. Already, our work has rippled outward; we've shared our training guides, canvassing scripts, and leave-behind literature to be put to use in chapters across California and as far afield as Ohio. Advancing the Program The advantages for our organization are only part of the equation. **Any unifying campaign will be beneficial to an organization finding its footing, but single payer is a strategic central focus.** In fighting for it, we can build solidarity across lines of difference and continue to build power for the working class. **Everybody needs health care. Nearly everybody in the working class**

has been hurt by private insurance greed, or has seen a friend or family member denied care so that a rich few can profit. When we organize in the East Bay, we share our own personal stories and ask our neighbors about what they could personally gain from single payer. We work to show how our direct self-interest intersects with that of all working people: we can only win single payer for ourselves if we win it for each other. **Political education that fosters this sense of shared self-interest** — rather than charity for a distant other — **is the foundation of a sense of solidarity built to last.** **The fight for single payer is an urgent anti-racist struggle.** Currently in the United States, **the uninsured rate is 60 percent higher for black people than for white people.** **The Movement for Black Lives platform demands a universal, guaranteed health care system,** with particular focus on equitable access for currently excluded communities of color. **In committing to the fight for single payer, socialists can take up that call to action.** Meanwhile, across the US, Latinos have an uninsured rate 300 percent higher than white people. **Undocumented immigrants — and many documented ones — are not covered by Medicare, nearly all Medicaid programs, and many subsidized private plans.** This cruel exclusion is despite the fact that immigrants pay into the public system through taxes, and worse, is in spite of the fact that they are members of our communities who need care like everybody else. By providing coverage to all state residents regardless of documentation status, California and New York's single-payer bills not only directly help millions, but could point a socialist path out of the current dead end around immigration politics in the US and Europe. Over the past decade, most parties of the center and many on the left have shifted towards far-right positions on refugees and migrants as a supposedly necessary concession to white-working-class xenophobia. This is morally and strategically wrong. When socialists win truly universal social programs that cover migrants, we can demonstrate that social care is not a zero-sum game. Instead, building social systems for everyone who lives here makes for stronger public institutions and a healthier society for all. If we are to push further towards building a powerful multiracial working-class movement, then a proud politics of inclusion for immigrants is not only right — it's essential.

Single payer is also a critical feminist fight. **Public health coverage for all would be transformational to a society in which most unpaid and underpaid care work falls to women.** When people can't get the care they need, someone is usually compelled to pick up the slack — and, especially in the realm of home care for family members, those people are disproportionately women. ("The best long-term care insurance in our country," concluded a recent study about home care for older adults, "is a conscientious daughter.") **Women are more likely to receive health insurance as dependents, which means that losing a spouse through death or divorce puts them at greater risk for being uninsured.** Single mothers are nearly twice as likely to be uninsured as mothers in two-parent households. Meanwhile, **women who are insured also suffer disproportionately from confusing and predatory private insurance industry practices.** Care costs more for women, is harder to obtain, and employers can **refuse to cover contraception on religious grounds,** meaning **a woman's reproductive health is in many cases dependent on the conditions of her employment.** California's Medicaid program covers abortion, contraception, and prenatal care. **To universalize that comprehensive and inclusive care is an urgent and crucial feminist reform.** The California Nurses Association, which is leading the charge on the state single-payer effort, has eighty thousand members across both unionized and non-unionized workplaces in the state. These workers are overwhelmingly women, and about half are people of color. Women fill nearly all of the top leadership roles at CNA. Who better to lead the fight to bring care into the public sphere than women care workers, who disproportionately shoulder the burden of undervalued care? Organizing in close alliance with care workers is an essential way we can put our principles into practice and expand socialist-feminist understanding within our ranks. Working with organized nurses is also strategic for building solidarity between socialists, the labor movement, and the broad working class. CNA has led the drafting of legislation and steered the inside game while coordinating and supporting grassroots allies across the state. Nurses at the helm makes this not just a "consumer movement," made up of health-care users, but a workers' movement. The nurse-led campaign sets up a clear dynamic of workers, both inside and outside the industry, against our common adversaries at the very top: health insurance executives, shareholders, and the 1 percent. Over the last half-century, the relationship between socialists and the labor movement has grown tenuous, as both groups have been diminished and devitalized by state repression and capitalist advancement. As socialists, we know that acting in concert with organized labor is fundamental, and that it's necessary to rebuild our role, both as socialist organizers and workers ourselves, in the labor movement. **By uniting with nurses against CEOs, we're committing to working-class solidarity in practice, not just in theory.**

Socialists must continue to build our own independent organizations steered by the democratic power of our members, but the nurses are a strategic ally to learn from and fight alongside in this moment. Finally, single payer would win power for the working class like no other reform popularly on the table in the US today. When socialists consider fighting for a reform, we should ask if it builds working-class power towards future struggles. **Some left organizers and scholars call this "building the crisis": by winning reforms that strengthen the material conditions and class consciousness of working people, we advance the fight for more radical victories.** Many union workers, who have seen spiraling private health insurance costs undermine their position for wage and benefit increases, have rallied behind single payer as a bulwark for future battles with management. For non-union workers, too, single payer would strengthen both their actual health and their bargaining position for raises and other benefits. A push for single payer, in this political moment,

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is uniquely able to draw clear lines of class conflict: it's capitalists versus all of us who work. Single payer is already a concession on the part of socialists. We want fully socialized medicine, which would function on the same principles but extend to hospitals and doctors themselves, and which already exists in many nations. We envision single payer as a first step in a long struggle to implement full universal social programs. We see it as a non-reformist reform: that is, a structural modification of power relations that elevates the ability of working-class people to fight against capital while radically shifting the window of political possibility. We're interested in using SB562 as a political education opportunity for our membership and neighbors, and publicly advancing the idea that universal social programs are better than means-tested ones. According to the neoliberal logic of means-testing, some people need public assistance to attain things like health insurance, but only those in the direst of straits. Socialists, on the other hand, believe in the decommodification of essential goods and services for all, for both moral and politically strategic reasons. Universal programs are essential to eliminating wealth inequality. They decrease disparities in the here and now, creating a stronger working class that is less fearful and insecure, and therefore less easily exploited by capital. They also build powerful new constituencies dedicated to defending public goods against privatization. In this way, universal programs can function as “engines of solidarity.” To make health insurance universally guaranteed and public is to both assert that coverage is a right, and to build a stronger body politic that can mobilize to protect that right. In our discussions at peoples' doors, we hear our neighbors' indignation that the wealthy are able to receive medical care when necessary without fear of ruinous financial consequences, while everybody else is faced with hard choices about whether to go into massive amounts of debt to seek necessary treatment. In those conversations, we hear the raw material for a mass oppositional class politics. That's why we ask for commitments from those people to join the campaign, instead of just signing a petition or donating once. For example, behind one door was a twenty-six year old with a bandage wrapped around his hand. He had just lost his job, where he was paid poorly to work with dogs, one of which had bitten him badly. He was a few months too old to be listed as a dependent, and suddenly found himself uninsured. He talked to our neighborhood canvassers for twenty minutes. At the next neighborhood canvass there he was, DSA clipboard in his healing hand, knocking on doors with the rest of us. California's Single-Payer Melee Pressured by a growing movement and a single-payer bill that has passed the State Senate, elite Democrats have been forced to show their true loyalties. In late June, Assembly Speaker Anthony Rendon froze the bill in committee, halting any formal legislative progress in his chamber until next year. We knew this opposition was coming. Contrary to recent allegations of unpreparedness and deception, from the start of the campaign, CNA leaders have been clear on statewide conference calls with coalition activists that we are building strength for a multiple-year effort — which could require a ballot campaign as a costly last resort. That's only necessary if the legislature can't be pushed to deliver single payer past the state's tax and spending constraints. The coalition's current effort to turn up pressure on Rendon and other resistant Democrats is essential to build that necessary legislative will. At doorsteps, DSA organizers have been talking with our neighbors about what it will take to win this protracted and difficult fight. After fifty years of conservatives and centrists passing severe restrictions on taxes and spending, California's political playing field is badly rigged. That's why our victory requires building a powerful movement off that field. Democratic elites — steered by donors from real estate, insurance, dirty energy, and tech, and backed up by the management of huge non-profits and major unions — treat the handcuffs on state power as "sacred doctrine that should never be questioned." Even if they wanted to overturn suffocating restrictions on the state, Democratic leaders can't imagine building the popular power needed to do it. If Democrats bury the legislation now, they will be opposing the idea that politics ought to involve imagination, mass effort, and the will to fight uphill battles so that people's lives might be freer and better. In this context, socialists have a critical role to play in the movement for single payer: unlike the Democrats, we can build broad working-class power while expanding the public imagination of what politics could be. East Bay DSA regards SB562 as an opportunity to build, mobilize, and grow our organizations and movement. While the bill is frozen in committee, we're going to continue educating, coordinating, and taking full advantage of the swelling interest in both single payer and socialism. In those respects we're already winning, and no legislative defeat can undo our victories. But this isn't a trap, or a trick question meant to expose neoliberal hypocrisy. Single payer is a real policy demand, and we want it to pass. If it does, there will be several subsequent obstacles to actually implementing a functional single-payer health care system in our state. If we proceed to a ballot measure, the health insurance lobby will wage a media war to scare Californians out of it. (Of course, the best way to combat a propaganda campaign that well-funded is to organize and educate people on the ground, grassroots-style — which we're currently doing.) In the meantime, socialists around the country must start thinking critically about building and wielding organizational power. Not every socialist group has the opportunity to rally behind state single-payer legislation like we have. But given our national moment of historic upheaval for health care and the broadening popularity of Medicare for All, we think socialists throughout the nation can build alliances and open political imagination by being a loud voice — and given the refusal of the Democratic Party to champion it, perhaps the loudest voice — for single payer in their specific political climate. A nationwide single-payer campaign that embraces a diversity of location-specific tactics can help socialists replicate a skill-building, infrastructure-honing strategy across cities and states. This shouldn't preclude simultaneous local and regional campaigns on other issues, but we believe a primary

nationwide focus on single payer, more than any other issue, will build power for socialists and the working class. East Bay DSA's campaign for single-payer legislation shows how we can get started.

Acting through the government is empirically effective AND necessary in this context, even if no other--AND supplements extra-legal strategies

Merlin Chowkwanyun 14. Robert Wood Johnson Foundation Health and Society Scholar at the University of Wisconsin, Madison. 2014. "AFRICAN AMERICANS AND HEALTH CARE: STATE-SPONSORED AND GRASSROOTS ALTERNATIVES." *The Journal of African American History*, vol. 99, no. 4, p. 427.

The BPP is frequently caught between two unsatisfying modes of writing. At one extreme are **hagiographies**, influenced in no small part by the BPP's own talent for spectacle and theater—at the other, **[and] cynical hit pieces**, wherein the party becomes a metonymic symbol for all the perceived excesses of 1960s radicalism. Nelson is keenly aware of both these impulses. By turning instead to sites of activism that drew less public attention (both at the time and now), she avoids writing what could have been a narrow and celebratory book, and instead connects the Panthers to a number of larger themes: neighborhood-level social service, patient activism, and racist assumptions in mainstream science. As intrinsically interesting as the party is on its own, *Body and Soul* becomes a book about more than its immediate subjects. A key strength is its sophisticated conceptual approach, developed in the book's introduction and opening chapter. Here, Nelson lays out an African American health politics that spanned the 20th century and took different forms depending on the era. The chapter uses a number of historical examples, and many readers will find the survey handy to assign in courses on black health politics. Following the nadir of race relations" immediately following Plessy, African Americans founded health institutions of varying ideological stripes. They included National Negro Health Week, whose origins lie in the "Tuskegee Machine," the Garveyite United Negro Improvement Association's Black Cross Nurses, and black hospitals and public health campaigns. But this **institution building co-existed alongside regular engagement with the U.S. public health state**. The United States Public Health Service (USPHS) took over National Negro Health Week in the 1930s, and African American health professionals fought long and hard against the segregation of professional societies and facilities. Even as they built **parallel autonomous institutions**, Nelson points out that they simultaneously "pushed for comparable and shared facilities and services for black and white medical practitioners" and "full inclusion in the healthcare state" (25).¹⁵ This is important for understanding the Panthers, for their health **activities often transcended neat categories**—"separatist," "nationalist," "integrationist," among others. Even as the Panthers set up independent programs and institutions, they often relied on white medical personnel, lobbied rarefied medical organizations, and accepted government funds. In contrast to other oppositional movements to organized American medicine at around the same time, "the Party," writes Nelson, "did not reject medicine outright; rather, it sought to provide and model respectful and reliable medical practice" (79). This was less an overt contradiction than a continuation of a **decades-long practice: building one sphere, while fighting for recognition and equality in another**. And it extended beyond just the delivery of healthcare services, but into medical science itself. Since at least the late 19th-century rise of anti-black eugenic theories, Nelson argues, African American scholars mounted a steady critique of racist biological and medical science through an ongoing effort to "recontextualize" racist paradigms and the construction of a "scientific counterdiscourse." Nelson sees various campaigns of the BPP as manifestations of a "politics of knowledge" against scientific racism. All of the above showcased the Panthers' "social health" perspective, one that saw bodily ills as inextricably bound up with larger social determinants that transcended individual biology itself. The heart of *Body and Soul* consists of three chapters examining how social health was actually instantiated. The chapters cover free clinics, campaigns to raise political awareness of sickle cell anemia's prevalence among African Americans, and protests against racist assumptions in the emerging neuroscientific arena. The Panthers' free clinics opened during a flurry of health reform whose flashpoints included Medicaid and Medicare, but also the federal Office of Economic Opportunity (OEO) neighborhood health centers program, some still in existence. The OEO was one of many social service programs in the War on Poverty that by the mid-1960s legally mandated laypeople's "maximum feasible participation" in the administration of programs receiving federal funds. In actual practice, determining what exactly that meant, and who could legitimately invoke it, was often anybody's guess, and fierce battles around governance were recurrent throughout the era. For Nelson, one impetus for the BPP forming its own clinics—in 1970

it mandated that all chapters do so—was frustration over how much grassroots input could be realized within top-down bureaucratic mandates. But it also grew from a suspicion of contemporary medical practice itself, namely the disrespectful treatment of African Americans at institutions that were then predominantly white—or simply the absence of health resources altogether. As the organizers of the Panthers’ People’s Free Medical Clinic in Berkeley put it, “We know that as long as the oppressor controls the institutions within our oppressed communities, we will be subjected to institutionalized genocide whether it comes from inadequate housing, the barrel of a pig’s shotgun, Or from inadequate medical attention. . . [We] must create institutions within our communities that are controlled and maintained by the people” (77). Nelson’s analysis of the clinics resembles an ethnographic account that captures both the day-to-day experience and its occasionally improvised quality. Panthers scrounged for equipment, sometimes with the aid of black and white local physicians with access to medical resources. Most of the facilities were able to offer basic primary care, staffed by volunteer physicians, but also a non-professional “health cadre,” mostly women, who developed protocols of interaction between the patients and professionals. Indeed, patients were actively encouraged to call out the clinic staff when they showed signs of professional hubris. The BPP also saw the patient as part of a broader social context outside clinic walls. One novel program was a patient advocate system whereby those needing specialty services beyond the basic ones at the clinic were directed by staffers through the often labyrinthine health-care system at large. Altogether, the clinics amounted to a lived critique of a racialized hierarchy in the medical profession and a narrow biomedical focus antithetical to a social health perspective. For all their strengths, though, the clinics also exhibited some severe limitations. Reading through the activities of various sites does beg the question of how big a dent free clinics, however perfectly run in each locality, could make in the flawed structures of the American health-care system. Relying on volunteers and donations of supplies made for practices that were, in the end, rather shoestring. In fact, many people involved in the clinics recognized the problem, and one fascinating episode involves internal debates about whether to accept government funds to sustain the projects. Nelson herself is ultimately aware of the dilemma, noting that “because the health activist tactic of institution building is especially resource demanding, requiring both outlays of capital and access to (trusted) expert collaborators, the Party’s clinic program was a mixed endeavor” (112). But the inherent constraints on prefigurative medical experiments are sometimes more implicit than explicit in both Nelson’s account and the Panthers’ own claims about what they were accomplishing. Body and Soul’s concluding chapters detail the Panthers’ activism around sickle cell anemia awareness and against a UCLA neuroscience project formed in the wake of 1960s urban rioting. These sections on the “politics of knowledge” effectively demonstrate how the party’s health program, in keeping with a social health perspective, went far beyond the sphere of medical care. Sickle cell attracted the Panthers’ attention after critics pointed out the comparative dearth of federal research funds that went towards its study, a gap that carried much symbolism given sickle cell’s disproportionate prevalence among certain ethnic groups.¹⁶ Sickle cell activism served as a metaphor for medical neglect, and the party’s campaigns included screenings and educational programs that brought rarefied medical knowledge about the understudied condition to those it potentially affected the most. Highlighting neglect, in turn, was a way of rebutting racist and essentialist claims about congenital black bodily inferiority. The latter are the main subjects in Nelson’s account of a center at UCLA, whose intellectual leaders sought to find explanations for “violent behavior” in the physiology of the brain. Although the racial claims in the “Violence Project” were not always explicitly spelled out, they were clear enough for the party to mount a campaign that drew significant public attention and eventually closed the center. Nelson’s account of this important episode can be read alone, and it is necessary reading for anyone concerned with the resurgence in biologically reductionist claims, many with similar racial inflections. Body and Soul is an enormous achievement. Finishing it, I wondered how to position the BPP health program within the matrix of radical and liberal social reform during the era of the War on Poverty. The Panthers were master rhetoricians, and as political entrepreneurs, they had an obvious stake in accentuating the vanguard quality and revolutionary distinctiveness of their work. But in choosing to focus on the BPP health program—and away from the general revolutionary claims that have preoccupied most students of the organization—Nelson highlights more affinities between the BPP and various liberal and left-liberal counterparts than her subjects would have acknowledged. It is true, for example, that many of the OEO neighborhood health centers’ mechanisms for “maximum feasible participation” amounted to little more than pro forma tokenism. But there were other examples where shared medical governance did occur, even in imperfect ways. Though their architects often employed much more sedate rhetoric than the Panthers, many of the signature War on Poverty health programs shared the same goals: bringing health care to locales where it was absent, flattening medical hierarchy, and practicing a medicine aware of the social context in which it was embedded. Much of

the BPP's famous "Ten Point Program," when one puts the **revolutionary rhetoric aside**, amounts to a **sober call for access** to improved standards of living. In the sickle cell and UCLA episodes, the Panthers were willing to **work with researchers and attorneys** who shared their concerns, and though these alliances sometimes resulted in liquidation of the BPP's larger social health paradigm (especially in the sickle cell case), they were also often surprisingly fruitful and legitimized the Panthers' critique in the broader public sphere, as in the case of the Violence Project. This is not a criticism of Nelson's book so much as it is a call to bridge it with a new generation of work on liberal policymaking and activism of the period, collected to great effect in Annelise Orleck and Lisa Hazirjian's recent volume, *The War on Poverty: A New Grassroots History, 1964–1968*.¹⁷ As scholars have begun to question the **stark boundaries** between the mainstream "civil rights campaigns" and "Black Power," they might throw into the mix "liberal" and "radical." In the overlapping eras of civil rights activism, Black Power, and the War on Poverty, scratch a radical, find a liberal; scratch a liberal, find a radical.

Body and Soul is a major contribution to understanding an era that still confounds us.

Change is not circular, linear, NOR cumulative---those labels falsely imply coherent directionality---rather, it is a chaotic and eclectic stitching together of moments of oppression and resistance---formed but NOT determined by the system---AND remediable on multiple levels

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Fortunately, to the extent that the present global capitalistic system is the ultimate structure supporting regress in internal US progress toward social justice for African Americans, **resignation is not the only realistic or prudent response**. A global system works on many **institutional levels** of governmental and economic structure, including its injustice as experienced by real people who suffer from it in their **concrete daily existence**. And it is **that kind of individually experienced injustice**, which **can be addressed, on the ground**. It may not be (as Alexander and West have, respectively, called for and proclaimed to have begun) that even a movement is necessary or sufficient in order to address specific contemporary experiences of injustice. It may be that tangible practical first steps can be taken on the level of local activism and it may be that in societies with democratic structures, such activism is more effective than the promulgation of liberatory global system theory'. If local problems are corrected without at the same time calling for a new national or global movement, there may be less political opposition on local levels. We will return to this question of "scope of activism" in the next section, after more theoretical ground has been reclaimed for "what to do." NEW CONSTRUCTIONS OF RACE Global **understanding is important**—we are all required to be informed about the world—but it **is not the only worthwhile theoretical goal**. Theory and analysis are also important for developing ideas for how to correct injustice on **concrete, specific levels**. Under-examined in the construction of revisionist history, as well as in the idea of regress, is a **circular theory of human history**. We seem to **go ahead**, and then we **go back**. But what could it mean to "go back"? No one has claimed that the present or recent past **duplicates the more distant past or literally replays it**. Although, some scholars have claimed that some structures of status are remarkably resilient, even though the principles defending them have been rejected. For example, the idea that nonwhites are inferior to whites and need to be kept separate from them for the benefit of both groups has been abandoned as an explicit, official justification for racial segregation, but racial segregation—in US housing, education, and social life—has not been abandoned. (Residential segregation continues without legal requirement as the result of real estate prices, sedimented social practices, poverty, and mortgage lenders who redline.) Rival Siegel argues that status arrangements may persist with complete legality after their original justificatory principles are struck down, so long as different justifications are concocted: The ways in which the legal system enforces social stratification are various and evolve over time. Efforts to reform a status regime bring about changes in its rule structure and justificatory rhetoric—a dynamic I have elsewhere called "preservation-through-transformation." In short, status-enforcing state action evolves in form as it is contested.²² Siegel's thesis raises the question of what kind of thing or relation the original social stratification is, so that it can persist from generation to generation under different names, with different justifications. The social metaphysics could involve "memes," or intergenerational habits, or outright lies and conspiracies. Perhaps **there are power relationships between blacks and whites that members of each group inherit and whites are loathe to give up, because they have more power**. To relate the present to the past in such ways is a **complex interdisciplinary work** consisting at least of sociology, history, and legal and political history, before philosophers and other theorists could

formulate their own disciplinary interpretations. It may be simpler and more conclusive to approach this issue of permanent-status-through-change by starting fresh with present power and status differences.

When Alexander calls the present racially biased prison system "the new Jim Crow," she adds that she does not mean to draw a literal comparison, but to write metaphorically.²³ This raises the question of why we need a metaphor that invokes the past to describe present conditions that are well studied by contemporary social scientists, with events reported by journalists and recorded on video, as they occur. What would happen if we simply stayed with our current best descriptions and attempted to theorize them? One result might be to shift the discourse from a somewhat rigid idea of types of events, a kind of essentializing of history, to the use of more recent tools involving the idea of social construction. It's already well accepted within the academy that biological human racial divisions, as well as their social meanings, were constructed in the past.²⁴ We also know that biological foundations for human races are now repudiated in the same scientific fields that invented them. That knowledge supports recognition of racial construction within society which was explicitly based on assumed biological determinism in the past. Indeed, one indication of a lack of biological foundation for racial taxonomies in society is the historical and geographic variation of the epistemology of social race. Thus, for example, before they were assimilated into the middle class, Europeans who were Irish, Italian, Jewish, Finnish, Polish, and even German, were not considered white; the ethnic category of Hispanic/Latino was created by the US census and has since been regarded as a race or at least an object of racism; Middle Eastern Americans came to be identified as a nonwhite racial group after 9/11; mixed black and white people are conventionally identified as black. Such social construction of race has always been closely associated with citizenship rights and social status and it has been maintained and changed for changing political and economic purposes. Race and racial divisions should be viewed as constantly "under construction." Dominant groups may reiterate some general ideas based on their knowledge of history, but their present focus is always on their present goals for dominance.

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Race as it has been known, and as we continue to know it, is a dynamic process. Consider, for example, Richard Nixon's reported intentions to appeal to white racists, with language that would not explicitly mention blacks or other nonwhites. The social construction of black men as criminals that has accompanied broad public acceptance of police racial profiling, as well as the racial imbalance in incarceration, has its origins in this early 1970s political rhetoric and policy. That is, our present form of the social construction of black men started as a relatively new, post-civil rights movement strategy for getting votes. This is not to say that the strategy had not been successfully used before then, for instance, as Alexander notes, in extinguishing the late nineteenth-century populist movement.²⁶ But it was a new political strategy for the 1970s. And all that was required to sustain it from then on was a steady increase in the funding and construction of the infrastructure supporting it, and occasional ideological revitalization. For example, in the 1988 presidential campaign, George H. W. Bush used against Michael Dukakis, his Democratic opponent, the example of William "Willie" Horton, a convicted first-degree murderer, Horton committed rape and assault when released on furlough during Dukakis's second term as governor of Massachusetts. In his first term as governor, Dukakis had vetoed a bill that would have stopped furloughs for first-degree murderers. Ergo, Dukakis was portrayed as "soft on crime," and Bush won the election. ²⁷ If we view the social construction of race as an ongoing dynamic process, we need to understand that Nixon and H. W. Bush were not merely manipulating existing public fears about black men, but fanning them, exacerbating them, and giving them new faces—faces from their time, not faces from the late nineteenth century—and in that process reconstructing race. They were not turning the clock back to the beginning of a new era of Jim Crow (no matter how metaphorically that may be understood) but moving forward with new ideas about black male identity. Of course, these ideas were not difficult to "sell" because the paradigm case of black manhood they held up was genuinely scary and the mass of economically insecure white voters was already predisposed to accept a racist ideology. But

"predisposed" does not mean "predetermined." The construction of the idea of the late twentieth-century black male ghetto dweller as an inherently dangerous and later crack-crazed maniac was a newly constructed stereotype. It prompted a whole new generation of nonblack women to clutch their purses when a black man stepped onto elevators with them, and signaled everyone else to click their car doors into "locked" when they saw a black man advancing down the street.²⁸ In turn, these attitudes can be viewed as antecedents to acceptance of the legality of recent high profile cases of police homicide following attempted stops and frisks of unarmed young African American men. Overall, such stereotypes support the criminalization of black male bodies in the public imaginary because those bodies have become icons—they both symbolize criminals and are perceived as physically dangerous. That Willie Horton, who was a violent black male criminal, became the face of black male crime and not any one of hundreds of thousands other black men, who had already been incarcerated for possession of small amounts of marijuana or cocaine, meant and continues to mean, that the preoccupation with crime in America is a locus on physical crime. There is now a prevailing impression that "crime" means "physical violence," so that "white-collar crime" (a term now out of date sardonically) is not viewed as truly dangerous. And physical crime is imagined to be mainly perpetrated by black men, an association so strong that being a criminal has become part of the casual identity of being a black male. The quotidian phenomenology of that new construction of race for all black men, especially poor black youth, is nothing less than the

Medicare For All Master File

phenomenology of traumatic encounters with bullies against whom the victim cannot win—if the victim tries to win, he can be killed by police officers, with impunity.²⁹ I suggest that we view the post—civil rights movement association of crime with African American men and boys as a new construction of race. Alexander names this construction “criminalblackman,”³⁰ but does not sufficiently treat it as a new racial construction. She is aware that something new has occurred, but she views it as an attribute of crime, rather than a reconstruction of black maleness: “For black men, the stigma of being; a ‘criminal’ in the era of mass incarceration is fundamentally a racial stigma. . . . Whiteness mitigates crime, whereas blackness defines the criminal.”³¹ Alexander does not tell us what she means by the preexisting “blackness” that defines the criminal. There is no preexisting blackness, except for dark skin and poverty. In this case, “criminal” defines and constructs blackness. And that is why the almost 70 percent of African Americans who are black, but not poor, also suffer from this new construction of

“criminal black man.” Such slanderous characterizations of an entire group as dangerously criminal do not directly result from the financial and economic structures of a system of global capitalism, descending like the forefinger of God to shape the minds of the white populace. They are opportunistically discovered by politicians seeking votes, based on their assumptions that their highest good is getting elected, instead of getting elected for the right reasons. (It should go without saying that such politicians cannot be presumed to believe what they say in order to get people to vote for them.) If the politicians get elected, they

try out a few new programs. If those on whom the programs are inflicted (e.g., the victims of Reagan’s War on Drugs that followed a general valorization of “law and order”) are already vulnerable to government power and the rest of the population is not vigilant about everyone’s rights, the programs succeed and their growth accelerates in new times of crisis. Such programs will only work if they are able to intersect with existing or burgeoning corporate interests, in this case, private prison contractors. If the intersection “takes,” then soon enough, a criminal justice system such as the one in place is the historical result. It is a historical result because it developed over time and at many different stages its present state could not have been predicted with a high degree of probability. It may therefore be an unduly Manichean use of history to view such a system as a deliberate design by the ultimate architects of global corporate capitalism. That is not to say that individuals, especially poor and nonwhite people, do not encounter the present criminal justice system as both real and unyielding.

And it is not to overlook the jobs provided to law enforcement officers, prison personnel, and civilians who prosper from the economic stimulus of prisons in their locales.³² In addition, we should be concerned about Alexander’s account of the dire consequences for eligibility for government aid and prospective employment, as well as loss of personal and familial regard, suffered by contemporary felons. Once convicted, or sometimes, even only arrested for minor drug offenses, the poor and especially black victims of this system become branded as lifelong criminals. They are usually barred from both jury duty and voting and are precluded from ever fully rejoining respectable society. Their inability to vote in geographical areas with large poor black populations can tip the results of key elections. Most of the victims and fearful observers are now accustomed to this system, their habits settled within and outside it, as though it were completely natural, “just the way things are.”³³ These are terrible conditions of existence for millions of poor black people.

However, the question is not whether or not they are related to larger historical trends, which they without question are, but whether the most effective way to address them via activist discourse is to take on the big global picture or focus on comparative ways in which American blacks and whites, poor and middle class, are treated by their—everyone’s—government. The prison-poverty system became an entrenched institution by the mid-1990s. Alexander notes that during the Clinton administration, the prison budget, after increasing by 171 percent, became twice what was allocated to Aid to Families with Dependent Children (AFDC) and that funding for public housing was reduced by 61 percent. At the same time, those who had been convicted for drug offenses were barred from public housing and faced homelessness.³⁴ Described in these terms, the prison-poverty system exceeds the institution of Jim Crow because of its dedicated federal funding. In studying this structure, everything that happens can be described as though it were designed to oppress poor black people, for the benefit of others. But even that description, in addition to its transcendental excess, may rely too much on the net results of contingent, uncertain, incremental components. Moreover, although poor black ghetto dwellers are the main human resources for this system and the rate of poverty among American blacks is twice that among whites, most American blacks, about 75 percent, are not at this time poor ghetto dwellers.³⁵ The majority of American blacks, who are neither poor nor incarcerated are stigmatized and thereby endangered by stereotypes that connect the prison to the ghetto, but they are not directly part of that connection. This does not mean life is not unjust for all African Americans, but it does mean that the majority retains its civic ability to educate the next generation, vote, protest, and cultivate optimism about the future. (A visitor from another planet might wonder if that majority is doing enough to fulfill its civic obligations in the early twenty-first century.) HISTORICAL AND POLITICAL BOUNDARIES Unlike Jim Crow, which had mainly excluded blacks from mainstream economic and social life, the post—civil rights criminal justice system initiated positive federal programs that were intended to directly and punitively address African Americans, partly because key people in government believed that was what white Americans wanted. While it seemed at first that affirmative action for middle-class African Americans was a helpful positive program—and it did in fact help many—white backlash attacking it as “reverse discrimination” has curtailed explicit affirmative action policies, under the direction of the US Supreme Court. Antidiscrimination laws remain on the books, but there is little evidence that antidiscrimination lawsuits, since 1980 have been effective. In place of affirmative action there has been a perceived need for racial diversity in organizations and some observers conclude that compliance reviews are more effective than lawsuits for organizational change, especially in the diversification of management positions. Overall, the twenty years following the success of the civil rights movement was a period of regress, which many

observers in 2015 consider to remain in full swing. But, what is happening during this period is exactly a competition among

interest groups, and as Bentley might have predicted, with no clear-cut resolution yet. It therefore makes sense to consider appropriate time frames with which to think about the current situation of racial injustice. Raymond Williams was a twentieth-century English cultural critic who seems to be largely unknown to US philosophers of race who write about social justice. He was one of the founders of the British New Left Review, but his ideas were a site of contention for more orthodox Marxists, because he was skeptical of economic analyses that did not take lived cultural experience into account. Williams believed that masses, and also perhaps classes, did not literally exist, except for how theorists defined and viewed them. He also anticipated later feminist emphases on “nutritive and generative” aspects of lived experience as a major social institution on a par with the economy and politics. Williams has been considered most influential for his ideas that all members and groups in society contribute to its structured feelings at any given time and for his idea of the long revolution that recurred throughout his writing, after he introduced it in a 1961 book of the same title.³⁷ The Long Revolution named by Williams was a process of social change toward democracy, which began in modernity in the late eighteenth century with the French Revolution, “the mould in which experience was cast.”³⁸ By

"experience" in this context, Williams meant the experience of writers and poets, and he believed that what was expressed in literature both reflected feelings in society and influenced them. The structured feeling of the Long Revolution is centered on goals of universal human recognition for all members of society, as whole human beings.

Everyone is to be accepted for what they are in the system to come after capitalism: "There can be no acceptable human order while the full humanity of any class of men is in practice denied."³⁹ In disagreement with contemporary Marxists, Williams was skeptical of the ability of socialism or state control that would entail complex bureaucracy to realize the goal of universal humanity: "We seem reduced to a choice between speculator and bureaucrat and while we do not like the speculator, the bureaucrat is not exactly inviting either."⁴⁰ His proposed solution was a form of self-rule based on open discussion and voting, with representatives to larger governing bodies responsible to their constituents. Williams has been interpreted as advocating that "the people" rule themselves, but he is not usually associated with an archism.⁴¹ It is very difficult for a theorist to decide how big a picture to consider, how long a period of history to take as a unit for long-term trends. Since we cannot successfully intervene in a global system, and the same facts can usually be explained by more than one theory, there is little that can or should interfere with a long-term view that is tilted toward optimism. The temporal perspective introduced by Williams, although he probably would not have described it in these terms, permits us to think about history as extending into the future, as well as the past.⁴² Suppose that there is a Long Revolution and there are Wide Humanistic Values to match it, which preclude racism, because the full humanity of all human beings will be recognized, eventually. It might be useful, as a matter of sanity, as well as hope, to see the present conditions of American antiblack punitive racism as a relatively short span of events within those lengths. Such events need to be endured and the hope is that they will pass into the past at some stage in the future of the Long Revolution.

About hope, Williams wrote the following at the end of Towards 2000: It is only in a shared belief and insistence that there are practical alternatives that the balance of forces and chances begins to alter.... Once the inevitabilities are challenged, we begin gathering our resources for a journey of hope. If there are no easy answers there are still available and discoverable hard answers and it is these that we can now learn to make and share.

This has been, from the beginning, the sense and impulse of the Long Revolution.⁴³ The Elasticity and Inclusiveness of Identities Since the US civil rights movement, African American theorists, academics especially, have emphasized the importance of black identity, in the tradition of W. E. B. Du Bois and Frantz Fanon. There has been a shift toward prophecy in Cornel West's sense of speaking the truth about oppression in the present, but overall, the methodological consensus is that improvement in the conditions of African Americans needs to be demanded by and for African Americans, as a racial group. This discourse displays little confidence in human rights or a humani-tarianism such as Williams emphasized, because there is a longstanding belief that many whites have in the Long Oppression failed to recognize the humanity of blacks. Moreover, the language of "color blindness," which does not mention race, is strongly associated with the regress of post-civil rights movement black poverty and deep experience of injustice in the criminal justice system. However, this view may be too concrete, too focused on short-term historical contingencies, to get us from here to where and how we want the future to be. American politicians have been able for a while to manipulate and implement racism in racially neutral language, which leaves little opportunity for either nonwhite racial affirmation or successful race-based litigation—that is, judges do not accept wholly race-based affirmative action or complaints about antiblack racism in situations that have been already described in race-neutral language, such as the War on Drugs. Nevertheless, it does not follow from any of this that neutrality about race is not a humanistic ideal or that humanistic ideals are not valid general ideals. It may be a self-defeating long-term error, albeit expedient in the short term, to insist that all efforts toward improving the present conditions of poor African Americans be described in terms of their racial identities, rather than their human identities. There are more poor whites than poor blacks or Hispanics in the United States, even though black poverty is twice as common as white poverty and the residential segregation of the black poor creates additional race-associated vulnerabilities.⁴⁴ African American poor people are more vulnerable to the exploitation of being inducted into the US criminal justice system, as well as more vulnerable in lacking adequate housing, food, a living wage, and public education that provides real opportunities for their children. All of these ills and comparative disadvantages create distinct circumstances of the "blackpoor." But the condition of poverty itself, where the poor have less income and wealth than those who are not poor, is a measurable condition that includes people of all races, including whites and especially whites who are homeless or unemployed. There has been much debate about whether race or class is more important to consider for understanding the situation of poor African Americans: Does black racial identity in an antiblack racist society predetermine a high likelihood of poverty, which persists over generations as antiblack racism continues? Or, is poverty sufficiently oppressive to account for its own persistence, regardless of race? Does race and racism change the nature of poverty? Or, is poverty, like criminality, part of a new black identity? Much can be said in answer to such questions about the theoretical aspects of race or class as a lens for studying the oppression of the blackpoor. Lucius Outlaw has developed a now paradigmatic perspective that historical and contemporary studies of race support a critical theory of race that is more relevant to African American experience than traditional critical theories based on class.⁴⁵ Still, the question in terms of activism and the correction of concrete social injustice is not how poverty has been caused, but how it can be corrected. (It may have causes mainly in racism but mainly economic corrections.) To correct poverty and attendant issues such as food insecurity and homelessness among children, it neither makes sense, nor is it morally principled, to focus on the poverty of only African Americans. The discourse of social class may not be adequate to account for institutional racism and specifically racist institutions, because there is usually an added element of ignorance, neglect, or malice, concerning blacks. But addressing poverty needs to be an inclusive project. It would not only become another contentious form of "affirmative action" if only the blackpoor were considered, but it would be cruel insofar as the poor of all racial groups suffer. In 1961, at the age of ninety-three, W. E. B. Du Bois joined the Communist Party and then said the following to the New York Times': "Capitalism cannot reform itself; it is doomed to self-destruction. No universal selfishness can bring social good to all. . . . Communism—the effort to give all men what they need and to ask of each the best they can contribute—this is the only way of human life."⁴⁶ Black spokespeople have for many decades emphasized poverty as a primary human problem and not a problem for only black Americans. Martin Luther King Jr. expressed that humanitarian emphasis, as has Cornel West, in our own era. Following his award of the Nobel Peace Prize in 1964, King announced a shift from civil rights to human rights, through his organization of the multiracial Poor People's Campaign. Before he was assassinated in 1968, King envisioned a Poor People's March on Washington, D.C.⁴⁷ West and Tavis Smiley, in their Poverty Tours, have emphasized the importance of "jobs with a living wage," as a goal for millions of Americans of all races.⁴⁸ Poverty is also a world concern. In a way similar to this racially inclusive view of poverty, US government action toward peoples of nonwhite races outside of our borders has been an African American concern, in black liberatory discourse. As early as 1919, nine years after he founded the NAACP, Du Bois organized a second Pan-African Congress in Paris, presenting a petition to the Versailles Peace Conference (or recognition of worldwide peoples' rights to anticolonialist self-determination. The petition was rejected. Du Bois continued to connect the situation of American blacks with that of global people of color, until the NAACP expelled him in 1948, for reasons of political prudence involving the Cold War.⁴⁹ King carried on Du Bois's insights that the treatment of African Americans was related to America's international policies, especially after he was awarded the 1964 Nobel Peace Prize. His protests of the Vietnam War and beyond that his call for land reform (in his 1967 Riverside Church

speech), against US policy in Latin America, resulted in harsh assessments and dissension within the civil rights movement he had come to symbolize. He was also disinherited from the Johnson White House.⁵⁰ We have already noted, in chapter 5, West's emphasis on US foreign policy, as part of the black prophetic tradition, as well as his harsh remarks about President Obama. West is also not welcome in Obama's White House.⁵¹ These projects of making African American concerns more broad by extending the area of complaint and protest to nonblack American poor people and non-American people of color have not met with great success. They have neither strengthened the movements of their time, nor reduced or ended poverty (and American foreign policy has been impervious to their demands). Bitter reactions from the African American community to the US presidency reverberate when black liberatory spokespeople voice strong opinions on foreign policy. It is unimaginable at this time that such issues can be related to African American activism in official or public understandings, but it is also unimaginable that the issues are not related in reality. This is a situation of stasis. However, there is now another dimension to global aspects of US social justice activism media. The pleas in a number of local demonstrations and protests about police homicide⁵² of unarmed African Americans, such as "Hands Up, Don't Shoot,"* "I Can't Breathe," "Black Lives Matter" and "No Justice, No Peace," have been highly publicized by the mainstream media, as have successive police homicides after the death of Trayvon Martin in 2012.⁵³ The New York Times brought all of this to a head on April 6, 2015, by posting a video of Walter Scott being shot in the back while fleeing a police officer in South Carolina. With prose befitting the cool temperature of The New Yorker magazine, Philip Gourivitch posted the following about that video: There it was, front and center, on the home page of my local paper, the Times, and on the BBC, and the Guardian, and the Wall Street Journal, and thousands of other news sites, as well as hundreds of thousands of Facebook pages and Twitter feeds: a freeze-frame showing a white policeman in the process of shooting a black man to death, with a play button you could click to watch the whole killing from start to finish,⁵⁴ Gourivitch went on to discuss the ethics of journalistic displays of people getting killed and raised a question of respect for death on the part of viewers. What Gourivitch neglected to point out was the power of this video to provide conclusive evidence of contemporary injustice concerning the contemporary issue of police officer killings of unarmed black men, for which there have customarily been acquittals or failures to indict. The usual justification that an officer has acted out of fear for his own life is not supported by this video. What Gourivitch does succeed in pointing out is the global publicity that now attends such incidents. This international dimension of US race relations is different from the connection between US domestic and foreign policy on a theoretical level because it has the potential to spark vast external moral pressure on American government entities, perhaps similar to the Cold War pressures that were influential in Brown v. Board of Education and the 1964 Civil Rights Act, as discussed in chapter 4. Issues of poverty, including global poverty, expand theoretical concerns about the carceral and other existential vulnerabilities of poor African Americans, to include people of other races, notably whites domestically and other peoples of color abroad. By the same token US foreign policy raises issues of global white nonwhite racial divides Still in terms of activism, these have largely remained theoretical issues that support broader understanding. They may describe issues for move ments lost, past, or yet to be developed, but in terms of contemporary social justice activism, concrete change is a matter of US domestic issues concerning race relations and the practical tradition of the undra-matic, obscure aspects of the Long Revolution is very important. The vagueness of Williams s idea of the Long Revolution promises an ordinary, day-to-day methodology for addressing racial injustice.

Ordinariness is required given the time span of the Long Revolution that according to Williams began in 1789. The ability to sustain continual low key and undramatic liberatory efforts may require the kind of faith found in activists within the black prophetic tradition, who were not as charismatic as Martin Luther King Jr., but attended to specific issues over decades.

For instance, West contrasts the contributions of Ella Baker to those of King, describing her as "an unassuming person who helps the suppressed to help themselves." Baker's organizing work included her service as secretary of the NAACP, executive director of the Southern Christian Leadership Council, and cofounder of the Student Non-violent Coordinating Committee. Baker knew both Du Bois and King and was skilled at grassroots organizing, but she did not write essays or books or produce mesmerizing speeches. She talked about humility and service alongside everyday people and insisted that members of a movement motivate themselves.⁵⁵ "Think Globally, Act Locally" In light of the insight that amounts to "Think globally, act locally," borrowed from environmentalist planning discourse,⁵⁶ let's return now to Wacquant's general model of the contemporary carceral system as a form of social control that extends beyond punishment for crimes. Wacquant's analysis suggests that at least three different social situations would be more accessible to activist-sparked change than the overall global capitalist system: race-based residential segregation; impoverishment of the educational system as it serves the poor; assumptions about the traditional family that have had a slanderous effect on black family images. Residential segregation enables the architectural and geographic formation of ghettos as areas targeted for intrusive law enforcement surveillance, because poor and powerless blaeks are physically clustered in one place.⁵⁷ Also, insofar as schools are financed by taxes based on property values, residential segregation results in impoverished resources for K-12 education. Both segregated substandard housing and inadequate schools are issues that can be addressed through local activism and support for the development of employable skills and jobs. While the "feminization of poverty" has been well-documented, ad ditional attention could be paid to the assumption that women the primary caretakers for children, which explains why welfare and workfare programs have been concentrated on them, with the state replacing the function of a male provider in a nuclear family. However, ever since reactions to the 1965 Moynihan Report, and earlier in the work of E. Franklin Frazier, it has been known that many African Americans do not grow up in, or themselves form, traditional nuclear families with stay-at-home mothers and male breadwinner fathers. Positing poverty as the cause of this unconventional family structure had been the standing practice in sociology until Patrick Moynihan, writing for the US Department of Labor, claimed that the cause of black single mothers, illegitimacy, and extended family structures, was cultural pathology with roots in social arrangements that had been necessary under slavery and Jim Crow.⁵⁹ Despite the obsessive morbid interest in Moynihan's characterization of family organization among the black poor, it has been outpaced by more broad historical changes. Not only have women of color, especially African American women, always worked outside of their homes, but most white women and women in other racial and ethnic groups, on all socioeconomic levels, now work outside of their homes. For poor women, their employment hinges both on skills and available and accessible jobs. The surrogate traditional-family aspects of welfare and workfare can therefore be viewed as so outdated as not to be worth theoretical consideration. This means that the need for welfare and workfare programs reduces to a need for more jobs for poor black women—and a need for transportation to and from those jobs, as well as affordable childcare.⁶⁰ As of April 2015, adult African American women had the highest rate of unemployment at 9.2 percent, compared to 6.5 for Latinas and 4.2 for white women, (The website of the National Womens Law Center has portals for instructions on how those concerned about this issue can email their congressmen and senators.) Finally, a contemporary example of spoken and active discourse about an immediate problem has been provided by activists in Ferguson, Missouri, who met with President Obama in December 2014 to discuss their attempts to influences changes in local police practices. Said Ashley Yates, cofounder of the group Millennial Activists United, "We're definitely going to keep doing the work on the ground, but meeting with the president, for me—well, I'll say for everybody—is just an affirmation that this movement is working."⁶³ In February 2015, Ferguson activist groups called for 250 students to join them during spring break to provide community service such as clearing wreckage from earlier demonstrations and helping plant

gardens. Said Patricia Barnes, a Democratic committeewoman for Ferguson, "The protests have got us here. The next step is to target the ballot box, to get people elected and to change policy Students should take that back to their college campuses and build an infrastructure. . . . There is plenty to do."⁶⁴ Yes, there is plenty to do, but what needs to be done are fairly straightforward, day-to-day, community-based actions. Global systems are

overreaching causal factors of local vulnerabilities, but there is no reason to believe that their local effects cannot be addressed on their local levels.

LIBERTY, FREEDOM, AND INJUSTICE From a more abstract philosophical perspective, the foregoing discussion of revisionist history and active discourse, proceeding as they have from the concrete contemporary issue of racial injustice in the US criminal justice system, is a matter of liberty and freedom. Imprisonment is, after all, the classic, concrete example of not having liberty. And if we follow John Locke in saying that it is the whole person, and not the will, that can be free,⁶⁵ then a person in prison is not free. But philosophically, being in prison or not does not capture the abstract nature of liberty and freedom as political ideas and ideals. by influential political philosophers, for instance Isiah Berlin in his canonical 1958 lecture, "Two Concepts of Liberty."⁶⁶ Berlin distinguished between negative liberty, or what others including government officials are not permitted to do to a person, and positive liberty, an area of personal autonomy allowing for individual choice and development. He was wary of the abuses by paternalism or quietism to which the idea of positive liberty could be subject. On the one hand, paternalistic or despotic leaders could take it upon themselves to determine what was. The terms "liberty" and "freedom" have been used interchangeably good for others (for the good of a harmonious social whole, as well the individual freedom of rational beings)* And, on the other hand, stoic quietists might seek to shrink individual choice to what was not prohibited by law or punishable by government force: For this doctrine, as it applies to individuals, it is no very great distance to the conceptions of those who, like Kant, identify freedom not indeed with the elimination of desires, but with resistance to them and control over them ... a sublime but, it seems to me, unmistakable, form of the doctrine of sour grapes. Insofar as Berlin championed the idea of negative liberty, in the tradition of J. S. Mill, three important qualifications tempered his libertarianism in ways that make it still relevant for active oppositional discourse. First, following Mill in equating incursions on core or essential negative liberty with coercion or slavery, Berlin acknowledged that freedom is only of value to those who can make use of it: "It is only because I believe that my inability to get a given thing is due to the fact that other human beings have made arrangements whereby I am, whereas others are not, prevented from having enough money with which to pay for it, that I think myself a victim of coercion or slavery.⁶⁸ Second, Berlin understood that people who are not free may take action against those who are limiting their freedom(s): "Those who are wedded to the 'negative' concept of freedom may perhaps be forgiven if they think that self-abnegation is not the only method of overcoming obstacles; that it is also possible to do so by removing them ... in the case of human resistance, by force or persuasion." Third, Berlin recognized the importance of status or recognition, which in some cases might outweigh the value of negative liberty, to members of groups with a history of oppressive rule by others. However, in rethinking Berlin (as well as Locke), a focus on active discourse against injustice may require a distinction between liberty and freedom. What that distinction amounts to is that freedom can be used to expand the possibilities for resistance against unjust curtailments of liberty. The term "liberty" (or negative liberty in Berlin's sense) can be used to refer to lack of external constraint and "freedom" to refer to decisions, choices, and interests of a subject, apart from their expression. For example, racially biased stops and frisks infringe on the US constitutional liberty of black subjects to be free from arbitrary searches and seizures, according to the Fourth Amendment. Poverty, viewed as a cross-racial or multiracial condition, may also be a limitation on freedom. Liberty is an external political matter, usually pertaining to rights under positive law and compliance or noncompliance with such rights. Freedom is a contested, psychic issue. If constraints on liberty are persistent and systematic, they may limit a people's freedom, because individual decisions, choices, and interests are influenced and inspired by what individuals are practically able to do—that is, by their liberties. We can say that a people with a history of poverty accompanied by restrictions in economic liberty will not be as economically advantaged as a people whose history did not contain such restrictions because the accumulation of wealth is passed on from generation to generation. The disparity in family wealth between American blacks and whites is a strong example of this kind of ongoing constraint.⁷⁰ However, when economic disadvantage is combined with racist attitudes and undereducation, the distinction between liberty and freedom may be eroded. Children growing up in constrained circumstances may not develop freedom in the psychic sense, in addition to restrictions on their liberty. An important part of the choices enabled by psychic freedom requires imagination, as well as self-esteem and knowledge of the broader world beyond one's immediate family and neighborhood. Jean-Paul Sartre emphasized that the ability to realistically project oneself into a future set of circumstances that are different from undesirable present ones requires some knowledge of those future circumstances to cultivate a motivational dissatisfaction with present conditions. Progressive activists have shown how Sartre's hypothesis can become a politicizing method: Organizers during early stages of Second Wave feminism conducted "consciousness raising" exercises to make women aware of their oppression;⁷¹ practical leaders of ethnic and racial liberatory movements from Ella Baker to Paolo Friere have proceeded with education of members of oppressed groups,⁷² exactly to activate their freedom, so that they can choose greater liberty as a goal. The Distribution of Liberty To speak of rights violations is to speak of unjust curtailments of liberty. It is presumed here that liberty consists of all the things that people are able to do, that they are in some sense entitled to do, as human beings and which government is not supposed to obstruct them from doing. The reduction of procedural justice to distributive justice in chapter 4 is now useful for considering liberty and freedom as relevant to oppositional active discourse. The view of liberty and freedom, but especially liberty, as a matter of procedural justice is more nebulous than a view of liberty as a good that is distributed. Procedures tend to be imagined as methods that need only be justified by those who administer them and their superiors. But distributions give goods out and they have end recipients. If procedures are not always followed in the same way for blacks and whites, this can be defended by saying that something unusual happened in a particular case or that there was an innocent error. It may be claimed as an excuse that the client/citizen/resident/plaintiff/ defendant did not correctly perform her role in the procedure, interfered with the procedure delivered by officials, or failed to act in a way that expressed reasonable understanding of the procedure, for example, there was a "language barrier." Procedures can be legally designed in ways that have different effects on members of different groups. Police racial profiling as part of a general procedure for maintaining law and order, photo ID requirements for voter registration, and English instructions to residents who do not speak English are all examples of legal procedures that have been justified without mention of race or ethnicity, but have different effects on members of different populations. However, if justice is viewed as a matter of distribution, the relevant test that it has been carried out, given all other things equal, is whether the social good that the procedure is supposed to be a fair or neutral means for distributing, does get fairly and neutrally distributed. The view of just procedures as distributed goods, bypasses color-blind policies that do not have race-neutral effects. When the distribution of negative liberty or procedural justice is unfair, the result is distributional injustice. Judith Shklar, known mainly for her claim that cruelty should be a primary or foundational concern of secular, liberal political philosophy,⁷³ addresses injustice as a subject in its own right. Although Shklar does not refer to Berlin, her focus on the distinction between an external judgment that another who is disadvantaged is suffering from misfortune and the sufferer's perception that she has been treated unjustly does echo Berlin's qualification that there may be minimal material and cultural requirements for a person's negative liberty to be of value to her. A poor, uneducated person, who does not understand the broader institutional causes of her poverty, may not be able to use the negative liberty legally afforded her to do anything she chooses with her life. She might not have the freedom to take advantage of her liberty. It may not occur to her to resist micro-oppressions or try to move into a better neighborhood because she has not been educated in ways that stimulate imagination. Externally, she may be viewed as having made poor choices or lacking the virtue of a work ethic, but subjectively she may experience her situation as unjust. And if her freedom has been impaired by restrictions on her liberty, her situation is objectively unjust. In The Faces of Injustice, Shklar expresses an overall dissatisfaction with philosophical theories of justice, which is parallel to the project undertaken in this book. However, although she begins by defining injustice as "an act that goes against some known legal or ethical rule,"⁷⁴ her approach to defining injustice in this short text continually wrestles with the distinction between injustice and misfortune. On the way, Shklar is very mindful of the overwhelming odds against victims of injustice in societies considered just: they are not heard; their resignation is taken for granted; they do not have remedies for redress or timely access to rectification in the form of punishment against those who have been unjust to them; they lack the means to change social practices that cause their injustice. Shklar is particularly sensitive to the plight of those who suffer injustice in concrete ways on account of their "ascriptive" identities, such as women until very recently and US racial minorities more or less permanently.⁷⁵ Nevertheless, and this is where Shklar's otherwise pessimistic combination of history and political philosophy makes an invigorating contribution to the subject of activist political discourse, she posits the recognition of injustice as both an eons-long and fundamental human moral intuition and a general civic right and obligation in democratic

societies. Shklar writes: A black American may well expect that she will not get a fair hearing from certain public agencies, but as a citizen she knows this is not what is expected of our public servants, and she can certainly feel and communicate her sense of injustice when her claims are ignored. There is, however, a bond between these two kinds of expectation. Unpredicted, sudden injustices are resented far more intensely than those one has learned to endure as a member of a group. They tear away the emotional protection created by resignation and allow distress to burst from its confines. Furthermore, in a way that just happens to capture the spirit of this chapter and complete the book, Shklar provides this statement of legitimization for political activism: Democratic principles oblige us to treat each expression of a sense of injustice not just fairly according to the actual rules but also with a view to better and potentially more equal ones. To be sure, democracy does not fulfill its imminent promises quickly, but at least it does not silence the voice of protest, which it knows to be the herald of change.⁷⁷ Shklar here proclaims the democratic legitimacy of expression of a sense of injustice. When we add that idea to the known existence of injustice as part of a Bentleyan process of government, active political discourse in the form of real life action can be recognized as part of the whole process of government. There is sound reason to undertake it and support its undertaking with confidence, both for change now and in view of the Long Revolution.

ONLY the federal government has the resources and power to alleviate healthcare inequality – coverage solves

Kennedy 05 (Edward M. Kennedy, ranking Democrat on the Health, Education, Labor, and Pensions Committee, graduate of Harvard University and the University of Virginia Law School, March 2005. "The Role Of The Federal Government In Eliminating Health Disparities." Health Affairs Journal. <http://content.healthaffairs.org/content/24/2/452.full>)

Minorities live sicker and die sooner from too many acute and chronic illnesses. To eliminate racial and ethnic disparities in health, Congress and the Bush administration must address the serious challenge of increasing minorities' access to health care and improving the quality of care they receive. We clearly need to expand Medicaid and the State Children's Health Insurance Program (SCHIP), but we must also develop and train culturally competent providers, increase the diversity of the health care workforce, collect better race/ethnicity health data, and make a greater investment in public health. Strong federal action is crucial to marshaling the resources and political will to end minority health disparities. It boggles the mind that for a generation the United States, with all its wealth and leadership, has been the only industrialized country in the world that does not guarantee health care to all of its citizens. When it comes to good health and good health care, far too many Americans have been left out and left behind. Forty-five million Americans are uninsured, and each one of these uninsured people is a tragedy waiting to happen.¹ Even among those with access, the gap between what we should do in health care and what we actually do for many patients is so wide that the Institute of Medicine (IOM) has called it a "quality chasm."² In health care, as in so many areas, minorities are disproportionately harmed. They live sicker and die sooner from a wide variety of acute and chronic conditions. African Americans are more likely than any other racial and ethnic group to develop cancer, and 30 percent more likely than whites to die from it.³ Hispanics living in the United States are 50 percent more likely than whites to suffer from diabetes, and the incidence of diabetes among Native Americans is more than twice that for whites.⁴ Although Asian Americans and Pacific Islanders represent only 4 percent of the U.S. population, they suffer more than half of the nation's chronic hepatitis B infections and half of the deaths from it.⁵ Many factors contribute to these unacceptable disparities, including toxic environments, low levels of education, unsafe working conditions, and unemployment. However, lack of access and low-quality care are two major causes of these disparities. Levels of health insurance coverage are lower among minority populations. Of the forty-five million uninsured Americans, minority Americans account for half. Approximately 18 percent of Asians and Pacific Islanders, 20 percent of African Americans, and 32 percent of Hispanics are without health insurance coverage at any given point in time, compared with the national average of 16 percent and the average for whites of 15 percent.⁶ Even when minorities have health insurance, they are still less likely than whites to receive adequate health care. Minority patients are much less likely than whites to receive diagnostic and therapeutic interventions for heart disease, kidney transplants to treat end-stage renal disease, mental health services, appropriate pain management, and recommended medications for asthma and HIV/AIDS.⁷ More than 600 articles published during the past three decades have documented racial or ethnic variations in health care.⁸ Importantly, the studies also demonstrate that when minorities do

receive the appropriate standard of care, disparities in health outcomes are eliminated.⁹ How we respond to the minority health crisis is a basic measure of the depth of the nation's actual commitment to the ideals of liberty and justice for all.

The alternative to governmental distribution of healthcare is a dangerous, inaccessible private monopsony

Reich 16 (Robert Reich, Chancellor's Professor of Public Policy at the University of California at Berkeley and Senior Fellow at the Blum Center for Developing Economies, served as Secretary of Labor in the Clinton administration, August 24, 2016. "Why a Single-Payer Health Care System is Inevitable." <http://billmoyers.com/story/single-payer-healthcare-system-inevitable/>)

The best argument for a single-payer health plan is the recent decision by giant health insurer Aetna to bail out next year from 11 of the 15 states where it sells Obamacare plans. Aetna's decision follows similar moves by UnitedHealth Group, the nation's largest health insurer, and by Humana, another one of the giants. All claim they're not making enough money because too many people with serious health problems are using the Obamacare exchanges, and not enough healthy people are signing up. The problem isn't Obamacare per se. It lies in the structure of private markets for health insurance – which creates powerful incentives to avoid sick people and attract healthy ones. Obamacare is just making this structural problem more obvious. In a nutshell, the more sick people and the fewer healthy people a private for-profit insurer attracts, the less competitive that insurer becomes relative to other insurers that don't attract as high a percentage of the sick but a higher percentage of the healthy. Eventually, insurers that take in too many sick and too few healthy people are driven out of business. If insurers had no idea who'd be sick and who'd be healthy when they sign up for insurance (and keep them insured at the same price even after they become sick), this wouldn't be a problem. But they do know – and they're developing more and more sophisticated ways of finding out. Health insurers spend lots of time, effort, and money trying to attract people who have high odds of staying healthy (the young and the fit) while doing whatever they can to fend off those who have high odds of getting sick (the older, infirm, and the unfit). As a result we end up with the most bizarre health-insurance system imaginable: One ever better designed to avoid sick people. If this weren't enough to convince rational people to do what most other advanced nations have done – create a single-payer system that insures everyone, funded by taxpayers – consider that America's giant health insurers are now busily consolidating into ever-larger behemoths. UnitedHealth is already humongous. Aetna, meanwhile, is trying to buy Humana in a deal that will create the second-largest health insurer in the nation, with 33 million members. The Justice Department has so far blocked the deal.

Insurers say they're consolidating in order to reap economies of scale. But there's little evidence that large size generates cost savings. In reality, they're becoming huge to get more bargaining leverage over everyone they do business with – hospitals, doctors, employers, the government, and consumers. That way they make even bigger profits. But these bigger profits come at the expense of hospitals, doctors, employers, the government, and, ultimately, taxpayers and consumers. There's abundant evidence, for example, that when health insurers merge, premiums rise. researchers found, for example, that after Aetna merged with Prudential HealthCare in 1999, premiums rose 7 percent higher than had the merger not occurred. What to do? In the short term, Obamacare can be patched up by enlarging government subsidies for purchasing insurance, and ensuring that healthy Americans buy insurance, as the law requires. But these are band aids. The real choice in the future is either a hugely expensive for-profit oligopoly with the market power to charge high prices even to healthy people and stop insuring sick people. Or else a government-run single payer system – such as is in place in almost every other advanced economy – dedicated to lower premiums and better care for everyone. We're going to have to choose eventually.

The impact of the aff is beyond the individual – high levels of uninsurance undermine minority community cohesion and strength

McKay and Timmermans 17 (Tara McKay, Assistant Professor of Medicine, Health, and Society and affiliated faculty in the Sociology Department at Vanderbilt University, PhD in Sociology from the University of California, Los Angeles, Robert Wood Johnson Foundation Scholar in Health Policy Research at the University of California, Berkeley, Dr. Stefan Timmermans, Professor of the UCLA Department of Sociology as well as being a professor at ISG, Journal of Health and Social Behavior, 2017. "Beyond Health Effects? Examining the Social Consequences of Community Levels of Uninsurance Pre-ACA." <http://journals.sagepub.com/doi/pdf/10.1177/0022146516684537>)

Spillover Effects of Uninsurance on Healthcare Access and Quality While the lack of health insurance is traditionally considered a problem facing individuals and their families, the geographically bounded organization and funding of healthcare make it possible for the uninsured to have a broader impact, affecting everyone living in a community or health market. At the most elementary level, the spillover effect is a matter of economics: the costs of care to the uninsured in emergency and urgent care settings are mostly uncompensated and must be absorbed with public and/or private redistributions of funds. Among hospitals in California, where we focus our analysis, the cost of providing care to the uninsured prior to ACA accounted for 3% to 7% of total operating costs annually, with county hospitals and community clinics incurring the largest revenue losses (California Healthcare Foundation 2010). In order to reduce the costs of uncompensated care provided to the uninsured, healthcare providers may try to lower their exposure to an uninsured population by reducing, dropping, or redistributing staff and services disproportionately used by the uninsured, such as emergency care or substance abuse care (Brown and Stevens 2006; Cunningham, Bazzoli, and Katz 2008). Providers might also attempt to generate or expand services targeted to the insured, shift costs to the insured by increasing fees, or attempt to otherwise alter the insurance status composition of their patient pool in order to gain access to state and federal funds. These provider strategies affect access to healthcare, quality of care, and trust in healthcare providers for all members of a community, not just the uninsured (Gresenz and Escarce 2011; Pagán, Balasubramanian, and Pauly 2007; Pagán and Pauly 2006; Pauly and Pagán 2007). Additionally, provider strategies to reduce exposure to the uninsured may have real consequences for the individual health outcomes of the insured. While research by McMorrow (2013) has found inconsistent effects of uninsurance rate on the insured across some health outcomes, Daysal (2012) finds that California hospitals servicing a higher proportion of uninsured patients have 3% to 5% higher mortality following myocardial infarction among insured patients compared with hospitals servicing fewer uninsured patients, controlling for individual health status and past diagnoses. Similarly, Escarce, Edgington, and Gresenz (2014) find that a higher uninsurance rate has an adverse effect on the probability that insured adults with hypertension receive antihypertensive treatment and achieve blood pressure control. Beyond Health Effects? Given the strain that uninsurance places on individuals, providers, and healthcare markets, the consequences of uninsurance are likely to go beyond health and healthcare and impact the social lives of individuals and communities. In a 2003 report on community levels of uninsurance, the Institute of Medicine (IOM) acknowledged that in addition to thinking about the economic effects of uninsurance, researchers also needed to consider how uninsurance might "strain social relationships among community members and local institutions" (IOM 2003:133). Research on the social spillover effects of uninsurance remains in its infancy and has yet to present a clear or consistent theoretical framework. Our first aim in this paper is thus to bring together research in this area, distill the key pathways of influence, and link them to the sociological literature. Researchers examining links between uninsurance and community social life tend to highlight one of two pathways of influence: (1) higher burdens of uncompensated care generate competing interests and goals within a community, which contributes to the breakdown of social cohesiveness, trust, and reciprocity among community members; and (2) higher costs to the uninsured and their families contribute to increased social and economic inequality, which promotes class differentiation, social distance, and community disengagement (see Figure 1). We develop these two theories in more detail below. Competing interests and institutions. Much of the existing literature examining social spillovers of uninsurance focuses on the emergence of competing interests and institutions in communities experiencing high or very high levels of uninsurance. Since communities vary in the number of uninsured and have different resources at their disposal (Cunningham 2007), communities may adopt different strategies of resource allocation in order to absorb the costs of providing healthcare to the uninsured. While some communities may attempt to raise new funds to cover the uninsured (e.g., through taxation), other communities may attempt to redistribute existing funds or services. Yet, as Brown and Stevens (2006) observe, "improving coverage and care for the uninsured is inescapably an exercise in redistribution from the haves to the have-nots" (p. 151), and the interests of the uninsured are often pitted against those of other groups in political battles over budgets. Additionally, attempts to cover the uninsured through redistribution of new or existing funds may run into political barriers or be forced to compete with other public services, such as education and law enforcement (Brown and Stevens 2006). Such contentious trade-offs between healthcare and other public services may undermine residents' feelings of

connection to a community, mutual trust, and collective efficacy (Browning et al. 2008), or perceptions that community members can and will intervene to effectively address common local social and economic problems (Sampson, Raudenbusch, and Earls 1997). As Brown and Stevens (2006) demonstrate through their case studies of programs intended to expand coverage to the uninsured in Birmingham, Alabama, and Alameda County (Oakland), California, **debates around the provision of care for the uninsured may become even more contentious when they intersect with racial and class divides that have historically limited access to insurance and healthcare institutions among African Americans and Latinos.** In communities where local government and the private sector have failed to adequately cover the uninsured, local institutions, such as churches and schools, may develop their own programs to address the needs of the uninsured with varying success (Timmermans, Orrico, and Smith 2014). Thus, while **healthcare access** may **become a rallying point for social mobilization in some communities** (Steinberg and Baxter 1998), the literature above suggests that **high community levels of uninsurance** may also **decrease effectiveness and support of local government, decrease residents' feelings of cohesiveness and collective efficacy**, and generate perceptions that local institutions **are not serving the needs of residents**. Social and economic inequality. A second pathway through which **uninsurance** has been found to affect social life is via the **exacerbation of social and economic inequality**. Research by Kaplan and colleagues (1996) suggests that levels of uninsurance may contribute to **stratification** and **income inequality** within a **community**. Most directly, **uninsured individuals and families pay higher out-of-pocket expenses for healthcare**, aggravating existing inequalities in income and wealth among community residents (IOM 2003; Seifert and Rukavina 2006). At the neighborhood level, **higher levels of income inequality** are associated with **lower levels of civic engagement and trust** among residents (Kawachi et al. 1997). As stratification scholars have demonstrated (Schwartz and Mare 2005), **status distinctions become starker** and more socially meaningful **as inequality increases**, **making it more difficult** for individuals to form and maintain **social relationships** across status groups. Additionally, **due to strong links between private health insurance and full-time**, nonmenial **employment** and between public programs for the uninsured and lower-quality care, health insurance constitutes both a marker of social status as well as a nonmaterial asset that stratifies residents within communities on the basis of their access to healthcare. Kim, Haney, and Hutchinson (2012) examine the effects of exclusion from healthcare among Korean Americans, one of the most highly uninsured population groups among Asian Americans. In their qualitative investigation, the authors find not only that **exclusion from healthcare has effects on individual health behaviors and healthcare seeking** but also that uninsured individuals experience a sense of **devaluation relative to other U.S. citizens**. In twin top-down and bottom-up processes, **exclusion** and disenfranchisement by the state and **healthcare institutions foster avoidance** and feelings of **disconnection, discouragement, and resentment at the bottom**. Becker (2004, 2007) and Horton (2004) take this premise further in their multiple analyses of healthcare exclusion of uninsured ethnic minorities and immigrant groups in the United States. Becker's work in particular repeatedly suggests that individuals and groups that are excluded from the U.S. healthcare system because they are uninsured or underinsured with high-deductible, catastrophic plans frequently experience poorer-quality care, discrimination, and depersonalization when they do seek care, which respondents view as an assault on their personal dignity. Other recent research on how being uninsured negatively affects patient-provider interactions and potential future interactions supports these findings (Allen et al. 2014). Implied in each of these works is the IOM's (2003) notion that access to healthcare and health insurance are part of an implicit social contract between employers and workers and between the state and citizens. The **lack of uninsurance "represents a breach of that social contract"** and, **when experienced by large numbers** of individuals **in a community, may erode the social bonds that define and nurture functioning, healthy communities**, as uninsured persons are made aware of their lesser claim on services and **resources that are generally valued as essential to a dignified and secure life** (IOM 2003:133). Phrased another way by Faden and Powers (1999): **In addition to** the stress, **powerlessness** and social disrespect that have been shown to be associated with poorer health status, [**uninsured individuals**] awareness of their disadvantaged social status has the potential to **undermine selfrespect and their sense of themselves as** the moral equals of the more fortunate **members of society**. (P. 3) At the same time, **the converse can also be observed**: **where local municipalities and state governments have made a concerted effort toward including marginal populations into the healthcare system**, various kinds of respondents—marginalized **populations**, service providers, and city officials—**describe these reforms as** important not just for providing access to care but are **motivated by broader** concerns around **fostering connectedness, collaboration, and feelings of a shared fate** (Marrow 2012; Marrow and Joseph 2015). Moreover, in some healthcare settings, the provision of

supportive, consistent, and nonjudgmental **care** has been shown to promote feelings of **belonging, dignity, and self-efficacy** among marginalized patients (Timmermans and McKay 2009). Thus, like inequalities in wealth and income, **inequality in access to health insurance** and healthcare may contribute to **national** and local processes of **identity formation, class differentiation, and social distance**; at the same time, **efforts to reform healthcare toward universal access** and quality may **improve feelings of belonging and connectedness** among previously **excluded groups**.

The aff solves – universal healthcare produces a spillover effect that is crucial to the survival and power accumulation of minority communities

McKay and Timmermans 17 (Tara McKay, Assistant Professor of Medicine, Health, and Society and affiliated faculty in the Sociology Department at Vanderbilt University, PhD in Sociology from the University of California, Los Angeles, Robert Wood Johnson Foundation Scholar in Health Policy Research at the University of California, Berkeley, Dr. Stefan Timmermans, Professor of the UCLA Department of Sociology as well as being a professor at ISG, Journal of Health and Social Behavior, 2017. "Beyond Health Effects? Examining the Social Consequences of Community Levels of Uninsurance Pre-ACA." <http://journals.sagepub.com/doi/pdf/10.1177/0022146516684537>)

While **spillover effects of uninsurance on communities constitute a crucial social and political issue**, the IOM noted in 2009 that this field of inquiry remains in its infancy (p. 91ff). Existing research has focused primarily on effects of spillovers from the uninsured to the insured in the areas of healthcare access and quality. **We extend research on the spillover effects of uninsurance into the purview of sociologists by examining other aspects of social life that may be affected by high levels of uninsurance** prior to and after ACA implementation. We focus specifically on a dimension of social capital: social cohesion, operationalized as perceptions of trust, sharing, support, and obligation among community residents. Overall, **we observe a consistent, negative association between community levels of uninsurance and social cohesion** using panel data from Los Angeles: **lacking health insurance is bad not only for one's health but also for community life**. We show that **residents of communities with higher levels of uninsurance report significantly less social cohesion** net of other individual factors, like income, health, and perceived safety, and neighborhood factors, like demographic composition, poverty concentration, and residential stability. This effect is **consistent** across multiple analyses and extends previous qualitative and cross-sectional studies documenting the existence of negative social spillovers of uninsurance for communities by leveraging **new, longitudinal data** specifically designed to examine social and neighborhood contextual effects. These data allow us to better account for potentially confounding factors at the individual and community level, such as the age, racial-ethnic, nativity, and income composition of communities. Importantly, **we observe a substantial effect of uninsurance on social cohesion using the LAFANS data: more than a standard deviation decrease in residents' perceptions of the trustworthiness, reliability, and obligation to neighbors when we compare a neighborhood at the lowest level of uninsurance with a neighborhood at the highest level of uninsurance**. However, these data are representative only of Los Angeles County, a metropolitan area with a large unauthorized immigrant population that is excluded from most insurance benefits and that therefore relies heavily on local safety-net providers. Additionally, the results suggest that the **insured have much to gain from the expansion of insurance** benefits under the ACA. Given previous research on the economic spillovers of uninsurance, we expect the **expansion of public coverage through state Medicaid programs and private insurance through state and federal exchanges to increase healthcare access** for both the uninsured and the insured currently living in communities with very high levels of uninsurance. However, discussion of the potential social benefits of ACA for individuals and communities has been noticeably absent from debates around ACA implementation. We demonstrate here that the expansion of health insurance benefits under the ACA **has the potential to reverberate beyond healthcare access and improve community functioning** by promoting social cohesion among residents regardless of insurance status. As a counterfactual, we also estimate the effects of an ACA-type intervention on perceptions of social cohesion and show that changes in the insurance composition of LAFANS sample tracts after Wave 1 would have significantly increased individuals' perceptions of social cohesion in their neighborhoods at Wave 2 data collection, five years later. **These findings speak not only to contemporary policy debates but also to the need for ongoing engagement by sociologists with the social consequences of uninsurance**. As

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elements of ACA are increasingly implemented and scaled up over the next few years, scholars may perceive additional research on the uninsured as no longer relevant to the larger policy concerns of the country. Yet, we argue that the social consequences of uninsurance will remain important for two reasons. First, like the period following the implementation of Social Security and Medicare, ACA is likely to remain contested for several years to come. While pundits contend that it is unlikely ACA legislation will be entirely repealed, elements of the act have been stalled, blocked, left unimplemented, or revised through state and federal processes. Each of these policy developments may have the potential to counter or reinforce the spillover effects of expanding insurance. Thus, there remains a need to consider the effects of the ACA's insurance expansion, the variability of those effects across states and communities, and the various pathways by which those effects manifest themselves. Second, a substantial minority of Americans will remain uninsured following implementation of ACA. Due to the Supreme Court's decision to allow states to opt out of Medicaid expansion, an estimated 30 million Americans will remain uninsured in 2016 (Nardin et al. 2013). Contrary to popular perception, only 20% of these uninsured will be ineligible due to unauthorized legal status. Post-ACA, uninsured individuals are more likely to live in states and communities that historically lack good access to care, have poorer health outcomes, and have substantial racial and economic inequality. At the community and state levels, many of the uninsured post-ACA reside in low-income minority communities, concentrating any spillover effects in communities that have fewer resources and less political will to compensate for the uninsured. To this end, any social or economic spillover effects will be disproportionately felt by the already disadvantaged. Finally, this research contributes more broadly to an expanded view of health as pertaining solely to healthcare services or public health interventions. As private foundations, such as the Robert Wood Johnson Foundation, gear up to promote a "culture of health" in order to foster health as a priority across various social institutions (Lavizzo-Mourey 2014), our examination of the social spillover effects of healthcare legislation demonstrates that leveling access to healthcare also pays social dividends.

The aff isn't an end-point – single payer opens up revolutionary avenues to health justice and spurs future radical reforms

Faust 17 (Timothy, Chapo Trap House healthcare correspondent pursuing an MPA in health policy and finance at NYU's Wagner Graduate School of Public Service, contributor to the Jacobin and Indypendent, "Still Unsure About Single-Payer Healthcare? This Might Change Your Mind," August 1st, 2017, <https://indypendent.org/2017/08/still-unsure-about-single-payer-health-care-this-might-change-your-mind/>)

I recently had the privilege of doing some interviews and speaking at a north New Jersey Democratic Socialist of America meeting (it kicked ass) about universal single-payer health care. One question that came up several times is, "Well, how do I persuade people who are on the fence?" It's symptomatic of my bubble that this isn't something I had a ready answer for! So I thought about it and I think I have something I can commit to. In short, it's that we're already spending the money, but profit-seeking corporations aren't giving us our fair value for it. To break it down further: 1) **The same care costs much more in the United States than anywhere else.** I really like this Organisation for Economic Cooperation and Development (OECD) working paper on relative hospital costs, which shows that U.S. hospital costs, adjusted for GDP, are 42 percent greater than the average of the sample — or, basically, 40 percent more expensive than France. Sarah Kliff at Vox has been on this beat for a while and has a great viz of comparative MRI costs. MRIs are a great example — the procedure consists of "push button" (I'm exaggerating). There is no reason it should cost five times what it costs in Australia! 2) **We're already spending massive amounts of money on healthcare, but we're spending it [irresponsibly].** American public money pays for 64 percent of all healthcare costs in America. That's fucking bonkers! Total health spending in 2015 was \$3.2 trillion, of which public money represented \$2.1 trillion. A little less than half of that is actual Medicare, Medicaid, or Veterans Affairs spending. The rest is government spending on private insurance for government employees, about \$190 billion, and government subsidies to insurance companies and individuals via tax subsidies for employer coverage, about \$300 billion. We know that Medicare can negotiate much better prices for treatment because it is a larger payer. Scale that idea up — imagine how much better things would be if we had a single payer to regulate costs more effectively across all healthcare spending! 3) **Only a federal single payer bears the costs of providing care and the costs of not providing care.** Align our incentives appropriately! Right now, your private insurer only bears the costs of you receiving care. Because you are likely to change insurers in the future and eventually go on Medicare, they don't actually feel the

pressure to provide you care that keeps you healthy in the distant (and near) future. Instead, we all do — we all suffer when our friends and family get sick; our public money is allocated to care for people when they get sick. So it makes perfect sense that the same actor who suffers when people don't get preventative care — all of us, united, represented by our federal government — should be the actor who also pays for that care in the first place. Because: 4)

Once you have universal, single-payer health care, you can begin the work of actual health justice. The actual goal of health reform isn't just payer reform, universal expansion and cost coverage — those are just the beginning. **The actual work is the social determinants of health.** I've said this before and I believe every word of it: **Because the federal actor bears costs of providing care and not providing care, it can finally be a tool for realizing health justice.**

If your population is getting sick and dying because they don't have a place to live, then housing is healthcare, and you build housing to bring healthcare costs down. If your population doesn't have access to healthy food to eat, then food is healthcare, and you provide them with affordable food options to bring food costs down. If you want to read more about social determinants of health care, it's hard to go wrong reading about New York Medicaid director Jason Helgerson. Here's the 2014 document summarizing his Medicaid Redesign Team's approach to social determinants in New York. It's interesting! Here's some more good stuff on Helgerson and value-based payments. Does that make sense? I think that makes sense. Some other questions that come up Someone needs to do the extremely sexy work of standardizing medical data feeds and outputs. What about the jobs of people who currently work in the insurance industry? The easy, callous answer is "Well, at least they'll have healthcare if they lose their jobs." I'm not satisfied with that (even though it's true). I also think it's shortsighted. **Much of the infrastructure in the insurance industry is still necessary. So why not reallocate these workers to the federal sector, where their labor goes to the good of all,** instead of private profit? Someone needs to do the extremely sexy work of standardizing medical data feeds and outputs. Here is a great way for people with hyper-specialized skills to be paid fair wages to design and implement that standardization. And, hell, we're trying to fix a three-trillion-dollar sector here. It's peanuts to build a work program to help those who might otherwise be left behind. **Solidarity for all workers, including those whose skills are an invention of the payer-provider labyrinth.** What about doctor salaries? I believe that the reduction in per-service costs (and the adoption of smarter standards of payment, like "pay for treatment" instead of "pay for specific service") will be more than matched by an increase in people seeking affordable preventative care, so most physicians will find their compensation to be fair. But that might not be a perfect argument. Ultimately, some physicians will find their total compensation reduced— mostly specialists, who have been unfairly privileged in price increases over time. (Primary care physicians and rural medicine doctors, on the other hand, are due for a compensation increase relative to median American physician salaries — which are, it should be noted much, much, much higher than salaries in other countries...) One of the reasons physicians need high salaries is because they graduate ten years of education with \$300,000 in student debt and 7 percent of compounding interest. That's two decades of paying off debt. How cruel! So I think **there is room in universal single-payer healthcare for tuition relief and/or free medical training for doctors, nurses and other essential health providers.** Relieve their pressure to be locked into a career path and insurmountable education debt in exchange for fairer salaries. This should be a net better result for everyone. What about hospital revenues? Won't they fall year over year? That's the wrong way to think about it. Consider "Roemer's Law" — if a hospital builds a new bed, it will be filled. So much of hospital annual revenues are ER and inpatient admissions that don't necessarily need to happen. Those admissions could have been prevented with preventive care or screening, or affordable care in clinics closer to home. Those procedures often could have been handled by a less specialized physician at home or in a local clinic. It's not about cutting spending, it's about reallocating spending to better places and making sure it ends up in the hands of people providing care.

Defensive or symbolic attempts at resistance are doomed to fail – only proactive, policy options like universal health care can push society closer to justice and serve as a starting point for broad-based movements of solidarity

Greene 17 (Robert, PhD Candidate in History @ University of South Carolina specializing in African American political mobilization in the South, "The Left After Charlottesville," Sept, <https://www.jacobinmag.com/2017/09/charlottesville-antifa-trump-medicare-for-all>)

The post-Charlottesville moment does demand **antiracist mobilizations**, and it's heartening that left organizations have sprung into action and seen their numbers swell. Standing up to the far right – particularly when done effectively and en masse, like in Boston – can energize people who are otherwise frustrated and disenchanted because of the Trump administration. **But that needs to be linked to tangible political organizing that goes beyond the defensive or symbolic.** Discussions about antifa are also important. Interviews with counter-protestors on the ground in Charlottesville made it clear they were more than happy antifa was there to help. In fact, Cornel West credited them with saving his life. But the debate over antifa cannot be at the center of left political discussion. **I am less concerned about being murdered by a neo-Nazi than I am about the lack of access to quality health care.** I am more exercised about the suppression of voting rights and the damage it does to democracy in the here and now than the damage simply represented by Confederate statues. This is not to dismiss the efforts to tear down Confederate statutes. What lies in the public commons, after all, needs to represent the kind of country we want the United States to be. But we shouldn't allow the conflagration to cloud our vision. In short, the lessons post-Charlottesville are the lessons we should have learned earlier this year. We cannot simply react to Trump or the "alt-right." **Being proactive, advancing a clear program that can mobilize and galvanize a huge swath of the public — this must be the hallmark of the American left.** Otherwise, the genuine anger directed at Trump and the GOP will be wasted. And we'll squander our chance to build the kind of broad-based left that, in the end, is the best bulwark against the far right. **Most of the planks of the left platform we need are already out there**, waiting to be used to spur genuine debate and action across American society. Two in particular should **top any left agenda. The first is universal health care**: Medicare for All. The Republicans' haphazard bid to scrap the Affordable Care Act showed that even an extremely flawed version of "universal" coverage was still popular enough to scuttle repeal attempts. Now, according to recent polling, **public support for single-payer is on the rise.** Even centrist Democrats like Kamala Harris are getting on board. After decades of struggle, universal health care is, if not right around the corner, at least on the near horizon. Crucially, **the demand for Medicare for All also offers a means to build the bonds of solidarity.** As Atlantic writer Vann R. Newkirk recently pointed out, **Martin Luther King Jr and other civil rights activists saw universal health care as a critical component of their struggle for a just and equitable society.** The same is true today. **Across movements — whether for black lives or a fifteen-dollar minimum wage or immigrant rights — universal health care is a demand that unifies.** There's another reason to prioritize the push for universal health care. Far-right organizations like the Traditionalist Workers Party have begun making overtures to poor whites in places like Appalachia by talking about jobs and access to quality health care. We can't allow a pitch for decent health care, or an argument for good jobs, to be used as a gateway to fascism.

The aff is realistic hope— focusing on the prophetic future of single-payer healthcare instills hope in change and can facilitate and galvanize reform

Hern 12 (Lindy, Department of Sociology at the University of Hawaii, "Everybody In and Nobody Out: Opportunities, Narrative, and the Radical Flank in the Movement for Single-Payer Health Care Reform," May 2012, p. 116-118)

For social movement actors, **stories of origin are not comprised of hard data that is accessible and representative of the true origins of the social movement.** Rather, origin stories involve the strategic reconstruction of experience and memory. **Although origin narratives are most frequently discussed as an integral in the narrative practice of identity building, they are also tied to many other aspects of narrative practice.³⁷ Through the telling of their origin stories, Health Care NOW and MoSP make sense of, or develop a causal argument about, why they developed as they did as an organization.** Both **organizations could have rooted their origins in previous efforts for health care reform** (MoSP was actually created as an organization during the Clinton era of reform and Marilyn Clement

was also active in the movement at this time). However, rather than locating their origins in past efforts for health care reform that were not successful, both organizations attach their birth to **successful movements for reform**. Both of these sense-making causal arguments for the birth of these organizations **facilitate further liberating narrative practices**. By rooting the birth of their organizations in earlier successful movements, social movement actors can also use these narratives to develop and support the use of **specific strategies**. In this way, they also enhance the strategy of Health Care NOW and MoSP – they are strategy enhancing. MoSP's origin story, which is rooted in the “trip to Canada”, directs this organization to retain the state-by-state strategy for achieving single-payer and gives them a positive example of the outcomes of this strategy. Yet, MoSP activists are also attracted to the origin story of the Civil Rights Movement and this encourages their support of Health Care Now. This origin story directs Health Care NOW toward **building a nation-wide campaign that involves both beltway political and grassroots strategies**, depending on the opportunities that confront the single-payer movement. This origin story (as discussed in later chapters) is also used as a location for mobilization efforts and to legitimate the use of more radical tactics involving civil disobedience (i.e. sit-ins). Both MoSP and Health care now also use this narrative form in the narrative practice of recruitment – they are recruitment facilitating. MoSP participants often point to not only the positive outcomes of the movement for single-payer in Canada (often referencing the folk hero figure of Tommy Douglas), but they also reference the positive outcomes (in health, patient satisfaction, etc.) of the Canadian medicare system in order to encourage outside audiences to support single-payer. Health Care NOW activists are also able to reference the successful outcomes of the civil rights movement in order to encourage outside members to support their “insurmountable struggle” to achieve single-payer. The identity as the New Civil Rights Movement which arises from this origin story also taps into a collective understanding of this movement and encourages the involvement of those who were previously active in the civil rights movement. It encourages members of the public who are concerned about rights to become supportive of the very focused goal of single-payer health care. These origin stories are not only important narrative strategies for encouraging the support and participation of movement outsiders, but they are also a central way in which movement actors encourage themselves to “keep on keepin on” in the face of “insurmountable struggle”. The importance of having hope in the face of desperate circumstances cannot be overstated. Emotions are also a central issue for social movement actors who are already committed to the cause. Hope that change can occur even when faced with negative opportunities for that change is a central factor in whether or not organizational members continue to work towards their primary goals, or change their goals to fit the negative aspects of the environment in which they exist. I cannot examine the cognitive aspect of “hope”, but this examination of origin stories illustrates the narrative practice of producing hope. The single-payer narrative does not have an ending. While the dominant narrative of health care reform indicates that single-payer is not politically feasible, linking this movement to the “insurmountable struggle” experienced by the Civil Rights Movement and the Movement for Canadian medicare allows single-payer activists to construct a “prophetic ending” for the singlepayer narrative – that this “insurmountable struggle” will also one day be successful. This constructed ending for the single-payer narrative encourages activists to continue the struggle even in the face of seemingly insurmountable odds. These narrative practices, which utilize the narrative form of origin stories, are integral to the continuing process of pragmatic liberation. As activists construct their origin stories they are also developing the practice of liberation. By developing these origin stories they are also producing empowering identities that facilitate the use of empowering strategies and legitimate the empowering emotion of hope in the face of incredible odds. As I continue this story by discussing the actions of single-payer activists in historically specific contexts we will see how this narrative practice using other narrative forms, particularly that of opportunity narratives, also promotes the practice of pragmatic liberation.

Racial bias in health care is malleable and not inevitable---but only legal solutions work

Matthew 15 --- Nonresident senior fellow in the Center for Health Policy. University of Colorado School of Law, Colorado School of Public Health, and Center for Bioethics and Humanities at the University of Colorado Health Sciences Center (Dayna Bowen, "Just Medicine: A Cure for Racial Inequality in American Health Care." New York University Press. 2015)

For the past thirty years, medical doctors, social scientists, psychologists, policy analysts, jurists, and a wide spectrum of health care providers have been studying and discussing health inequality in America. Meanwhile, by one estimate, 83,570 minority patients die annually due to health care disparities. Black and brown patients consistently receive inferior medical treatment—fewer angiographies, bypass surgeries, organ transplants, cancer tests, and resections, less access to pain treatment, rehabilitative services, asthma remedies, and nearly every other form of medical care—than their white counterparts. Yet minority patients are sicker and more likely to die than whites from a wide range of diseases and illnesses for which we have data. Certainly, this picture is complicated. For example, health and illness for all racial and ethnic groups follow a social gradient so that minority populations, which disproportionately occupy low socioeconomic strata, also predictably suffer relatively worse health outcomes than whites do. Although it is popular to blame the poor for the their poor healthy by pointing to risky health behaviors, careful studies of nationally representative populations conclude that the significantly higher prevalence of cigarette smoking, alcohol consumption, obesity, and physical inactivity are only one aspect of the relationship between lower socioeconomic status and poor health. Moreover, behavioral disparities must not be taken out of their societal context where unequal exposure to the stress of discrimination, inequitable access to healthy food and built environments, and inferior access to resources generally are integrally associated with many racial and ethnic differences in health behavior. In fact, racial and ethnic differences in health treatment and outcomes persist in multiple studies even after controlling for differences in insurance status, income, education, geography, and socioeconomic status. Researchers have identified numerous structural and individual determinants of these disparities at all levels. These include socioeconomic circumstances such as poverty, inferior education, and segregated housing conditions along with lack of access to healthy food choices or recreational facilities; systemic and organizational contributors such as medical practice settings and sources of insurance; and geographic proximity to care. The economic and social conditions called "social determinants of health" often drive patient-specific contributors to poor health such as poor family health history, diet, and low physical activity. All have been shown to contribute to the disparity of health outcomes experience by ethnic and racial minority patients in the United States. However, this book is about the single most important determinant of health disparities that is not being widely discussed in straightforward terms: this determinant is racial and ethnic discrimination against minority patient populations, an uncontroversially significant contributor to health inequality. The evidence that the majority of Americans involuntarily harbor anti-minority prejudices makes it impossible, even immoral, not to examine the impact of unconscious racism on health and health care. Therefore, this book makes a thorough examination of the scientific evidence that does exist to confirm that providers discriminate against patients and patients discriminate against providers. This cycle of discrimination produces inequality throughout the health care system. The inequality itself is not news. But the fact that it is avoidable challenges the complacency that allows the racial and ethnic discrimination that produces them to persist. This book calls for providers, patients, scientists, and

jurists to face the uncomfortable truth that although overt racism, prejudice, and bigotry may have subsided in America, racial and ethnic injustice, unfairness, and even segregation in American health care have not. The most tragic proof that racial and ethnic injustice is alive and well is the phenomenon we politely call "health disparities." The message of this book is that a significant cause of these health disparities is the unconscious racial and ethnic bias that infects our delivery system. Implicit racial and ethnic biases in health care are harmful, avoidable, and unjust. This book charts a way to deal with health and health care disparities as injustices, not merely as inevitable byproducts of human nature or a phenomenon subordinate to biological and social differences. Instead, the argument made here is that health inequality due to unconscious discrimination is a structural

Change through policy reform is possible and effective

Bouie 13 — Jamelle Bouie, Staff Writer at *The American Prospect*, 2013 ("Making (and Dismantling) Racism," *The American Prospect*, March 11th, Available Online at <http://prospect.org/article/making-and-dismantling-racism>, Accessed 04-04-2014)

Over at The Atlantic, Ta-Nehisi Coates has been exploring the intersection of race and public policy, with a focus on white supremacy as a driving force in political decisions at all levels of government. This has led him to two conclusions: First, that anti-black racism as we understand it is a creation of explicit policy choices—the decision to exclude, marginalize, and stigmatize Africans and their descendants has as much to do with racial prejudice as does any intrinsic tribalism. And second, that it's possible to dismantle this prejudice using public policy. Here is Coates in his own words:¹ Last night I had the luxury of sitting and talking with the brilliant historian Barbara Fields. One point she makes that very few Americans understand is that racism is a creation. You read Edmund Morgan's work and actually see racism being inscribed in the law and the country changing as a result.¹ If we accept that racism is a creation, then we must then accept that it can be destroyed. And if we accept that it can be destroyed, we must then accept that it can be destroyed by us and that it likely must be destroyed by methods kin to creation. Racism was created by policy. It will likely only be ultimately destroyed by policy.¹ Over at his blog, Andrew Sullivan offers a reply:¹ I don't believe the law created racism any more than it can create lust or greed or envy or hatred. It can encourage or mitigate these profound aspects of human psychology – it can create racist structures as in the Jim Crow South or Greater Israel. But it can no more end these things that it can create them. A complementary strategy is finding ways for the targets of such hatred to become inured to them, to let the slurs sting less until they sting not at all. Not easy. But a more manageable goal than TNC's utopianism.¹ I can appreciate the point Sullivan is making, but I'm not sure it's relevant to Coates' argument. It is absolutely true that "Group loyalty is deep in our DNA," as Sullivan writes. And if you define racism as an overly aggressive form of group loyalty—basically just prejudice—then Sullivan is right to throw water on the idea that the law can "create racism any more than it can create lust or greed or envy or hatred."¹ But Coates is making a more precise claim: That there's nothing natural about the black/white divide that has defined American history. White Europeans had contact with black Africans well before the trans-Atlantic slave trade without the emergence of an anti-black racism. It took particular choices made by particular people—in this case, plantation owners in colonial Virginia—to make black skin a stigma, to make the "one drop rule" a defining feature of American life for more than a hundred years. By enslaving African indentured servants and allowing their white counterparts a chance for upward mobility, colonial landowners began the process that would make white supremacy the ideology of America. The position of slavery generated a stigma that then justified continued enslavement—blacks are lowly, therefore we must keep them as slaves.¹ Slavery (and later, Jim Crow) wasn't built to reflect racism as much as it was built in tandem with it. And later policy, in the late 19th and 20th centuries, further entrenched white supremacist attitudes. Block black people from owning homes, and they're forced to reside in crowded slums. Onlookers then use the reality of slums to deny homeownership to blacks, under the view that they're unfit for suburbs.¹ In other words, create a prohibition preventing a marginalized group from engaging in socially sanctioned behavior—owning a home, getting married—and then blame them for the adverse consequences. Indeed, in arguing for gay marriage and responding to conservative critics, Sullivan has taken note of this exact dynamic. Here he is twelve years ago, in a column for The New Republic that builds on earlier ideas:¹ Gay

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men—not because they're gay but because they are men in an all-male subculture—are almost certainly more sexually active with more partners than most straight men. (Straight men would be far more promiscuous, I think, if they could get away with it the way gay guys can.) Many gay men value this sexual freedom more than the stresses and strains of monogamous marriage (and I don't blame them). But this is not true of all gay men. Many actually yearn for social stability, for anchors for their relationships, for the family support and financial security that come with marriage. To deny this is surely to engage in the "soft bigotry of low expectations." They may be a minority at the moment. But with legal marriage, their numbers would surely grow. And they would function as emblems in gay culture of a sexual life linked to stability and love. [Emphasis added]¶ What else is this but a variation on Coates' core argument, that society can create stigmas by using law to force particular kinds of behavior? Insofar as gay men were viewed as unusually promiscuous, it almost certainly had something to do with the fact that society refused to recognize their humanity and sanction their relationships. The absence of any institution to mediate love and desire encouraged behavior that led this same culture to say "these people are too degenerate to participate in this institution."¶ **If the prohibition against gay marriage helped create an anti-gay stigma, then lifting it—as we've seen over the last decade—has helped destroy it. There's no reason racism can't work the same way.**¶ * Ta-Nehisi Coates =

National Correspondent at *The Atlantic*

The Fight for Health Care Has Always Been About Civil Rights, single payer is the most inclusive health care policy option

Newkirk 2017 (Vann R., June 27, The Fight for Health Care Has Always Been About Civil Rights, The Atlantic, <https://www.theatlantic.com/politics/archive/2017/06/the-fight-for-health-care-is-really-all-about-civil-rights/531855/>)

In dismantling Obamacare and slashing Medicaid, Republicans would strike a blow against signature victories for racial equality in America. It was a cold March night when Dr. Martin Luther King, Jr. turned his pulpit towards health care. Speaking to a packed, mixed-race crowd of physicians and health-care workers in Chicago, King gave one of his most influential late-career speeches, blasting the American Medical Association and other organizations for a "conspiracy of inaction" in the maintenance of a medical apartheid that persisted even then in 1966. There, King spoke words that have since become a maxim: "**Of all the inequalities that exist, the injustice in health care is the most shocking and inhuman.**" In the moment, it reflected the work that King and that organization, the Medical Committee for Human Rights (MCHR), were doing to advance one of the since-forgotten pillars of the civil-rights movement: the idea that health care is a right. To those heroes of the civil-rights movement, it was clear that the demons of inequality that have always haunted America could not be vanquished without the establishment and protection of that right. Fifty-one years later, those demons have not yet been defeated. King's quotation has become a rallying cry among **defenders of the Affordable Care Act**, the landmark 2010 legislation that has come the closest America has ever been to establishing a universal guarantee of health care. Their position is in peril, as the Republican effort to repeal the law and create a replacement that leaves 22 million more people uninsured over the next decade and will **slash Medicaid enrollment by 15 million** now sits just days away from possible passage. **People of color were the most likely groups to gain coverage and access to care under the ACA, and in the centuries-old struggle over health, they have never been closer both to racial equality of, access and to, the federal protection of health care as a civil right.** But if Republicans have their way, that dream will be deferred. Just as the ACA's defenders find themselves between a once-in-a-generation victory and a potential equally devastating loss, so the MCHR found themselves in 1966. King delivered his address just months after breakthroughs a century in the making. In the height of the movement in the early 60s that brought sweeping changes in voting rights, integration, and education, civil-rights actors had also won major victories in a push for universal health care. Chief among those victories were two of the defining pieces of 20th-century American policy: the Civil Rights Act in 1964 and the passage of Medicare and Medicaid in 1965. Of course, **the Civil Rights Act might not seem like much of a health-care bill**, and Medicare isn't usually counted among major civil-rights victories, but as detailed in **in health-policy researcher David Barton Smith's The Power to Heal: Civil Rights, Medicare and the Struggle to Transform America's Health System**, they were complementary pieces of a grand civil-rights strategy. Key to that strategy was the 1963 **Simkins v. Cone** lawsuit, filed by dentist and Greensboro, North Carolina, NAACP leader George Simkins against segregation in the local hospital. In finding in Simkins's favor, the The Fourth Circuit Court of Appeals ruled for the first time that institutions receiving federal funds could not abide by the "separate but equal" legal underpinning of Jim Crow. That ruling in turn helped shape Title VI of the 1964 Civil Rights Act, which bars segregation and discrimination among

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entities that receive federal funding, and to this day provides the most effective legal mechanism for federal civil-rights cases. The NAACP and the National Medical Association—the black professional organization that was formed because the the AMA was segregated—led by W. Montague Cobb fought for the passage of the first major American health reform policy in Medicare and Medicaid. They organized direct action, legal challenges, and lobbying efforts in support of the reform, in direct opposition to most of the rest of the segregated medical establishment. “Medicare was in a very real sense a creation of the civil-rights movement,” Smith says. In the ensuing hearings, Cobb was the only leader of any medical association to testify in favor of Medicare and Medicaid. In 1965, just a week before also passing the Voting Rights Act, Congress passed the amendment to the Social Security Act that authorized Medicare and Medicaid, with Cobb as the witness to Lyndon B. Johnson’s signing ceremony. The law’s effects on segregation were felt immediately. Since Medicare’s universal coverage of elderly people brought federal funds to about every hospital in America, it also bound them by Title VI’s nondiscrimination clauses, which essentially ended segregation in those hospitals—some of the last public arenas in which Jim Crow legally held sway. Medicare was the final federal legal blow for de jure segregation, and without it, there would still be few legal mechanisms to force hospitals to integrate. It’s hard to overstate how much Medicare and Medicaid themselves did to end formal segregation. By the same token, it’s hard to overstate just how deeply that waning segregation had mattered in health outcomes. From the end of slavery onward, American health-care has been deeply bifurcated along the lines of race, and that bifurcation was always reflected in how well people lived and how early and often they died. Jim Downs’s Sick From Freedom: African-American Illness and Suffering During the Civil War and Reconstruction explores how that bifurcation began, chronicling the role of the Reconstruction-era Freedmen’s Bureau in fighting severe epidemics among formerly enslaved populations. Although it is known mostly for its ill-fated and ill-administered attempt to guide freedmen through emancipation, in its brief life from 1865 to 1872, the bureau also became the first public-health agency for black people, as existing municipal and charity health infrastructure built for white people in the South denied them aid. “These institutions, which had historically offered universal support to the poor and dispossessed,” Downs writes, “began to claim that they would only assist ‘citizens.’” After white supremacy brought Reconstruction to a violent and premature end, medicine evolved along those same dividing lines of white citizens and black outcasts. America’s developing peculiar, private, decentralized, job-pension-based health-care infrastructure was the only fit for a modernizing society that could not abide black citizens sharing in societal benefits, and one where black workers had often been carved out of the gains of labor entirely. As German Prime Minister Otto Von Bismarck’s Health Insurance Bill of 1883 created the first modern national health-care system, and as many other countries moved down the path to truly nationalized, universal health care, America instead largely expanded the existing segregated system of local private providers and religious-based charity care. In essence, the United States’s peculiar private-based health-care system exists at least in part because of the country’s commitment to maintaining racial hierarchies. The results were deep racial disparities in almost every major disease, an enduring gap in lifespans and mortality, and the creation of entirely separate medical and public-health infrastructures. According to Smith, key figures within the resulting isolated black health infrastructure “ended up becoming the real leadership of the local chapters of the NAACP,” and spearheading local movements against Jim Crow. Emerging leaders in the mid-20th-century included people like Simkins and Cobb, as well as national NMA president and Mississippian T.R.M. Howard, who mentored the Evers brothers and Fannie Lou Hamer, and played a leading role both in the investigation of Emmett Till’s death and also in the creation of Medicare. The Medical Committee for Human Rights inherited that mantle of health-care and civil-rights activism and organizing in the 60s. Thomas J. Ward’s Out in the Rural: A Mississippi Health Center and Its War on Poverty details how the MCHR coalesced from a group of black and white physicians participating in Freedom Summer in 1964. Among that group, public-health champions H. Jack Geiger, Bob Smith, and John Hatch pushed to build the first rural community health center in the United States, in Mound Bayou, Mississippi, and created community health centers as one of Lyndon B. Johnson’s “War on Poverty” programs. They also set their sights squarely on universal health-care as a necessary component of the civil-rights agenda. The passage of Medicare and Medicaid in 1965 helped deliver some portion of that agenda, but as with every other civil-rights victory, the backlash was strong. The MCHR, NAACP, and NMA would encounter resistance to both the prospect of universal health care and to the use of existing systems to end health disparities that utilized the full muscle of white

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supremacy. Even as members of the MCHR listened to King's speech in Chicago, the AMA was digging their heels in against the prospect of integrating the expanding Medicare and Medicaid programs. Using the successful, red-baiting cudgel of "socialized medicine," and armed with the first major political advertising firm, the AMA, health-care industry organizations, and their conservative allies had already defeated a 1947 proposal from President Truman to create a true national health-care plan. Although they could not stop the remnants of that plan from eventually becoming Medicare and Medicaid, that coalition was able to obstruct further progress towards coverage for "able-bodied" adults and the creation of a coherent universal guarantee to care. They might not have known it at the time, but for those activists in 1966, health care had already become a dead end. After King's death in 1968, and the disintegration of the civil-rights movement, opposition from the AMA-led coalition would stymy the last organized effort from the MCHR to create and pass a single-payer bill. That failure also cemented the basic composition of American health-care: a patchwork dominated by private employer-based insurance, where non-elderly people who couldn't afford or didn't have such offers, and didn't fall into narrow special Medicaid eligibility groups were largely left out. And it's no coincidence or secret that those left out were more likely than not to be people of color. The law has also triggered the same conservative immune response that killed single-payer in the past. That basic shape remained all the way until 2010, when Democrats and President Obama pulled off the multi-pronged policy and legislative maneuver that became the ACA. Obamacare, as that law came to be known, wasn't the universal health-care guarantee or the single-payer system that civil-rights activists had pushed for decades, especially after the Supreme Court gutted the core provision of its Medicaid expansion to low-income adults and made it state-optional. Instead, Obamacare sidestepped the political pitfalls of such a plan by attempting alchemy, hoping to entice states to choose to expand Medicaid guaranteed coverage for low-income people, creating a subsidy and non-participation penalties instead of a guarantee for middle-income people, and generally trying to bend the health-care industry against its own exclusionary nature with large sums of money. Still, even though the ACA isn't a single-payer or universal system, it did a better job than the status quo ante at ensuring some sort of access to care. According to J. Nadine Gracia, the former Deputy Assistant Secretary for Minority Health and the Director of the Office of Minority Health at HHS—positions and an office that were themselves reauthorized and expanded by Obamacare—the ACA's benefits were immediately realized in communities of color. "The Affordable Care Act is the most important law to help reduce health disparities since the passage Medicare and Medicaid," Gracia said, "because the law is addressing issues of access, affordability, and quality of care, which have all been obstacles and barriers that relate to the health of minorities." For former Surgeon General David Satcher, whose work has helped popularize the concept of health disparities and kept the dream of universal coverage alive in the interim between Medicare and Obamacare, the ACA is a stepping stone. "I think we've made some progress with the Affordable Care Act, but as you know that has been greatly limited by the politics of Washington," he told me. "We haven't gotten half as far as we could've gotten with that because the ultimate goal is that everybody will have access to quality health-care." But if current events are any indicator, half as far may be as far as America gets. There is a broad consensus among health organizations (now including the AMA), former officials like Satcher, and the former titans of the civil-rights movement that the Better Care Reconciliation Act (BCRA) in the Senate and the American Health Care Act (AHCA), its sister bill in the House, will move America away from eliminating racial inequalities in health and health care. In addition to changes in private insurance that will make plans less comprehensive and less useful for sicker and poorer people—within which people of color are overrepresented—the BCRA also eliminates the ACA's Medicaid expansion to low-income adults and constrains the underlying Medicaid program to the point where in the future states will have no choice but to cover fewer people. In essence, the BCRA not only erases the ACA's market-oriented experiment in health equity, but also strikes a blow at the previously established elements of "socialized medicine" that were longtime objectives of the civil-rights movement. In this—as is true of other civil-rights victories that were the bedrock of the 50s and 60s liberation movement, like education and voting rights—a central tenet of American freedom now finds itself in danger of simply vanishing. The country cannot follow through on its commitment to equal protection for life and liberty under the law without addressing fundamental inequalities in mortality. It's worth noting that much of the animus behind the opposition to Obamacare is tied to race. Studies have shown that racial prejudice is a good predictor of opposition to the bill, and its central

policy of Medicaid has always been subject to implicit racial biases in public opinion. A [recent Kaiser Family Foundation study](#) found that Republican voters tend to view Medicaid as welfare, with all the attendant stereotypes and dog whistles. Much of that implicit opposition was summed up in a [famous 2009 rant](#) from conservative radio host Rush Limbaugh, who called the plan “reparations,” and said it reflected Obama’s belief that “this country was immorally and illegitimately founded by a very small minority of white Europeans … and it’s about time that the scales were made even.” The irony is that Mr. Limbaugh was correct about the bill in one respect: It did disproportionately help the poor and people of color, and in doing so, began to correct a centuries-old injustice. [In a statement defending his signature policy in May](#), President Obama articulated just why the ACA was such a historic piece of legislation. “When I took office, millions of Americans were locked out of our health care system,” he wrote. “We finally declared that in America, health care is not a privilege for a few, but a right for everybody.” [Contrary to Obama’s statement, the ACA actually didn’t manage to make health care a right, nor has it allowed all of those locked-out people into the system.](#) But it does come closer to those goals, and does grant access to millions of people of color who had been left out for generations. Unfortunately, the law has also triggered the same conservative immune response that killed single-payer in the past; the same kind of response that King so eloquently railed against in Chicago. [With 51 votes and a presidential signature, Republicans can begin turning back the clock.](#)

Lack of Health Care Kills

Lack of health care kills 18,000 per year

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As a psychiatric physician for nearly thirty years, I am always surprised when I hear politicians claim that the U.S. health care system is “the best in the world.” To be sure, we are among the most advanced nations when it comes to medical technology, and we are second to none when it comes to the dedication of our doctors, nurses, and allied professionals. But if we examine indices of public health such as infant mortality and preventable deaths, we are far from having the best health care “system.” For example, according to a [2002 study by the Institute of Medicine](#), 18,000 Americans die every year because they don’t have health insurance. And in a [2008 Commonwealth Fund-supported study](#) comparing “preventable deaths” in nineteen industrialized countries, the United States placed last.

Those without access to health care die, lack of *universal care* makes death and poor health more likely

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Empirical Evidence The empirical evidence for the minor premise is the substantial research on disparities in both health and health care, and the negative consequences experienced by uninsured and underinsured Americans. A few examples should suffice. Research evidence that the uninsured suffer ill health was presented by the American College of Physicians-American Society of Internal Medicine in their 2000 report entitled, “No health insurance? It’s enough to make you sick—Scientific research linking the lack of health coverage to poor health” (available at www.acponline.org/uninsured/). Moreover, a May 2002 report by the non-partisan Kaiser Commission on Medicaid and Medicare documented that the uninsured have a 10 to 15 percent higher mortality rate and earn 10 to 30 percent less because of their poor health (Kaiser Family Foundation, 2002). In short, because they are uninsured, they are both sicker and poorer. In the same year, the Institute of Medicine (2002) issued a report estimating that more than 18,000 adults die each year in the United States because they “are uninsured. With the population increase since 2000, the Urban Institute’s estimate of deaths in 2008 due to lack of health insurance was 22,000 Americans (as cited in Reid, 2009, p. 208). A more recent estimate is an annual death rate of 45,000 (Wilper et al., 2009). A current review of research on health disparities is Anderson, Rice, and Kominski (2007).

The minor premise of the argument asserts universal health care, not simply health care. Compared to other countries in Europe and Scandinavia, the U.S. is the only industrialized country that lacks a national policy and system of universal health care. There is additional evidence that the health status of people living in countries with universal health care is equal to, and better than in the United States. On the sole outcome measure of health status, the World Health Organization (2000) ranked the U.S. 24th on the level of health and 32nd on the distribution of health throughout its population. In overall attainment of the three goals of health status, responsiveness, and fair financing, the U.S. health care system was ranked 15th by the World Health Organization. In overall health system performance of four universal functions (stewardship, creating resources, financing, and delivery of services), the U.S. was ranked 37th of the 191 member nations of the World Health Organization (WHO, 2000, Annex Table 1, p. 155). It is the distribution of health care that relates most directly to the issue of universal access, though the limited access to health care for 47 million uninsured Americans also contributes to a lower level of health of the population as a whole. The lack of universal access in the American healthcare system also makes it less responsive to the population's expectations and needs. Related to the criterion of responsiveness, McGlynn et al. (2003) estimated that Americans are receiving on average only 55 percent of the medical care they need. A beneficent health care delivery system provides medically necessary care for the entire population it is designed to serve. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 2781-2786). AuthorHouse. Kindle Edition.

Distribution

The quo is heavily unequal because of economic disparities---single payer solves by removing the financial incentive for disparate treatment

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The US healthcare system provides unequal care. Just as life expectancy is determined by which neighborhood you live in, for many Americans what hospital or doctor you can see is influenced by neighborhood, insurance, race, and ethnicity. And if you live in a high-mortality neighborhood, a trip to the local hospital might just be a matter of life and death. There are three major reasons why health care delivery in the United States is not equitable. The first is that health care is treated as commodity, not a right. The poor (with or without insurance) living in neighborhoods of concentrated disadvantage often have more limited access to quality health care.² Those who are uninsured and underinsured experience great difficulty accessing needed care.³ Minorities and the poor are less likely to have private health insurance than white middleclass Americans.⁴ When minorities and the poor do have insurance, it is more likely to be one of the publicly funded insurance policies that not all hospitals and doctors accept. The second reason is that minorities sometimes get different treatment for the same illness from what whites get, regardless of insurance. Health care providers' implicit racial bias and patients' mistrust may be the causes of this differential treatment.⁵ The third reason why health care delivery is unequal is that the health care institutions that serve the poor in general suffer from cash and capital shortages. Neighborhoods of concentrated advantage where people with better insurance live have better-resourced hospitals and clinics than poor neighborhoods do. This is how structural violence works within the fabric of the health care system. It is not as if great care cannot be delivered in underserved settings. It is, every day. But it is inconsistent or constrained by a lack of resources. Thus minorities and poor people die disproportionately as a result of an unfairly structured

American health care system. The Deadly Divide Take breast cancer care. It is a gruesome fact that in the United States, black women are 40 percent more likely to die from breast cancer than white women. While black and white American women now develop breast cancer at the same rates (something that was not always the case), more black women will die of the disease.⁶ Why does this particular death gap exist? An oncologist will tell you that black women first seek treatment with larger, more deadly, laterstage breast cancers.⁷ But the truth is that the breast cancer death gap is not just a biological phenomenon but a consequence of structural violence. A woman's neighborhood can determine whether she will survive breast cancer or die from it. It would be grisly enough if breast cancer were the only disease that discriminated. It is not. From heart disease to hepatitis C, depression to diabetes, blacks throughout the United States suffer higher rates of illness and death than whites. It is tough to name many diseases that do not discriminate by race, place, and poverty. But breast cancer is a disease that demonstrates vividly how structural violence is woven into neighborhood fabric, especially in black communities. The Missed Breast Cancer The key to unlocking the inequity in breast cancer mortality came from a radiology reading room on the top floor of Mercy Hospital on Martin Luther King Jr. Drive on Chicago's South Side. The room was dark except for the projected image of a mammogram. Amid the cool gray background of fatty breast tissue was an unmistakable irregular-shaped mass, its speculated white tentacles invading the surrounding tissue—a telltale sign of advanced breast cancer. It was as obvious as a ticking bomb. Dr. Paula Grabler, a radiologist specializing in reading mammograms and diagnosing breast cancer, was then the director of breast imaging services. At most of the other small hospitals that served South Side African American communities, mammograms were read not by specialists but by general radiologists. Too often cancers were evident but missed. This case was no different. "She was a middle-aged African American woman," Dr. Grabler recalled.⁸ "The patient had been seen in the past at a small South Side hospital and had a screening mammogram that was reported to be normal. Months later she came to me with a lump in her breast. I asked to get a copy of the prior mammogram and there it was: a large, very obvious breast cancer." Grabler typically removes mammograms from the view box when she meets with patients. She does not want the image of the cancer to shock the patient. "But on this particular day, I forgot to," she said. The patient gasped when she saw the large white mass that exploded from the gray background of the x-ray. "How did they miss it?" she asked. It was a glaring mistake that could cost her her life. "I honestly don't know," Grabler replied. But she did know. The doctor who read her mammogram was not an expert. He was an itinerant radiologist who read all types of x-rays. Detecting breast cancer early requires meticulous attention to detail. Trained experts who read mammograms find six times more breast cancers than general

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radiologists do.⁹ In Chicago, most of the breast centers that are near or in the black wards do not have such specialists. Cancers are missed. Women die. An obvious breast cancer on a mammogram. The patient presented with a lump in her breast; the prior mammogram had been read as normal. Sometimes the cause of racial disparities in health care can be as banal as an inexperienced or busy doctor missing cancer. Source: authors personal collection. That missed breast cancer held the key to understanding an aspect of premature mortality: access to screening is important for finding breast cancer early—but the quality of that screening is even more critical. We found a screening facility serving Chicago's black community that found two breast cancers for every thousand women screened, when the correct number should have been at least six.¹⁰ More than half were missed. Add to this injury the insult a black woman feels later when she goes to see a doctor with a bad cancer and is told that her genetics are at fault. Institutional racism as a structural cause of increased mortality can sometimes be as banal as a poorly qualified doctor missing a cancer in a poorly run mammography center. In a Chicago study of missed breast cancers, poor women, minority women, and publicly insured women were significantly more likely than well-insured white women to have their cancers missed (they were there on the mammogram on a lookback).¹¹ Socially disadvantaged women (poor, minority, and uninsured) are significantly more likely to have a cancer missed on mammography because they are more likely to receive care at substandard facilities, in segregated neighborhoods, than advantaged women are.¹² Even if women of color do everything right—get screened, schedule follow-up appointments—they can still fare worse than white women simply by virtue of where they live. This is not just a product of poverty, though poverty itself is a big predictor of inequity. There are plenty of poor white women in Chicago, but there is not one poor white Chicago neighborhood.¹³ Poor white women can get their breast care in the same neighborhood hospitals as the more wealthy women in their neighborhoods. This is structural violence and institutionalized racism at work. Women living in Chicago's neighborhoods of concentrated advantage are 37 times more likely have ready access to a "breast center of excellence" than women living in high-poverty neighborhoods.¹⁴ This maldistribution of resources did not occur by chance. The Spread of Racial Disparity None of this mattered when there were no effective treatments for breast cancer. From the mid-i930S, when breast cancer mortality was first measured in the United States, until the early 1980s, when screening mammography and new chemotherapy agents were shown to be effective at reducing mortality, there were no black-to-white or rich-to-poor gaps in breast cancer mortality.¹⁵ But in the early 1990s, as breast cancer became more amenable to new treatments, the breast cancer death rate for white women across the United States began to plummet.¹⁶ The death rate for black women in Chicago did not budge.¹⁷ The improvement for white women was easy to comprehend. Years of effort to raise awareness about the importance of regular mammography screenings coupled with improvements in technology and the emergence of specialists like Grabler meant that more cancers were detected early. Meanwhile, advances in treatment further increased survival rates. But it was here that a new racial death divide emerged. It grew from a sliver to a chasm over the next twenty years. Poor women, and specifically poor black women, were not getting the same quality of breast cancer care as wealthier and white women. Researchers have described this growing racial gap in cancer mortality as the "amenability factor."¹⁸ As cancers such as breast cancer become more amenable to treatment interventions, racial cancer survival disparities widen because poor minority women do not have easy access to the lifesaving cures.¹⁹ Inequality In Quality In 2007, 160-plus doctors, researchers, and community activists in Chicago convened the Metropolitan Chicago Breast Cancer Task Force to investigate the gap and decide how to close it. We analyzed the data. We drilled into the deaths. We held focus groups of black and Latina women on the South and West Sides. We heard their stories of fragmented and disrespectful health care in their communities. We released a report.²⁰ It confirmed that access to quality of care was responsible for the wide racial gaps in breast cancer mortality. The report also made thirty-seven recommendations for closing the gap. Yet breast cancer researchers scoffed. They clung to the usual genetic and biological explanations. We fought back, pointing out the structural components of the death gap, both in Chicago and nationwide. Chicago's gap was twice as large as the national gap and seven times larger than the gap in New York City, suggesting that geography is a significant variable.²¹ Cities like Memphis and every major Texas city had even larger breast cancer death gaps than Chicago's.²² In Detroit, black and white women had the same terrible mortality rates. The cities with the greatest breast cancer death gaps were also the ones with the largest dissimilarity index scores, denoting advanced degrees of racial segregation.²³ Moreover, biology cannot explain the variability in the racial death rates in cities within the same state. For example, in Los Angeles black women are 71 percent more likely to die from breast cancer than whites. In Sacramento and San Francisco this gap does not exist.²⁴ A Map and a Story The task force published a map of Chicago showing the communities with the highest breast cancer mortality. Twenty-three were black communities and one was white. All were located on the West and South Sides. All the black communities were neighborhoods of concentrated US Health Care: Separate and Unequal * 119 Years Disparity ratios in breast cancer mortality between white and black women across New York City, the United States, and Chicago from 1990 to 2010 show that geography, more than biological and genetic factors, influences womens mortality. Source: Metropolitan Chicago Breast Cancer Task Force. poverty and disadvantage.²⁵ In mostly black neighborhoods, not one hospital has earned the American College of Radiology's seal of approval for breast imaging centers. Only one hospital in a high-mortality black neighborhood has been certified by the American College of Surgeons' Commission on Cancer as a cancer treatment center. In contrast, in the white wards there are fourteen cancer accredited hospitals. This was a bleak picture of the structural nature of racial inequality. It's one thing to look at disparity on a map. It's another to hear from the women who try to navigate the fractured system of care. Chicago and other cities have a hodgepodge of public and private hospitals and clinics, with little communication between them and poor coordination of care. Barbara Akpan is a retired nurse in Chicago. After her breast cancer diagnosis and treatment at an academic medical center, she began serving as a volunteer community advocate for other African American women on the South Side. Her observations reinforce the notion that inequality in the quality of breast cancer care was failing women. "Many of the women I work with are afraid," she said. "They do not trust the health care system. Many of the clinics and hospitals they go to do not provide the best care, or they simply give them the wrong Hospitals with American College of Surgeons Approved Cancer Programs African American Community Areas with Elevated Breast Cancer Mortality In Chicago's African American neighborhoods with high mortality for female breast cancer, there are few hospitals with American College of Surgeons-approved cancer programs. Consequently, black women with breast cancer concerns have to either travel for care or receive care at nonapproved cancer treatment sites. This map depicts how health inequality is structured into the geography of a region. Source: <http://link.springer.com/article/10.1007/s10552-009-9419-7>. information. It's hard to overcome the mistrust. For women in the southland—Ford Heights, Chicago Heights, Harvey, poor areas on the South Side—access to mammography screening sites is really poor," says Akpan. "Women are falling through the gap—they don't know where to go."²⁶ When we traveled around Chicago and other cities, showed audiences of black women the mortality curves illustrating the black breast cancer death gap, and gave our explanations, they cried. We had validated something they knew to be true: the systems that served them were often inadequate. They cried because our data told them that the breast cancer death gap was a system problem and not a problem within black women. Their reactions galvanized us to focus on fixing the system. Because the mortality gap was structural, we needed hospitals to work together to improve care for black women. We identified hospitals with undertrained mammography technicians and radiologists and arranged free continuing-education courses. We met with CEOs to share their hospital's quality data and make recommendations for improvement. But this was not going to improve care fast enough. If a small inner-city hospital lacked the expertise to provide comprehensive breast cancer care, no amount of quality improvement would remedy it. But what if we could move women from poor institutions to good ones? Navigating to Quality We hired health "navigators." These were community health workers and nurses who could direct women to high-quality hospitals for screening and treatment. We solicited breast cancer services from all the region's top hospitals. Most obliged. The navigators guide their clients into care at the city's highest-quality medical centers even when they are two hours and two bus transfers away. Sometimes the navigators battle with the local doctors to wrest the patient into better care. Gerri Murrah is typical of the patients navigated. She was 60 and developed a sore lump in her breast in 2015. Not having a primary-care physician, she had gone to her local emergency room. The doctor didn't even consider

cancer; Gerri was given antibiotics and sent home. Luckily, Murrah knew something was wrong and went to a different clinic and requested a mammogram. The results were suspicious. Murrah was assigned to a surgeon at a neighborhood hospital. This surgeon, not a breast specialist, made two bungles: Instead of doing a needle biopsy, he surgically removed the lump—a painful and unnecessary procedure. Then, without informing Murrah of the stage of her breast cancer (stage III), he recommended an unneeded mastectomy. When DeShauna Dickens, one of the task force navigators, finally connected with Murrah, she referred Murrah to the University of Chicago Hospital for a second opinion. There, Murrah learned she had other options that would preserve her breast. “DeShauna came in just in time to stop me from having my breast cut off,” she says, in an O, the Oprah Magazine interview.²⁷ There are setbacks. Not all women respond. Not all institutions have the will to better their conditions. Some facilities were deplorable, such as the mammography facility in the Washington Park neighborhood’s Provident Hospital, which the task force staff visited in 2014. The room that was used to develop mammography films had a sewer manhole cover in the middle of the floor and was suffused with noxious sewer fumes. The path to improve quality and reduce mortality can be slow and painful. The Breast Cancer Quality Consortium Yet progress has been made. The grassroots team persuaded 160 health care providers across the state, including every Chicago hospital, to share their data, such as tumor detection rates and follow-up rates. Slow improvements in quality were made even in the poorly performing hospitals. In 2013, after seven years of work, the black-white breast cancer death gap in Chicago had narrowed by 35 percent.²⁸ While the exact reasons for the improvement in the mortality gap are not easy to tease out, in no other metropolitan area of the United States has that death gap been reduced. The reduction in black breast-cancer deaths in Chicago shows that mortality inequities caused by structural violence are fixable. Focused and deliberate work directed at equalizing the health care system can save lives. Racial disparity can be reduced—and possibly eliminated. “We don’t need a magic bullet to fix this,” says Dr. Patricia Ganz, a member of the Breast Cancer Research Foundation Scientific Advisory Board and professor of medicine and public health at UCLA. “We just need to give black women the same standard of care.”²⁹ Implicit Bias Contributes to Unequal Care While the

story of the Chicago breast cancer death gap has had early success, in too many areas and on too many levels we are still dealing with the most basic inequities and prejudices. Bias, even if unconscious, affects individual physicians and their treatment decisions. This is unsettling but true. While most doctors do not exhibit explicit racial bias, such as refusing to treat certain patients because of their race, on tests of implicit bias they, too, show unconscious preferences for whites over dark-skinned faces. The Implicit Association Test is a widely used test of social cognition. More than 70 percent of the millions of Americans who have taken it exhibit a subconscious preference for whites over blacks.³⁰ Physicians score similarly. An ingenious 1999 experiment showed how unconscious bias affects clinical decision making. Thousands of doctors were asked to test their clinical acumen by reviewing the medical history given by a performer who acted out the symptoms of a potential cardiac syndrome on film.³¹ There were eight elderly patients. Four were men: two white and two black. Four were women: two white and two black. Physicians were asked to recommend a cardiac workup based on the clinical information the patients relayed. In addition, physicians were told whether the patient was insured or uninsured. The results were not surprising. Based on the gender, race, and insurance status of the patient, doctors recommended entirely different medical workups. Men of both races were more likely to be referred for angiograms to evaluate symptoms of chest pain. But blacks of both genders were less likely than the whites to be referred for the full cardiac workup. Those who were noted to be insured were more likely to be referred for a full workup as well. While this was an experiment and not real clinical care, unconscious bias in health care delivery seems to be a real phenomenon. In an eye-opening 2002 report on health care disparities, the Institute of Medicine found “strong but circumstantial evidence for the role of bias, stereotyping, and prejudice” in perpetuating racial health disparities.³² Some research suggests that there is a direct relationship among physicians’ implicit bias, mistrust on the part of black patients, and clinical outcomes.³³ In a prospective study of older adults, patients who experienced discrimination in health care more than once yearly were twice as likely to have a disability four years later than cohort members who suffered no discrimination.³⁴ What needs to be done to address implicit bias in medicine? Awareness is a start. Mandatory bias testing and cultural intelligence training have been proposed. But it requires day-to-day interactions between people of different backgrounds to break the implicit boundaries that prevent deeper understanding.³⁵ And that’s necessary, but fair. But bias is only a piece of the story. Having No Insurance Is Bad for Your Health Another major factor driving inequitable care is lack of health insurance. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether. Twenty-five percent of adults without coverage say that they went without care in the past year because of its cost, compared to 4 percent of adults with private insurance coverage. Moreover, 55 percent of uninsured adults do not have a regular place to go when they are sick or need medical advice.³⁶ When uninsured patients get injured or develop a chronic disease that requires follow up, they are less likely than those with coverage to actually obtain all the services that are recommended.³⁷ Blacks and Latinos are more likely to be uninsured than whites, which only increases the burdens of health care inequity borne in neighborhoods of concentrated poverty. Prior to the Affordable Care Act, an estimated 45,000 residents died each year due to a lack of insurance, or one person every twelve minutes. If being uninsured was a cause of death, it would be the tenth most common one in the United States.³⁸ The next chapter will deal further with the issue of health insurance. Apartheid Hospitals Once people do get insurance, there is no guarantee they will get good treatment. As Nobel Prize winner Angus Deaton has noted, “Hospitals in the United States are run on something close to an apartheid basis with few white patients in the hospitals that treat mostly African Americans and vice versa.”³⁹ Hospitals in which the majority of patients served are minorities have higher mortality rates across the board, whether from trauma, cardiac surgery, or general surgery procedures. In fact, as the percentage of minority patients served increases at an institution, so do the mortality rates across many conditions. There seems to be a direct correlation between the proportion of minority patients served by a hospital and death rates.⁴⁰ Take trauma care as an example. Trauma centers that serve mostly minority patients have higher mortality rates than those that serve mostly white patients. There is a gradation of trauma mortality based on the percentage of

minority patients served by the trauma center. Those trauma hospitals with fewer than 25 percent minority patients have 60 percent better trauma survival rates than trauma hospitals with more than 50 percent minority patients. Hospitals with 25-50 percent minority patients have trauma mortalities in between the two.⁴¹ Why would this be? Trauma centers require specific levels of physician and other staff coverage, and they require periodic rigorous certification. Shouldn't this attention and regulation lead to better care, regardless of race and ethnicity? There are only two possibilities. One is that trauma severity or high-risk conditions are more prevalent among patients in institutions that serve mostly minorities. However, even when severity of illness is controlled for, minority trauma centers have 37 percent higher mortality rates than those serving mostly whites. The other possibility is that the care is actually unequal. I have shown how this is true for breast cancer care. It seems to be true for many conditions. What hospital you attend is literally a matter of life and death. In general, hospitals and clinics where many minority patients receive care are lower quality than those that serve white populations, whether for medical or surgical conditions.⁴² Further, hospitals treating a higher proportion of black patients have higher mortality rates for many surgical procedures. In addition, these hospitals have higher mortality rates independent of race: both black patients and white patients have higher mortality in hospitals with mostly black patients than their racial counterparts in other centers.⁴³ The federal Center for Medicare and Medicaid Services recently created a national star ranking system for hospitals, to allow consumers a means to assess hospital quality. A hospital can be ranked from five stars to one star, with five stars denoting a very high quality hospital with lower mortality and one star being a low-quality hospital with high mortality.⁴⁴ In practice, star rankings vary by the whiteness of the hospital's clientele. Five- and four-star hospitals in America serve patient populations that are predominantly white. One- and two-star hospitals in America serve predominantly minority patients and very few whites. This is true for care at clinics as well as hospitals. The doctors who work at clinics that care for predominantly black and other minority populations are less likely to be board certified, have less access to specialty consultation, and work in more chaotic conditions. It is not a matter of the patients' race or ethnicity. Hospitals and clinics in poor neighborhoods, those that serve uninsured populations or those on Medicaid, often do not have enough resources to provide the very best care.⁴⁵ What seems at first blush to be a racial disparity is actually a consequence of structural violence and institutionalized racism. Just follow the money. Let's compare the cash situations at two Chicago hospitals, both trauma centers. During my decade at Mount Sinai Hospital, located in a low-income black neighborhood, 20 percent of the patients had no insurance. Another 60 percent had Medicaid. The patient population served is virtually 100 percent black and Latino. If a white person happens to be hit by a car down the street from Sinai, then they might be brought there. Otherwise a white patient, or anyone who is well insured, would rarely set foot inside Sinai. Then there's Northwestern Memorial Hospital. One of the top hospitals in the United States, on the US News and World Report Honor Roll, it towers over Lake Michigan about five miles from Sinai, in Chicago's predominantly white Streeterville neighborhood. It has an A bond rating, and about 500 days of cash brimming in its accounts. This translates to \$2 billion in bank reserves. Most of Northwestern's largely white patient population has private insurance. A small number are uninsured. During my time at Sinai, there were often only a few days of cash on hand. Sinai had no bond rating—meaning no bank would lend it money for capital investments. Just as Lawndale had been redlined seventy years prior, Sinai and other hospitals that serve poor communities are redlined by the banking industry today, limited in their ability to borrow. Sinai has been an anchor in the Lawndale neighborhood since 1919, and it takes care of everyone who comes to its doors, regardless of ability to pay. The price of this noble mission is a hospital's equivalent to a vow of poverty. From a banker's perspective Sinai is a bad investment. Compare Northwestern and Mount Sinai's spending on capital in 2012. Capital dollars reflect the amount of money that a hospital has to spend on patients, doctors, equipment, and upgrades. Northwestern spent \$273 million on buildings and equipment. Sinai spent just \$6 million.⁴⁶ The failure of capital markets to support Sinai contributed to its chronic struggles to maintain service quality. If we really want to achieve equity in health care outcomes, then we have to invest more into the institutions serving those who need care the most, like Sinai. This means redistributing capital dollars based on need from Northwestern and its neighborhoods to invest in Sinai and its Lawndale neighborhood. This is just the opposite of how the American health care system works. In America we have arranged it so those who need it the most (often black people and other minorities) get less, while those with the most (white and affluent people) get the best care and facilities available in the world. It is no surprise that life expectancy in Northwestern's neighborhood is 85 years. In Sinai's neighborhood it is 72 years.⁴⁷ Failure to Rescue When it comes to providing the highest quality of care, volume matters. The doctors and the nursing staff who are exposed to high volumes of particular kinds of cases have more time to hone their skills, and this leads to better outcomes. A surgeon who does liver transplants every week is better at them than one who does one per year. As for complex surgical conditions where high volumes of cases are crucial to achieve the best outcomes, nonwhite patients are more likely than whites to receive them at low-volume institutions. These patients are also less likely to be rescued if they deteriorate postoperatively. Procedural complication rates are exactly the same at high-mortality and low-mortality hospitals. So what is the reason for the death gap? The answer is culling failure to rescue. When a sick patient gets a complication, the doctors and nurses have to recognize and treat it—that is, rescue the patient from dying. Hospitals with well-developed systems to recognize complications and rescue patients have lower mortality.⁴⁸ While all the components of rescue have not been identified, adequate nurse staffing and training is critical. The hospitals with the least capability to rescue—due to nursing shortages, lack of training opportunities for staff, or other factors—serve significantly more minority patients and suffer higher mortality rates.⁴⁹ Truth or Consequences Cardiac surgery at Mount Sinai Hospital is an example of a low-volume and high-mortality program. Its struggles are instructive for understanding the day-to-day decisions in a poor hospital and how they lead to health inequities. When I worked there, the heart surgery program was small—about fifty cases each year. Programs this small have trouble maintaining quality because there is not enough repetition for all the staff who need to be in top form. In addition, because the capital investments required to maintain the service were so high, Sinai managers thought the limited capital we had should be invested elsewhere. So we closed the program and partnered with a nearby, higher-volume academic medical center (University of Illinois) to take our patients. It made sense. The neighborhood did not need a small, poorly functioning heart-surgery program. Then one day we had a patient in the cardiac-care unit with three blocked coronary arteries. He needed emergency bypass surgery. Our cardiologists inserted a special pump into his aorta to boost to his failing heart until lifesaving cardiac surgery could be performed. Time was critical. But the patient was uninsured, and the University of Illinois refused the patient. In desperation I phoned the chief of cardiology there. He recommended that the patient be discharged from Sinai and instructed to walk to the University of Illinois emergency room. Then, he said they would be required to treat him. I was shocked. Not only was this immoral, but it was medical malpractice. The patient was hooked to life support, teetering on the edge of death with an artificial heart pump attached to a blood vessel in his groin. Without surgery soon he would surely die. It took a call from our CEO to U of I's CEO to get this patient transferred. After this event, against their better judgment, our cardiologists urged our CEO to restart cardiac surgery at Mount Sinai. Despite the low volumes, inability to guarantee quality, and high capital costs, it became a necessary investment. These are the choices faced by safety-net hospitals in communities of concentrated disadvantage. Provide nothing and let patients die from neglect; or provide the best care you can, at risk of higher than desired mortality, and hope to pull most patients through. More broadly, a 2014 study evaluated cardiac-surgery mortality in patients insured by Medicare. Nonwhite patients succumbed at a 33 percent higher rate than whites (after risk factors were controlled for). Thirty-five percent of the death gap was due to deficiencies in hospital quality. The highest-mortality hospitals were those that served predominantly minority populations. Both white and black patients who received their heart surgery at predominantly minority hospitals had higher mortality rates, suggesting structural factors were responsible. When we speak of institutionalized racism as a structural cause of premature death, it is not the virulent type of racism that we associate with opposition to the civil rights movement of the 1960s. It's a more banal but deadly form of brutality woven into the tapestries of our institutions and thus harder to eradicate. I was not shocked by the study's findings.⁵⁰ I knew that race itself—as a social marker—was not the reason for the cardiac mortality gap at predominantly minority hospitals; it was our tolerance for inequality in quality across our health care system. This becomes even more obvious when we contrast these findings with the outcomes in the Veterans Administration system, where care is structured the same way nationwide. In the VA system there is no equivalent racial heart-disease death gap.⁵¹ Inequality in Quality and Unequal Treatment It is not only in majority minority hospitals that black health-care inequities exist. When black and brown patients receive medical care in any setting, they are more likely than white patients to receive unequal care. This was documented in the Institute of Medicine's shocking Unequal Treatment report, which synthesized hundreds of studies of age, sex, and racial differences in medical diagnoses, treatments, and health care outcomes. The report concluded that for almost every disease studied, black Americans received less effective care than white Americans. These disparities prevailed even among groups with identical socioeconomic or insurance status. Minority patients received fewer

recommended treatments for diseases ranging from AIDS to cancer to heart disease.⁵² How much of the treatment gap is related to implicit bias, patient mistrust, physician practice style, or systematic organizational dysfunction is not known, but these gaps have persisted over the decade and more since the Institute of Medicine report.⁵³ Each year since 2003, the Agency for Health Care Quality and Research has tracked progress on health care inequity across America, analyzing more than 250 quality measures across a broad array of settings and services. In the 2014 report, the agency reported no overall improvement in racial health disparities from prior years. Not one iota. The American Hospital Association Pledge In 2015, in response to years of intractable health care inequities, the American Hospital Association called upon CEOs of hospitals across America to sign a pledge to measure health inequities within their own institutions and to fix them. The Equity of Care Campaign to End Healthcare Disparities focus is on four areas. First, hospitals are to choose a quality measure that is important to their community. Next, they are to develop a plan to address a disparity, whether by race, ethnicity, or language preference. Third, hospitals are asked to provide cultural competency training for all staff or finalize a plan to do so. Finally, hospital operations teams are asked to initiate a dialogue with the board and leadership team about this disparity work.⁵⁴ After over a century of documented health-care disparities, this step is important. But it is hardly enough. The nation's hospitals have been organized for the most part to make money by attracting the best clientele with the best insurance policies. For most hospitals this means avoiding poor and minority neighborhoods. Those frayed and capital-poor hospitals that have made it their mission to care for poor and uninsured often struggle in poverty like their clients. Just as the neighborhoods of concentrated disadvantage were created by white and industrial flight and the expansion of neighborhoods of concentrated advantage, a similar phenomenon has occurred in health care. The nation's wealthiest health care systems for the most part have avoided serving the residents of concentrated disadvantage by placing offices and hospitals only in white communities of advantage. So pledges are well and good, but without larger structural changes that level the insurance and capital decisions that underpin the health care system, health care equity will continue to be elusive. Only with national health insurance reform that begins with the idea of health as a human right could these structural issues be resolved. The Affordable Care Act, the most recent response to the need for health care reform, has tried to address these issues. However, as we will see, it has been an inadequate solution so far. HEALTH INSURANCE IN AMERICA You guys are evil. Canada's the best country in the world. We go to the doctor and we don't have to worry about paying him, but here your whole life you're broke because of medical bills.¹ J U S T I N B I E B E R It will not do to note that under the Affordable Care Act almost 90 percent of Americans currently have some form of health insurance, any more than it would do for a hotel to note that 90 percent of the time the roof over your bed does not leak when it rains.² Of all possible ways to remedy structural violence in America, the creation of an equitable universal health-care system based on the idea that health care is a right, not a commodity, ranks high. While the health care law was a reform of the old system that saw fifty million Americans uninsured, the Affordable Care Act perpetuates health care inequity and fragmentation by its very design. Yet if Republican calls to repeal the law are heeded, we will be back to square one. And bad will revert to worse. I was not surprised that the solution for universal health care in the United States would be to prop up the existing costly, inequitable, and inefficient insurance system. In 2003 my wife and I cosponsored a fundraiser in Chicago for the then little-known Illinois state senator Barack Obama, who was running for the US Senate. In the living room of a modest single-family home in the neatly manicured South Shore neighborhood of Chicago, I asked the future president his position on national health-care reform. His words presaged what came to be known as "Obamacare." "I'm a proponent of a single-payer system," he responded. But he explained that the political power held by the health insurance companies was so formidable that opposing them would be political suicide. He noted that the insurance industry had over 250,000 employees across the country and a lobbying apparatus that had to be reckoned with in any drive for universal health care. "Single payer will never get passed in the United States," he concluded. He was correct. Single payer did not even get a hearing. The Affordable Care Act was a modest reform of the existing tiered healthinsurance system, which treats health care as a commodity, not a human right. The coverage provisions in the Affordable Care Act built on and attempted to fill in the gaps in a piecemeal system that had left many without affordable coverage. There have not been impressive gains since the passage of health reform.³ A net of twenty million more people gained health insurance coverage between 2013 and 2015. Medicaid has expanded in thirty-two states and the District of Columbia, providing new access to coverage to millions of previously uninsurable Americans.⁴ The Affordable Care Act has been successful in reducing the number of uninsured, but about 30 million Americans remain uninsured.⁵ Most important, the Affordable Care Act fails two critical parameters of health justice: it is neither universal nor equitable. Elegant, Equitable, and Not to Be The most elegant, comprehensive, fairest, and lowest-cost solution to the health care crisis would have been to expand and improve the Medicare insurance plan to cover all Americans.⁶ Medicare, enacted in 1965 as a single governmental payer system to provide health insurance for Americans 65 and older, has been well liked since its inception. Before Medicare, 48 percent of such Americans had no insurance; now only 2 percent are uninsured. In addition, before Medicare 56 percent of senior Americans paid out-of-pocket health care expenses, compared to 13 percent now.⁷ Satisfaction with coverage is substantially higher among Medicare recipients than for those who

have private insurance. Only 8 percent of Medicare enrollees report their experience as fair or poor, compared to 20 percent of those with typical employer-based health insurance coverage and 33 percent of those who purchased private insurance directly.⁸ Moreover, the costs of administering the program are substantially lower than those of private insurance companies—only about 2 percent of the total cost for Medicare, compared to 12 percent for the least expensive insurance company's overhead charges.⁹ Most important, experts estimate that since its inception Medicare has added five years to the life expectancy of older Americans.¹⁰ Polls have shown that universal government-sponsored health coverage is preferred by half of Americans.¹¹ And an improved Medicare would be an entitlement available to all Americans, with the exact same benefits for the wealthy and the poor.

Medicare for all would achieve the goal of universal access to health care. As an entitlement for all US citizens (and extended to noncitizen residents), access to health care would be a right. This would contribute to the improvement of the life expectancy gap between rich and poor. Plus it would save an estimated \$400 billion yearly by eliminating administrative waste.¹² So if one wanted to solve the problem of the uninsured and reduce the death gaps between rich and poor, expansion of Medicare with other enhancements would have been the most logical approach. This is not a radical idea. Thirty advanced industrialized nations have forms of universal health care.¹³ Canada has a “Medicare for All” health insurance with easier access to care, lower costs, and better health outcomes (including life expectancy) than those of the United States. The evidence is compelling. While health inequity has not been eliminated in Canada, the differences between poor and rich are not as striking as they are in the United States.¹⁴ In Canada, men in the poorest urban neighborhoods experienced the biggest declines in mortality from heart disease from 1971 to 1996.¹⁵ Life expectancy gaps between income groups declined during that period as well. Poor Canadians with cancer had better survival than poor people from Detroit, an outcome The Poison Pill: Health Insurance in America * 135 136 * CHAPTER TEN attributed to the Canadian system.¹⁶ Of all the major Western economic powers, the United States is the only one without a universal health care system in which health care is considered a human right.¹⁷ Rather than treating access to health insurance as a universal right, the language of the Affordable Care Act endorsed the idea that health care is a mandate.¹⁸ The difference between health care as a right and health care as a mandate is critical, as these conceptions lead to very divergent solutions. If health care is a right, universal health care is an entitlement that should be the same for all citizens. If health care is a mandate, however, then there is no such entitlement, and health care is a commodity to be bought and sold. The Affordable Care Act established the mandate as a core component of health care coverage, perpetuating the complex system of multiple payers, limited access, variability in quality of care, high costs, and large rich-poor life expectancy gaps. Obamacare and Beyond The 2010 Affordable Care Act remains the most significant overhaul of the American health care system since the passage of Medicare in 1965, expanding insurance coverage to millions. The law survived multiple attempts by Congress and two Supreme Court challenges that aimed to gut its major provisions.¹⁹ As a reform of the current for-profit insurance marketplace, the Affordable Care Act addressed two major gaps in the existing system. First, it allowed young adults to stay on their parents’ health insurance until the age of twenty-six—a popular provision that benefits almost eight million Americans.²⁰ The second major reform prevented insurers from denying coverage to people with preexisting medical conditions. Medicaid was expanded to include millions of previously uninsurable individuals who had been excluded from the health care system. Uninsured rates among whites, blacks, and Hispanics dropped, narrowing though not eliminating racial and ethnic insurance coverage gaps.²¹ At the same time, the Affordable Care Act incorporated the worst aspects of our fragmented for-profit health insurance system. The tiered system of insurance—where the coverage options for the poor are markedly different from those for the rich—has further hardwired inequity into the law. In 2004 there were fifty million people without health insurance in the United States. That year the Institute of Medicine published a report, “Insuring America’s Health,” that outlined the principles against which any health reform legislation would have to be measured.²² The institute identified the ideal system as having “universal, continuous insurance coverage that is affordable and sustainable for individuals, families, and society, and should enhance well-being through care that is effective, efficient, safe, timely, patient-centered, and equitable.” Eleven years later, none of these standards was being met. Even after the passage of the Affordable Care Act, there are around thirty million Americans without insurance and an equal number of underinsured who have health insurance policies but with deductibles and copayments that are high enough to deter care.²³ How did the United States end up with a more fragmented, more costly, and more confusing health care system? Simply stated, collusion between members of Congress and entrenched corporate health insurance and Big Pharma interests precluded a more equitable and lower-cost solution. What Americans got with the Affordable Care Act was complicated insurance marketplaces in every state with a complex array of confusing private insurance products. The health reform process exposed, in the words of the British medical journal The Lancet, “how corporate influence renders the US Government incapable of making policy on the basis of evidence and the public interest.”²⁴ When the moment arrived to consider having a Medicare-like “public option” on the state exchanges to compete with private insurance companies, Senator Joseph Lieberman of Connecticut, the deciding Senate vote, deep-sixed the idea by threatening a filibuster.²⁵ The capital of Connecticut is Hartford, the home of Aetna, one of the big five health insurance companies. Skin in the Game There are three major structural flaws in the Affordable Care Act, all of which could be solved by a single-payer system. The first flaw is The Poison Pill: Health Insurance in America * 137 138 * CHAPTER TEN that the insurance expansion is neither universal nor equitable. For example, because mandatory Medicaid expansion was blocked by the Supreme Court, nineteen states have left millions of poor people uninsured.²⁶ These states account for over half of poor uninsured blacks, single mothers, and the country’s uninsured working poor. For poor people in these states, it is as if Obamacare was never enacted. Note that for the most part these states that have refused to expand Medicaid are the former Confederate slaveholding states, accentuating the legacy of structural racism. Access to specialty care for those who receive Medicaid coverage is limited compared to access for patients with private insurance.²⁷ More than one-third of US doctors refuse to take Medicaid—another structural barrier.²⁸ The second flaw is that premiums, copays, and deductibles for private health insurance and products on the marketplaces are prohibitively high for many people, especially the working poor. In 2015 average annual premiums for employer-sponsored health insurance were \$6,251 for single coverage and \$17,545 for family coverage. Between 2014 and 2015, premiums increased by 4 percent, while during the same period workers’ wages increased 1.9 percent. Premiums for family coverage increased 27 percent during the last five years, while cost sharing has skyrocketed.²⁹ The average individual deductible across the marketplace plans in 2016 was \$5,765 for bronze plans. After the deductible is paid, an individual with such a plan will face 40 percent copays for services.³⁰ Insurance companies have reacted to their rising costs by creating narrow networks of providers and hospitals.³¹ This limits choice of patients by restricting the doctors and hospitals whose services they can use. At the heart of the Affordable Care Act are subsidies for the working poor to pay for health insurance premiums.³² The goal was to keep these premiums within reach of most Americans. It was a sweet deal for the insurance companies. The insurance companies are guaranteed to get their premiums; the federal government poured billions of dollars into their coffers. In exchange, an individual gets an insurance card. But with that card came unprecedented out-of-pocket expenses that kicked in before the insurance company paid one cent.³³ The belief is that without “skin in the game,” the newly insured will overuse the system. As a result, coinsurance and deductibles that many Americans now are forced to pay have skyrocketed across the insurance markets. Yet every study ever done on the impact of copays and deductibles (even for middle-class people) is that they cause individuals to delay medical care.³⁴ Under a single-payer health care system there would be no copays or deductibles. Obamacare

Bullshit The third flaw of the Affordable Care Act was that long-term doctorpatient relationships have been disrupted by insurance restrictions. President Obama said, "No matter how we reform health care, I intend to keep this promise: If you like your doctor, you'll be able to keep your doctor; if you like your health care plan, you'll be able to keep your health care plan."³⁵ This turned out to be untrue. Windora Bradley, a year before her stroke, struggled to pay her health insurance premiums. Faced with the dilemma to buy food or go without medications, she chose to go without medications. At one of her office visits, she let loose. "I'm tired about this Obamacare bullshit," she shook her head, frowning as her jowls quivered. "I worked for thirty-five years. Those people on welfare who never worked are getting free health care. I am paying \$700 each month and there is not enough left for medicines and food. That's not right. That's why I call it Obamacare bullshit." Windora lived on a pension of about \$1,000 per month. Most went for the premiums on her health insurance, which she still received through the Chicago Board of Education. She scrimped and saved to pay for her medications for her diabetes, hypertension, asthma, and vascular disease. Her situation is common among the working poor. Windora was ultimately able to get insurance on the marketplace that reduced her premium costs but not her out-of-pocket expenses. At first she purchased a Blue Cross insurance plan that she was told my hospital accepted, but this proved incorrect. She then had to purchase a more expensive plan to stay with me. Meanwhile her two sisters, who The Poison Pill: Health Insurance in America * 139 140 * CHAPTER TEN had also been my patients for over thirty years, had to switch doctors because my group did not accept the insurance they enrolled in. A number of my long-term patients found themselves in this dilemma. In 2015, after her stroke, Blue Cross dropped my hospital and many others from the plan Windora had just purchased. There was only one plan, from United Health Care, in all of Cook County that included my hospital and me in the network. The week after Windora signed up for it, United Health Care let it be known that it was considering withdrawing from all the exchanges in 2017.³⁶ In three years of the Affordable Care Act, Windora had purchased three different insurance policies just to retain me as her physician. In the fall of 2016, United Health Care announced it would drop my hospital from its network, and Windora, now wheelchair bound and speechless, is forced to find another doctor (to say nothing of her many specialists) after thirty-six years. For someone like Windora with complex medical and social obstacles, keeping a team of providers who are familiar with her medical travails is essential to getting good care. For me, her longtime doctor, it is a gut-wrenching experience. The fact is that Obamacare, despite its modest benefits, does not remedy American health care inequity. It will never achieve universal coverage. Eleven million noncitizen residents will never be eligible for its benefits. Thirty million people will remain uninsured. While insurance coverage has increased for all races, there is still a large racial and ethnic gap in insurance coverage, which will perpetuate health disparities. For those with health insurance, spiraling copays and deductibles have made access to care more difficult. Finally, by allowing a dizzying array of for-profit insurance carriers with high administrative overhead expenses, the Affordable Care Act as currently configured will not control costs. In 2016, the third year of Obamacare, insurance companies asked for double-digit increases in premium prices, as they claimed costs of delivery had outstripped the revenues. Meanwhile, health insurance stocks are trading at all-time highs, while patients like Windora Bradley face rocketing expenses and uncertainty about the future.³⁷ The Poison Pill: Health Insurance in America * 141 A Call for Single Payer I speak for many of my health care colleagues across the nation when I say that the Affordable Care Act is a **disappointment**. In contrast, an improved and expanded Medicare for All would achieve **truly universal care, affordability, equity, and effective cost control**. It would put the interests of our **patients**—and our **nation's health**—**first**. By replacing multiple private insurers with a single nonprofit agency like Medicare that pays all medical bills, the United States would save approximately **\$400 billion annually**. **Administrative bloat** in our current private-insurance-based system would be slashed. That waste would be redirected to **clinical care**. Copays, coinsurance, and **deductibles** would be eliminated. A single streamlined system would be able to **rein in costs** for medications and other supplies **through** the system's strong **bargaining clout**—clout **directed to benefit health, not profits**. Finally, it would create an equitable system of care that would provide **equal access to rich, poor, black, and white**. As a result, **life expectancy gaps** between rich and poor would narrow. Hospitals that serve poor communities would have access to capital investment based on need. It has been done in other countries, and it can be done in the United States. Single-payer health care stands in **stark contrast to the ACA's incremental reform**. Yet it is important to remember that enactment of a single-payer system requires the defeat of **deeply vested, deep-pocketed ideological opponents, health insurance conglomerates, and a thick alliance of health care constituencies along with other interest groups**. The Affordable Care Act, passed by a Democratic majority and signed by a Democratic president, was a weak compromise that left the foundations of our flawed \$2.9 trillion health care system intact. It will be some time before political conditions are again right to tackle an improved Medicare for All. So **why, given these hurdles, do I (and many other health care providers) persist?** I persist because I have watched too many patients suffer and die because they lacked **health insurance** or had the wrong insurance card. I persist because I have witnessed the **racial and ethnic death gaps** enabled by our current health insurance arrangements. I persist because **simple fairness** dictates that health care is a fundamental human right. I persist because of patients like Win142 * CHAPTER TEN dora and Sarai, who deserve better. For those who counter that single payer is too expensive or politically unfeasible, we persist because the American ideal of "life and liberty" cannot be achieved without an equitable and universal health care system. Winston Churchill reportedly said, "You can always count on the Americans to do the right thing... after they have tried everything else."³⁸ We have tried everything else. I look forward to being part of a single-payer health care system that values the health of individuals, families, and communities as a common good—where health care is valued as a human right. Someday.

The impact is unique: 84,000 deaths annually

Mantou Chong 17, citing David Atkins, of the Agency for Healthcare Research and Quality, "Health inequalities in US kill 84,000 - expert", <http://www.mantouchong.com/2017/02/health-inequalities-in-us-kill-84000-expert/>

Health inequalities in the United States cause about **84,000 additional deaths a year, more than the equivalent of a hurricane Katrina every week**, a health care expert said on Friday. David Atkins, of the Agency for

Healthcare Research and Quality (AHRQ) in the United States, said the images of people clinging to rooftops made it clear that being poor and black in a poor southern state is hazardous to health.

Stats prove our internal link

Adam **Gaffney** 16, fellow in pulmonary and critical care medicine at Massachusetts General Hospital. He is also an adviser to the board of the Physicians for a National Health Program, Is the Path to Racial Health Equity Paved with “Reparations”? The Politics of Health, Part II, <https://lareviewofbooks.org/article/is-the-path-to-racial-health-equity-paved-with-reparations-the-politics-of-health-part-ii/>

But would “true” universal health care do much to combat racial health inequalities, if it were, say, a single-payer system that eliminated out-of-pocket expenses and was equally accessible by all, without tiers or walls?[25] **Or would it replicate current biases and inequalities?** To some extent, the answer is yes to both questions. But even so, a body of research has suggested that, even if these biases persist, a fully universal system might nonetheless be a powerful tool in reducing racial health care inequalities. That evidence comes from what is arguably a quasi-single-payer system located in the US: the Veterans’ Administration (VA). Notwithstanding recent scandals that are indeed of great concern, the modern-era VA has justifiably earned praise for delivering a high – indeed, comparatively superior – quality of health care.[26] There is also evidence that it may indeed effectively reduce, even potentially eliminate, some racial health inequalities. Last fall, a study published in Circulation, the premier journal of the American Heart Association, received wide coverage in the media for some provocative findings. “The US Veterans Health Administration (VHA),” as the study notes in its introductory section, “is a healthcare system that does not impose the typical access barriers of the US healthcare system that may disproportionately impede enrollment of blacks.” The investigators therefore hypothesized that racial inequalities in cardiovascular outcomes and mortality found in the general population might be reduced in the VA, a “healthcare system that allows enrollment independent of race or socioeconomic status.”[27] Consistent with previous studies, in their analysis of data from the general (non-VA) population, they found racial inequalities much as they expected to find them: blacks had a much higher mortality (after adjusting for various other factors) as compared to whites (indeed, approximately 40 percent to 50 percent higher).[28] In striking contrast, in the VA population, even though the risk of stroke was either higher or similar among blacks as compared to whites depending on which statistical adjustments were used, the risk of coronary heart disease as well as overall death was actually lower among blacks. This is, of course, only a single study, albeit a rather large one with more than three million subjects. An accompanying editorial concedes that a number of factors may be at play. Nonetheless, the fact is that, as described by the investigators, these findings build on an existing literature consisting of multiple studies that together point to a reduction of racial health inequalities within the VA for critically important outcomes like mortality.[29] No doubt, there are still discriminatory practices in some or all of these facilities, and we can assume that there are conscious or unconscious biases at work in the minds of some of its clinicians, as there are elsewhere. Indeed, other studies clearly show that, even after the significant reorganization and reform of the VA in the late 1990s, there are still racial disparities in the VA.[30] If we moved to a single-payer system on a national level, such biases would still need to be addressed along the lines Matthew argues. But the point is that a more egalitarian structure of the health care system itself might go even further in reducing them. Indeed, in light of this research, it seems fair to say that health care universalism could be a very powerful tool in combatting ubiquitous racial health inequities. Attaining health care equality, in other words, requires true equality of access. And yet this simple notion is all too often ignored entirely in any discussion of health “disparities.” 5.

Imposing audience costs on the government through grassroots activism is an effective strategy---but it has to grapple with complexity

Ashley **Farmer** 17, historian of African-American women's history, 3-5-2017, "The Black Freedom Struggle, Healthcare Activism, and the Affordable Care Act," AAIHS, <http://www.aaihs.org/the-black-freedom-struggle-healthcare-activism-and-the-affordable-care-act/>

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At a recent press conference President Donald Trump remarked, “nobody knew that healthcare could be so complicated.” This statement was in response to questions about his administration’s efforts to repeal the Affordable Care Act (ACA), also known as “Obamacare,” and replace it with something “better.”

Trump’s statements were met with bewilderment by many, especially black activists who have been grappling with the complex nexus of healthcare and racism for years. In fact, black activists and intellectuals have made healthcare education and activism an integral part of the black freedom movement, developing many creative ways to help engage this complex system and make it more accessible for all people today. Throughout the twentieth century, activists have simultaneously created community-focused grassroots healthcare infrastructures and compelled the federal government to support their health-related work. In the early 1900s, black club women fundraised and staffed black hospitals, such as the Provident Hospital and Nurses’ Training School in Chicago, to help train black healthcare professionals and provide care to neglected black communities. These club women also developed groups, like the Tuskegee Woman’s Club of Alabama, to engage in grassroots health education initiatives. Through these and other endeavors black women filled the gaps in healthcare access and education in their local communities. Pamphlet from Negro Health Week. Photo: National Archives. Black club women’s private endeavors became public with the help of HBCUs like the Tuskegee Institute. Following Booker T. Washington’s lead, Tuskegee’s staff built on black women’s infrastructure to develop “Negro Health Week,” aimed at amplifying public health education and challenging segregated healthcare facilities. This programming eventually spread. Black nurses, doctors, and uplift clubs developed community programming to support these initiatives. Leaders of this movement—including Washington and sociologist Monroe Work—eventually lobbied the government for support. In 1921, the Surgeon General agreed to offer government facilities and funding. Although limited in scope, federal support for “Negro Health Week” reflected a direct instance in which the government-backed black healthcare education and access. By the 1940s, black activists and intellectuals had pushed the government to establish the “Office of Negro Health Work” as part of President Franklin D. Roosevelt’s New Deal programs. Black healthcare activists had argued for decades that the government should be accountable to the black communities that they decimated in the past. In establishing this office, the government acknowledged that it had a role to play in supporting black health education and that it could finance black healthcare workers’ existing grassroots efforts. The office employed black doctors to expand the programs started by “Negro Health Week” activists. With the help of healthcare leaders like Dr. Roscoe Brown, the office broadened community campaigns aimed at improving communal living conditions, educating black communities about diseases and care, and “practical work” like check-ups and vaccines. Black Panther member attends to a young girl. Photo: Stephen Shames/Polaris. By the 1960s, grassroots activist groups had effectively pressured the government to fund community health centers in rural and underserved areas.

During the 1964 Freedom Summer, the Medical Committee for Human Rights (MCHR) partnered with civil rights organizations in order to bring medical care to workers. A collection of black and white doctors, nurses, dentists, psychologists and social workers volunteered their services. The MCHR acted as a sort of medical wing of the Civil Rights Movement. By 1965, members had expanded programming, assisting local community health associations in establishing a series of rural health centers in Mississippi. The MCHR’s physician-activists lobbied the government, eventually securing Office of Economic Opportunity (OEO) funding to establish a set of health clinics in disadvantaged communities. A direct outgrowth of the Civil Rights Movement, these free clinics used government aid to provide healthcare to disadvantaged communities in cities like Boston, Denver, and Chicago. Perhaps the most notable example of black activists’ contributions to national conversations about healthcare access and activism was the work of the Black Panther Party. The Panthers created free clinics across the country to supply black communities with basic healthcare needs. At the George Jackson Free Health Clinic, for example, black community members could get basic check-ups and medications as well as learn about the interrelationship between racism and the lack of access to medical care. Poster for free health clinic held by the Black Panther Party. Photo: Black Panther Party Survival Programs. The Panthers also influenced national healthcare policy. In the early 1970s, the group launched a Sickle Cell Anemia initiative, which led to increasing national awareness and ultimately millions of dollars to study and treat [Sickle Cell Anemia] the disease. Their initiative had “two interdependent emphases”: health education and genetic testing. Members engaged in an ambitious campaign to educate the black community on sickle cell anemia and increase testing for the disease, connecting it to larger discourses of black suffering and state-sponsored racism. The Party was integral to raising awareness about sickle cell in black communities. As Alondra Nelson notes, it also “likely influenced the Nixon administration’s decision to allocate significant federal resources for research on the disease.” Despite the

president's sudden epiphany, many have understood that healthcare is complex, particularly black activists and intellectuals who have continued to advocate healthcare as a basic human right. The administration is correct in stating that there are legitimate issues with the ACA and its implementation. However, the ACA has also reduced the uninsured rate and improved access, particularly among African-Americans. It seems, then, that part of the administration's concerns are based on the fact that the law was passed by a black president and disproportionately helps black and brown communities, not "government overreach" or "one-size-fits-all spending." As we continue to mobilize against authoritarian and anti-democratic practices, we must also view healthcare activism as part and parcel of our emancipatory visions. We must also make it clear that a significant part of its complexity lies in overcoming the discriminatory frameworks that undergird our current healthcare system, not in the idea of healthcare as a right itself.

Translating details into policy meets the demand for incisive scholarship about single payer proposals in political spaces

Matthew Yglesias 17, American blogger and journalist who writes about economics and politics from a liberal/progressive perspective. Yglesias has written columns and articles for publications such as The American Prospect, The Atlantic, and Slate, 8-29-2017, "It's time for Democrats' wonk class to write some single-payer plans," Vox, <https://www.vox.com/policy-and-politics/2017/8/29/16196608/wonks-single-payer>

Most of the people I know who work on health policy on a practical level don't think the idea of a big political push to enact a Medicare-for-all plan makes a lot of sense. But the push is already underway, whether the wonks like it or not. Medicare-for-all bills have come close to passing in both New York and California, Bernie Sanders's national political organization is firmly behind the idea, and giving some form of verbal endorsement to the notion is becoming a litmus test of character for huge swaths of grassroots activists. But the plans that are out there tend to suffer from grave design flaws that make it extraordinarily unlikely they'll ever be enacted. The authors and sponsors of the existing single-payer bills ought to try harder to address their flaws, but it's also legitimately difficult for them to do the work without the support of the kinds of institutions that would normally craft proposals. Yet at the same time, technocrats fundamentally can't steer the course of a political movement. Some group of well-informed progressive health care wonks who work at one of Washington's several well-known Democratic Party-aligned think tanks ought to sit down and write out the details of a single-payer health care plan that they think make sense. Their reluctance to do this work as of two or three years ago — when single-payer health care was considered laughably implausible — was entirely understandable, but in the wake of the 2016 election outcome and the apparent failure of the Republican Party's drive to repeal the Affordable Care Act, it's [has] become counterproductive and dysfunctional. If progressive activists want to make a push for single-payer health care, then a push is going to be made. If competent technocrats don't help, then the push will end up being for something unworkable and will likely end in tears. It's time for Democratic health wonks to stop refighting old wars and start working on the health care system of the future.

The dance of political feasibility The basic paradox of the intra-Democrat war on health care policy is that very few people are willing to say clearly that the single-payer proponents are wrong. Instead, Barack Obama's 2009 observation that "if I were starting a system from scratch, then I think that the idea of moving toward a single-payer system could very well make sense" is a much more common thought. In a 2014 press conference, Nancy Pelosi — who really did spend all of 2009 and much of 2010 fighting for the inclusion of a public option in the Affordable Care Act — said that on some level she "wanted single-payer," but that she's very proud of the ACA as passed, imperfect though it may be. Kathleen Sebelius, former governor of Kansas and secretary of health and human services in Obama's first term, probably put the mainstream Democratic thesis most clearly in a July podcast produced by the Center for American Progress. She said that if you were to "wipe the slate clean and come up with a different American system for health care, you would never put together health care based on people's employment." The current system, "where if you turn 65 you have insurance, if you're below a certain poverty level or in a certain category you have insurance, if you work for the right company you have insurance, but otherwise you're out on your own," she said, fundamentally does not make sense. But she thinks it would be unnecessarily disruptive to try to overhaul tens of millions of people's existing health insurance, and the priority, instead, should be to focus on the fact that "we need to get everyone in" and keep expanding coverage until we achieve true universality. These are completely reasonable kinds of concerns to have. But on other issues, considerations of political feasibility aren't considered a halting point for policy discussion. The CAP plan for universal access to affordable, high-quality pre-K was not feasible for the foreseeable future when it was published in 2015. Nor was the Economic Policy Institute's 11-point plan to build a high-wage economy when they published it last December. Len Burman of the Urban Institute recently sketched out a plan to create a massive new system of wage subsidies financed by a 15 percent consumption tax. That's obviously not politically feasible either. But wonks try to develop these ideas anyway, in part because publishing and discussing them can itself shape the landscape of feasibility and in part simply because it's good to have ideas on the shelf if conditions change. Right now there's a risk that if future events do dump a cartload of

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political power in progressives' lap, it'll largely go wasted due to a paucity of workable plans. Just look at the single-payer debate in California. California's single-payer push is a cautionary tale. The Golden State has long been a Democratic Party stronghold, but the Trump-induced shake-up of the electoral landscape has left it bluer than ever before. California is also big — with a population significantly larger than that of all five Nordic countries combined — and it's richer than the average American state. Consequently, it's a very reasonable place to try to field test ambitious progressive ideas that might later go national, and it naturally became the target for a single-payer organizing effort led by the National Nurses Union — one of the few interest groups that backed Bernie Sanders in the 2016 primary. But while the idea of a single-payer health care system for California makes sense, the specific legislation that the California Medicare-for-all movement got behind was strange in a number of ways. For starters, the basic challenge for any plan to move people off private health insurance and onto a Medicare-like system is you're going to need a big tax increase to pay for it. The California legislative framework would have substantially exacerbated that difficulty by proposing a program that's actually much more expensive than Medicare, because unlike Medicare there would be "no co-pays or deductibles," but the expansive coverage package would offer everything from vision services to nursing home care — all with no premiums. Also unlike Medicare (but like Canadian health care), California's Medicare-for-all bill would essentially ban private health insurance. Then, having set up the need for a very large tax increase to pay for a very generous program, the California bill didn't specify what kind of taxes should be raised. There's no doubt that the state could, economically speaking, afford higher taxes and a more expansive welfare state (households and companies would, after all, save money by not needing to pay for health care), but the design of the taxes is a big, important question that the bill just punted on. Last but by no means least, as the Intercept's David Dayen has explained in some detail, the whole thing was unworkable. The California Constitution requires that half of the state's budget go to fund K-12 schools and community college. Shifting a huge amount of health care spending from the private sector onto the state budget would thus require a gigantic boost in education spending, which would require its own tax hikes. This, like the design of the taxes needed to finance the health care system, is a solvable problem (you'd need a ballot initiative to amend the constitution), but to achieve the goal, someone would have to actually solve it. The upshot of this was that organizing work, rather than leading to progress toward a single-payer system, led to a game of political hot potato. Most California Democrats didn't want to tell activists "no" even though the shell bill was unworkable, so it was eventually killed by the speaker of the state assembly, who now has to play the role of bad guy. Meanwhile, a broadly similar process is playing out on Capitol Hill, where a John Conyers single-payer bill is gaining momentum even though many of its co-sponsors don't actually think it's a good idea. Democrats are signing on to a bill they don't support Among House Democrats, the big way to signal true progressive commitment in the year 2017 has been to sign on as a co-sponsor of John Conyers's HR 646 — the Expanded & Improved Medicare for All Act. This is a bill that Conyers has had kicking around for years, always intended as more of an aspirational statement than a real piece of legislation. But it's gained new momentum in the wake of Bernie Sanders's primary campaign, and now fully 60 percent of the House Democratic caucus has signed on as co-sponsors. Sanders himself is expected to introduce a broadly similar bill next month, and the odds are that House challengers seeking the support of the grassroots left will face pressure to endorse it too. Yet like the California bill, the Conyers plan is very expensive and dramatic — it would eliminate Medicare's existing cost-sharing provisions, extend the program to everyone immediately, and cancel basically all private insurance — without really specifying how it's to be paid for. Members of Congress who've signed on as co-sponsors for this bill, it turns out, don't actually expect that to happen or think it would be a good idea. "The goal is to move forward with ways to strengthen it and get more people covered and look at a public option and extend Medicare to more people" says Rep. Jared Polis of Colorado, by way of explaining that he doesn't actually envision the Conyers bill he's co-sponsored becoming law. "That's where this bill goes and it's part of a discussion." Arizona Rep. Ruben Gallego thinks the legislation he's co-sponsored is an excessively disruptive way to achieve its goal. Single-payer, he says, "is something you phase in. I have different ideas for how to do it, though it's not in the Conyers bill — you could start with Medicare phase-in, dropping the enrollment age to 55 and then covering everyone up to 18 just for the first couple years." Over time, "you keep moving inward and inward until you get to a happy medium." Vermont Rep. Pete Welch says the Conyers bill "is more of an aspiration," and says that since Medicare "works and it's more popular" than private insurance, it makes sense to move everybody onto it as a goal. But "the challenge is the transition." Indeed, that's a big problem. And it's one that health and tax policy wonks ought to be working on in partnership with politicians who support the goal. Instead, politicians who support the goal are plowing ahead with legislation that even they don't really support —

setting up unnecessary intraparty fights and not really laying the groundwork for policy success. The transition problems aren't just politics The difficulties of

transitioning a couple hundred million people off their current health insurance and onto a new federally run system, it's worth saying, aren't just problems of political feasibility.

The tax issue, for example, is a critical substantive lacuna in the major health care bills. There's no serious doubt that America could afford a heavier tax burden to finance a publicly provided health care system. But the design of that tax burden still makes a big difference. If you finance the system mostly with a value-added tax like many European countries do, for example, then senior citizens who already get Medicare will end up paying higher taxes in exchange for a program that doesn't help them. But if you finance the system mostly with higher payroll taxes (how Social Security and Medicare work), you are creating a pretty strong new disincentive to work, since everyone would get the benefit whether or not they pay for it. These aren't insuperable obstacles any more than the California

Constitution is. But the policy work would have to be done, followed by the difficult job of selling the plan to politicians and stakeholders. There are also some real questions about the transition. Right now I, like most Americans, get my health insurance mainly through my job. If that insurance were to be replaced by a new tax-financed system, the result would be a financial windfall for my employer. In a standard economic model, the long-term consequence of that windfall is higher cash wages for employees, which offset the new taxes. But there's no economic model at all that suggests the higher wage bill will be paid out evenly to each current employee. If Vox Media's health care costs fall drastically, I might be able to bargain for a raise for myself. But someone else with more bargaining power might get it instead. Or the money could be spent on increasing the pace of hiring. There are particular questions here about the fate of union workers whose pay and benefits are set by multi-year collective bargaining agreements and public sector workers whose pay is set by law. The jobs and livelihoods of people who currently work for insurance companies or in medical billing are also not an entirely trivial concern. And the interaction of the new health care system with existing programs like the Veterans Administration also needs to be thought through. All of this is potentially doable, but very little of it has actually been done. Send in the wonks

Sanders's 2016 campaign started as, essentially, a protest movement that didn't particularly seek expert

policy advice in crafting its proposals and certainly didn't receive it, given fear of retaliation by presumed victor Hillary Clinton against anyone who worked for

her opponent. The result was, among other things, a health care plan that was fairly sketchy and technically unsound

and was criticized as such by people like me. That, in turn, prompted counterattacks on the entire

concept of sweating the details of policy and the ensuing standoff has largely defined left-of-center

politics ever since. Paul Krugman writes that the political logic that counseled against a single-payer approach in 2009 still applies, while Jacobin articles explain that even failed state-level campaigns help build organizing capacity for socialism. To the extent that people want to endlessly refight the 2016 primary, this is all fair enough, and there's plenty of grist for the mill. But there is something perverse about politicians signing on as co-sponsors of legislation whose provisions they don't actually support. And there's something doubly

perverse about policy experts refusing to engage with an idea that actual elected officials want to

embrace on the grounds of political inexpediency. The politics, at the end of the day, is the politicians' job. What

they need are some concrete policy options that would let them begin to seriously weigh the pros and

cons of different possible approaches. How much revenue would be needed, and what taxes could raise it? Can disruption be usefully minimized by phasing in

the new program over time? Can both disruption and tax increases be minimized by structuring payments as "premiums" or something that employers "buy in" to? What happens to private insurers' participation in selling of Medicare Advantage and Medigap insurance plans? How can we help ensure that the money employers save actually does pass through to workers as

wages? These are the kinds of details that voters don't really care about right up until something is about

to become law. But if you want to pass a law, you need to address them. And as the ultimate collapse of

Republicans' ACA repeal efforts shows, it's not good enough to simply assume that good solutions will

emerge in the future. Nothing at all is politically feasible from a progressive point of view right now. But

in truth, nobody knows what 2019 or 2021 will hold or **what avenues for action may open up** in state government. Right now, though, the left wing of the Democratic Party has a **big idea on health care but no plan. It's time for the wonks to step up.**

AND provides the tools for grassroots to pressure policymakers into credible commitments---promises absent detail are posturing

Jim Newell 17, Slate Staff Writer, 9-13-2017, "Advice for Democrats on Single-Payer: Don't Lie About It," Slate Magazine,

http://www.slate.com/articles/news_and_politics/politics/2017/09/advice_for_democrats_on_single_payer_don_t_lie_about_it.html

On Wednesday, Vermont Sen. Bernie Sanders introduced the **Medicare For All Act** of 2017, his long-awaited single-payer health care proposal that (as of this writing) has earned 16 Democratic co-sponsors. That's a 16-senator improvement on the last single-payer bill he introduced in the Senate. It's not just fellow lefties, like Oregon Sen. Jeff Merkley and Massachusetts Sen. Elizabeth Warren, supporting the Sanders plan. The bill has also earned the co-sponsorship of more typically cautious Democrats like New York Sen. Kirsten Gillibrand and New Jersey Sen. Cory Booker, as well as one senator, Wisconsin's

Tammy Baldwin, who's up for re-election in a state Donald Trump won. **It has become difficult for any Democratic senator considering a 2020 presidential bid not to co-sponsor Sanders' bill, a sign that support for single-payer will be the default position. But how committed will that support be?** Single-payer supporters shouldn't just take these supposed believers in government-sponsored health care at their word. **Until they answer the difficult questions** the Medicare for All Act of 2017 evades—**omissions that were made specifically to earn** their **buy-ins**—**their support should be treated as posturing and not a true commitment** to push for single-payer if and when they have the chance. The politicians latching onto single-payer to **score points** with the Democrats' progressive base **don't owe those answers to Washington's** scolding **policy wonk class**. They owe a **full litigation** of the **process to single-payer's supporters**, who deserve to know that their representatives aren't making them promises they're **not willing to keep**. The Medicare for All Act is built on a compromise that works well in the short-term for both Sanders and his co-sponsors: **the decision not to include financing details** within the bill itself and instead offer a separate white paper with some financing options to "begin that discussion." **By separating out the spending, Sanders makes co-sponsorship an all-gain, no-pain decision.** As Vox's Jeff Stein explains, structuring the bill this way "will make it easier for Senate Democrats to co-sponsor the legislation and win over Sanders's supporters, but also not co-sign their names to legislation calling for billions in new personal income taxes." The push for single-payer is a long project, and Sanders and his co-sponsors don't need to commit to a financing model now.

"We'd rather give the American people options," Sanders said in an interview with the Washington Post. "The truth is, embarrassingly, that **on this enormously important issue, there has not been the kind of research and study that we need**." Further study is a reasonable enough excuse for the moment, since it's not like this bill is going anywhere in Paul Ryan and Mitch McConnell's Congress. And there's value, in terms of expanding the Overton window, in showing that an idea once relegated to America's leftist fringe now has mainstream party buy-in. But **the process gets much harder from here, and it takes more than a chummy press conference** for these members to show they're serious. Introducing single-payer—which would eliminate most existing insurance arrangements in a country where two-thirds of people are satisfied with their coverage—is always going to be the steepest of steep political tasks. The only way I'm certain it will never, ever happen, though, is if the politicians who promise they'll support it don't reckon with the difficult challenges that single-payer presents until the moment they're forced to. I spent the first half of this year writing about what happens when a party rides the wave of a promise it's made to its base without bothering to address the trade-offs required to keep that promise. By ignoring those questions during the many years when they didn't control every lever of government, Republicans ensured that the country would learn at the last possible moment that repealing Obamacare might make some stuff Americans care about a whole lot worse. Politicians got scared, the bill died, and Republicans lost whatever credibility they ever had on health care. There is a lesson here. That lesson is: Don't do that. I have never not supported single-payer. Though it is striking, and welcome, to hear more than one-third of the Senate Democratic caucus lay out a case for why for-profit insurance needs to go, that alone is not commitment. **Commitment means educating the public** on the whole product, including the specific levels of tax increase that will be necessary, **and explaining why they're worth it**. It means telling voters directly that their taxes will go up, and not by a small amount—but by less than they had been paying in annual premiums. **This means having the courage to risk collapsing single-payer's polling support** and only then determining whether it's a product worth pushing for legislatively. **Anything else is opportunism** and a guarantee that whoever wins the Democratic nomination in 2020 will **stop talking about single-payer** the

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moment he or she emerges from the primaries. Cory Booker, Kamala Harris, Elizabeth Warren, Bernie Sanders, and Kirsten Gillibrand don't need to commit to a funding model now, or even next year. But they do need to make a commitment well before they have unified Democratic control of government and have to make good on a promise to the base. They need to tell people who are satisfied with their employer coverage that they will no longer have that coverage, and convince them that what they'll get from a government-sponsored system will be better. They need to show, in short, that they're not duping single-payer supporters to get their votes—that they care about single-payer health care as a government program they're serious about implementing, and not just as a talking point.

AND spills over to future political gains by building organizing capacity

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In Bernie Sanders's wake, the socialist left has experienced a historic resurgence. The Democratic Socialists of America (DSA), which now counts over 25,000 members, is the largest socialist group in the United States since Students for a Democratic Society in the late 1960s. The challenge now is to hone its political vision and build a durable and democratic organizations that can affect real change. A focus on winning single-payer health care can help us do that. The growing demand for single payer rankles establishment Democrats, who insist that the Affordable Care Act — with its labyrinthine subsidies program meant to provide coverage without undermining the private insurance industry — is the best deal on offer, and to demand anything more is pie-in-the-sky and politically counterproductive. But with Obamacare given reprieve for the moment (albeit unsafe from future attacks), and our still-broken health care system on everyone's mind, socialists have an opportunity to organize ordinary people toward a better common goal: genuine universal coverage, managed and dispersed by democratic, transparent, and efficient institutions that are accountable to us, not corporate shareholders. California has the unique potential to become the first state to pass single payer. A grassroots movement for the cause, spearheaded by the California Nurses Association, goes back decades. This movement twice passed single-payer bills through both houses of the state legislature in the 2000s, but both were vetoed by then-Governor Arnold Schwarzenegger. Out of this legacy of popular action, 70 percent of California voters now support single payer in polls. To appeal to that active grassroots and public support, California Democrats have made single payer an official plank of their party platform. Democrats hold the Governor's seat and an exact two-thirds supermajority in both houses of the legislature, so the time has come to deliver on promises. We are two organizers with the East Bay chapter of DSA, which has made a strategic decision to focus on a single campaign: organizing around single-payer health care legislation, SB562, in California. The lessons from our campaign aren't universal (no one's are), but in explaining the strategic thinking behind our mass canvassing program and sharing the lessons we've learned from implementing it, we want to show how a focus on Medicare for All can increase socialist organizations' organizing capacity and build working-class power for long-term struggle. Zeroing in on Single Payer In recent months, socialists — many of them newcomers to the movement — have flocked to DSA, seeking opportunities to continue pushing for left political-economic reforms after the Sanders campaign. Both the national DSA organization and local chapters have begun a program of political education to introduce these members to socialist history, theory, and strategy — some for the first time in their lives. The East Bay chapter has been no exception: over five hundred people joined after Trump's election. At East Bay DSA's chapter elections in January — our first following the membership explosion — many candidates running for a leadership role pledged to focus our organizing on the California single-payer effort. The members who won election were nearly unanimous in their interest in pursuing this campaign. Based on that mandate, the leadership voted to officially join the campaign for Healthy California in February and started canvassing almost immediately. Two generations of our elected leadership have now committed to single payer as the core focus for our organizing work. Importantly, this hasn't prevented ongoing chapter actions on other issues: our direct action committee helped blockade an ICE office and held the line to protect an elderly renter from eviction; we were at the airport protests, the Women's Strike, and May Day; we have a housing caucus, a prison abolition caucus, and a socialist feminist caucus. But we've found that focusing the bulk of our organizing effort on single payer comes with major benefits: we concentrate and replicate our capacity for training members, we stress-test our organizing against the clear benchmarks of a single campaign, and we build internal unity and transparency by working together on a common cause. The singular focus helps convey to our coalition partners and members alike that we're in this for the long haul, and we're in it to win. As a result of our recent growth in both size and legitimacy, coalition partners have asked to table with us at events for increased visibility, and local candidates have sought our endorsement. East Bay DSA's commitment to campaigning for SB562 is a tactic in service of a larger strategy to build good internal structures in our burgeoning group and effective

organizing skills among a new generation of grassroots leftist activists. We also seek to strengthen ties between socialists and the labor movement — in this case the women-led and substantially non-white nurses' union — and win reforms that will strengthen the power of the working class. The Ground Game Our focus on winning single payer has driven the evolution of our organizing process. Our canvassing strategy began with a focus on large canvasses that gathered members from across our entire chapter as well as non-members interested in joining in. Before these canvasses, a select team of canvass captains received training from the union and community organizers in the chapter. On the day of the large canvasses, these captains trained and facilitated practice sessions for teams of about a dozen people each. To date, five hundred people have received training from team captains, then pounded the pavement together to knock on doors. In a frightening national political moment, door-to-door organizing has been heartening for many members, showing us we're not as alone as we think. One of our members, who originally described herself as shy, remarked that her canvassing experiences with our chapter had convinced her there are only two kinds of people in the Bay Area: socialists, and people who aren't home. Across all of our canvassing, we've focused on empowering neighbors to see their experiences with medical fees and debt in terms of class conflict, explained the mechanics and upsides of single payer, and gathered thousands of pledges to support DSA and our coalition partners in the fight for public universal coverage. In the process, our organizers have also developed as leaders. In a testament to the skill- and commitment-building potential of this tactic, about half of the chapter's newly elected Local Council started out as single-payer canvassers. The large, chapter-wide canvasses provided a good way to kick start training across our membership but weren't well suited to build steady teams of organizers consistently working the same neighborhoods. To address this issue, our organizing tactic has shifted since May to focus on district canvasses, where our members develop dedicated teams for their own neighborhoods. The point is for socialist organizers to talk to their own neighbors and build lasting political relationships. We live in an atomized, alienating society where most of us don't know our neighbors' names, and don't see any reason to learn them. These district canvasses break our own members out of their isolation, while simultaneously building stronger community ties between our organization and existing neighborhood networks. In early July, one of our canvassers, after a particularly successful round of door-knocking, was invited to speak at a block party. The person then found themselves literally organizing their neighborhood. Another district canvasser was invited to give a talk for a second block party just last week. A third stage in the evolution of our organizing is just beginning. Our canvassing program has done well at training our members for the initial conversations with neighbors, but we've found we need more structure and shared skills for follow-up to keep our neighbors consistently involved. As our chapter grows, the most involved members have largely had their workload expand just as fast; this has made it clear that helping members develop into leaders needs to become a central part of our organizing system. To clarify who should take on our member development efforts, we passed new bylaws in April which created distinct positions (both elected and appointed) for internal organizers and external organizers. The internal organizers, who were elected in June, are now focused on developing a member steward system based on the model used in many unions and the New York City and Philadelphia DSA chapters. This will build a trained network of stewards among our membership, with each responsible for supporting and catalyzing a set of less-active members and interested neighbors to become regular participants. Strong local relationships like these are invaluable to socialist organizers and can be tapped in future campaigns for fights around housing justice or workers' rights. Democratic elites have all but abandoned field organizing, especially in down-ballot races, in favor of exorbitant, consultant-led media strategies. In many places, by training even a few dozen regular canvassers through the single-payer cause, socialists can quickly develop one of the strongest ground games in town. By building ongoing relationships with our neighbors, this emphasis on field organizing will put us in a position to be helpful, in-demand allies for local unions and other Left campaigns, and lay the foundation for real impacts on electoral politics. And while we should only organize for what we are committed to winning, we should also organize so that, whether we win or lose one round in a fight, we are building the skills and relationships for power in the long term. The focused campaign gives us an opportunity to troubleshoot our organizational structure and its challenges, which makes our chapter increasingly resilient, responsive, and effective, and will serve us well beyond the fight for single payer. Already, our work has rippled outward; we've shared our training guides, canvassing scripts, and leave-behind literature to be put to use in chapters across California and as far afield as Ohio. Advancing the Program The advantages for our organization are only part of the equation.

Any unifying campaign will be beneficial to an organization finding its footing, but single payer is a strategic central focus. In fighting for it, we can build solidarity across lines of difference and continue to build power for the working class. Everybody needs health care. Nearly everybody in the working class has been hurt by private insurance greed, or has seen a friend or family member denied care so that a rich few can profit.

When we organize in the East Bay, we share our own personal stories and ask our neighbors about what they could personally gain from single payer. We work to show how our direct self-interest intersects with that of all working people: we can only win single payer for ourselves if we win it for each other. Political education that fosters this sense of shared self-interest — rather than charity for a distant other — is the foundation of a sense of solidarity built to last. The fight for single payer is an urgent anti-racist struggle. Currently in the United States, the uninsured rate is 60 percent higher for black people than for white people. The Movement for Black Lives platform demands a universal, guaranteed health care system, with particular focus on equitable access for currently excluded communities of color. In committing to the fight for single payer, socialists can take up that call to action. Meanwhile, across the US, Latinos have an uninsured rate 300 percent higher than white people. Undocumented immigrants — and many documented ones — are not covered by Medicare, nearly all Medicaid programs, and many subsidized private plans. This cruel exclusion is despite the fact that immigrants pay into the public system through taxes, and worse, is in spite of the fact that they are members of our communities who need care like everybody else. By providing coverage to all state residents regardless of documentation status, California and New York's single-

payer bills not only directly help millions, but could point a socialist path out of the current dead end around immigration politics in the US and Europe. Over the past decade, most parties of the center and many on the left have shifted towards far-right positions on refugees and migrants as a supposedly necessary concession to white-working-class xenophobia. This is morally and strategically wrong. When socialists win truly universal social programs that cover migrants, we can demonstrate that social care is not a zero-sum game. Instead, building social systems for everyone who lives here makes for stronger public institutions and a healthier society for all. If we are to push further towards building a powerful multiracial working-class movement, then a proud politics of inclusion for immigrants is not only right — it's essential.

Single payer is also a critical feminist fight. Public health coverage for all would be transformational to a society in which most unpaid and underpaid care work falls to women. When people can't get the care they need, someone is usually compelled to pick up the slack — and, especially in the realm of home care for family members, those people are disproportionately women. ("The best long-term care insurance in our country," concluded a recent study about home care for older adults, "is a conscientious daughter.") Women are more likely to receive health insurance as dependents, which means that losing a spouse through death or divorce puts them at greater risk for being uninsured. Single mothers are nearly twice as likely to be uninsured as mothers in two-parent households. Meanwhile, women who are insured also suffer disproportionately from confusing and predatory private insurance industry practices. Care costs more for women, is harder to obtain, and employers can refuse to cover contraception on religious grounds, meaning a woman's reproductive health is in many cases dependent on the conditions of her employment. California's Medicaid program covers abortion, contraception, and prenatal care. To universalize that comprehensive and inclusive care is an urgent and crucial feminist reform. The California Nurses Association, which is leading the charge on the state single-payer effort, has eighty thousand members across both unionized and non-unionized workplaces in the state. These workers are overwhelmingly women, and about half are people of color. Women fill nearly all of the top leadership roles at CNA. Who better to lead the fight to bring care into the public sphere than women care workers, who disproportionately shoulder the burden of undervalued care? Organizing in close alliance with care workers is an essential way we can put our principles into practice and expand socialist-feminist understanding within our ranks. Working with organized nurses is also strategic for building solidarity between socialists, the labor movement, and the broad working class. CNA has led the drafting of legislation and steered the inside game while coordinating and supporting grassroots allies across the state. Nurses at the helm makes this not just a "consumer movement," made up of health-care users, but a workers' movement. The nurse-led campaign sets up a clear dynamic of workers, both inside and outside the industry, against our common adversaries at the very top: health insurance executives, shareholders, and the 1 percent. Over the last half-century, the relationship between socialists and the labor movement has grown tenuous, as both groups have been diminished and devitalized by state repression and capitalist advancement. As socialists, we know that acting in concert with organized labor is fundamental, and that it's necessary to rebuild our role, both as socialist organizers and workers ourselves, in the labor movement. **By uniting with nurses against CEOs, we're committing to working-class solidarity in practice, not just in theory.**

Socialists must continue to build our own independent organizations steered by the democratic power of our members, but the nurses are a strategic ally to learn from and fight alongside in this moment. Finally, single payer would win power for the working class like no other reform popularly on the table in the US today. When socialists consider fighting for a reform, we should ask if it builds working-class power towards future struggles. Some left organizers and scholars call this "building the crisis": by winning reforms that strengthen the material conditions and class consciousness of working people, we advance the fight for more radical victories. Many union workers, who have seen spiraling private health insurance costs undermine their position for wage and benefit increases, have rallied behind single payer as a bulwark for future battles with management. For non-union workers, too, single payer would strengthen both their actual health and their bargaining position for raises and other benefits. A push for single payer, in this political moment, is uniquely able to draw clear lines of class conflict: it's capitalists versus all of us who work. Single payer is already a concession on the part of socialists. We want fully socialized medicine, which would function on the same principles but extend to hospitals and doctors themselves, and which already exists in many nations. We envision single payer as a first step in a long struggle to implement full universal social programs. We see it as a non-reformist reform: that is, a structural modification of power relations that elevates the ability of working-class people to fight against capital while radically shifting the window of political possibility. We're interested in using SB562 as a political education opportunity for our membership and neighbors, and publicly advancing the idea that universal social programs are better than means-tested ones. According to the neoliberal logic of means-testing, some people need public assistance to attain things like health insurance, but only those in the direst of straits. Socialists, on the other hand, believe in the decommodification of essential goods and services for all, for both moral and politically strategic reasons. Universal programs are essential to eliminating wealth inequality. They decrease disparities in the here and now, creating a stronger working class that is less fearful and insecure, and therefore less easily exploited by capital. They also build powerful new

constituencies dedicated to defending public goods against privatization. In this way, universal programs can function as “**engines of solidarity.**” To make health insurance universally guaranteed and public is to both assert that

coverage is a right, and to build a stronger body politic that can mobilize to protect that right. In our discussions at peoples’ doors, we hear our neighbors’ indignation that the wealthy are able to receive medical care when necessary without fear of ruinous financial consequences, while everybody else is faced with hard choices about whether to go into massive amounts of debt to seek necessary treatment. In those conversations, we hear the raw material for a mass oppositional class politics. That’s why we ask for commitments from those people to join the campaign, instead of just signing a petition or donating once. For example, behind one door was a twenty-six year old with a bandage wrapped around his hand. He had just lost his job, where he was paid poorly to work with dogs, one of which had bitten him badly. He was a few months too old to be listed as a dependent, and suddenly found himself uninsured. He talked to our neighborhood canvassers for twenty minutes. At the next neighborhood canvass there he was, DSA clipboard in his healing hand, knocking on doors with the rest of us. California’s Single-Payer Melee Pressured by a growing movement and a single-payer bill that has passed the State Senate, elite Democrats have been forced to show their true loyalties. In late June, Assembly Speaker Anthony Rendon froze the bill in committee, halting any formal legislative progress in his chamber until next year. We knew this opposition was coming. Contrary to recent allegations of unpreparedness and deception, from the start of the campaign, CNA leaders have been clear on statewide conference calls with coalition

activists that we are building strength for a multiple-year effort — which could require a ballot campaign as a costly last resort. That’s only necessary if the legislature can’t be pushed to deliver single payer past the state’s tax and spending constraints. The coalition’s current effort to turn up pressure on Rendon and other resistant Democrats is essential to build that necessary legislative will. At doorsteps, DSA organizers have been talking with our neighbors about what it will take to win this protracted and difficult fight. After fifty years of conservatives and centrists passing severe restrictions on taxes and spending, California’s political playing field is badly rigged. That’s why our victory requires building a powerful movement off that field. Democratic elites — steered by donors from real estate, insurance, dirty energy, and tech, and backed up by the management of huge non-profits and major unions — treat the handcuffs on state power as “sacred doctrine that should never be questioned.” Even if they wanted to overturn suffocating restrictions on the state, Democratic leaders can’t imagine building the popular power needed to do it. If Democrats bury the legislation now, they will be opposing the idea that politics ought to involve imagination, mass effort, and the will to fight uphill battles so that people’s lives might be freer and better. In this context, socialists have a critical role to play in the movement for single payer: unlike the Democrats, we can build broad working-class power while expanding the public imagination of what politics could be. East Bay DSA regards SB562 as an opportunity to build, mobilize, and grow our organizations and movement. While the bill is frozen in committee, we’re going to continue educating, coordinating, and taking full advantage of the swelling interest in both single payer and socialism. In those respects we’re already winning, and no legislative defeat can undo our victories.

But this isn’t a trap, or a trick question meant to expose neoliberal hypocrisy. Single payer is a real policy demand, and we want it to pass. If it does, there will be several subsequent obstacles to actually implementing a functional single-payer health care system in our state. If we proceed to a ballot measure, the health insurance lobby will wage a media war to scare Californians out of it. (Of course, the best way to combat a propaganda campaign that well-funded is to organize and educate people on the ground, grassroots-style — which we’re currently doing.) In the meantime, socialists around the country must start thinking critically about building and wielding organizational power.

Not every socialist group has the opportunity to rally behind state single-payer legislation like we have. But given our national moment of historic upheaval for health care and the broadening popularity of Medicare for All, we think socialists throughout the nation can build alliances and open political imagination by being a loud voice — and given the refusal of the Democratic Party to champion it, perhaps the loudest voice — for single payer in their specific political climate. A nationwide single-payer campaign that embraces a diversity of location-specific tactics can help socialists replicate a skill-building, infrastructure-honing strategy across cities and states. This shouldn’t preclude simultaneous local and regional campaigns on other issues, but we believe a primary nationwide focus on single payer, more than any other issue, will build power for socialists and the working class. East Bay DSA’s campaign for single-payer legislation shows how we can get started.

BUT, pushing back against healthcare inequalities is valuable even absent spillover because it expands the tactical options available to those suffering from structural violence

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Equity in health care cannot be achieved simply by the actions of legislatures, doctors, nurses, and health care organizations. As we saw in chapter 11, one measure of collective efficacy and social cohesion is an activated community ready to organize and act on its own behalf. Such a community can be a powerful tool for health improvement. Communities that are interested in the health of their members and demonstrate this through community participation may be healthier communities in the long run.² A sense of purpose, so critical to personal health, can also be important to improve community health. In the absence of national or statewide policies to address health injustice, health inequity conflicts become local. The battlegrounds in these conflicts are often hospitals, clinics, insurance companies, and government agencies. Not surprisingly, Chicago has been ground zero for a number of churning health controversies. The transplant activism discussed in chapter 8 is one example.³

Environmental activists, stirred by high pediatric asthma mortality in the area, forced the mothballing of coal-fired toxin-spewing power plants in Chicago.⁴ The shuttering of public mental health clinics was accompanied by public outrage, demonstrations, and arrests.⁵ While health care institutions naturally try to avoid public confrontations about policies and practices, at times these skirmishes are unavoidable. Public actions directed against health institutions can be disruptive, but at the same time they foster opportunities for substantive structural improvements. Partnerships between communities and institutions are critical to overcome the structural and social conditions that precipitate premature mortality. While contentious conflicts between disadvantaged communities and powerful institutions can be painful, common cause, when achieved, can improve health.

In this chapter, against a backdrop of neglected and violence-torn neighborhoods, I spotlight a battle between a local black youth group demanding a Level 1 trauma center and the University of Chicago, a bastion of academic prowess.⁶ The fight for a trauma center was linked to citywide activism over the decline of health and the implosion of poor neighborhoods in the wake of the Great Recession. An epidemic of gun violence in Chicago and a rash of highly publicized police brutality cases fueled feelings of disenfranchisement among the youth. Two separate realities fanned the conflict: the business priorities of a successful, internationally renowned university medical center and the moral demands of members of a violence-stricken, poverty-afflicted neighboring black community. The battle zone was Chicago's South Side, but the conflict eventually breached the portals of the White House.⁷ Community Activists Target Health Care The underlying neighborhood conditions on the South and West Sides of Chicago that contributed to disease burden and premature mortality have also spawned a new generation of community activists. The years from 2010 through 2015 saw a flurry of this community activism around the issues of health care delivery, mental health, school closings, and public safety.⁸ Spawned by an epidemic of gun violence and fueled by long-standing mistrust between the communities and institutions like the police, city hall, and health care infrastructure, the activism caught the city by surprise. But these outbursts were more than a series of disconnected events. 162 * CHAPTER TWELVE Rather, they reflected the growing frustration of people living in longneglected neighborhoods. Simmering grievances and injustices needed airing. The residents of these inner-city areas had watched their neighborhoods deteriorate since the middle part of the twentieth century. Despite fair housing laws, blacks are still preferentially steered by realtors to black neighborhoods with overpriced housing and are forced to pay what has been called a "race tax": the increased cost of goods and services from food to insurance to gasoline.⁹ Underserved by banks, these neighborhoods had been targeted by the harsh terms and high interest rates of predatory subprime lenders in the latter part of the twentieth century. Like unscrupulous ghetto contract lenders of the 1950s, subprime lenders strong-armed people into taking on risky debt. These neighborhoods were then pummeled by the mortgage loan crisis that caused the Great Recession in 2008. Foreclosures ravaged poor African American and Latino neighborhoods in particular.¹⁰ In sixteen poor black Chicago neighborhoods, 10 percent of the homes were in foreclosure.¹¹ Boarded-up houses blighted residential neighborhoods, inviting drug dealing and vandalism. The devastation crippled even middle-class neighborhoods. The Bronzeville neighborhood recovered more slowly than other middleclass black neighborhoods in the nation, such as Harlem.¹² Black families, stripped of jobs, homes, cars, retirement accounts, and savings, saw wealth gains of a lifetime wiped out.¹³ By 2011 black median household net worth had nosedived to \$7,133.¹⁴ (By comparison, the average white household's wealth was \$111,146.)¹⁵ Half the collective wealth of African American families was obliterated during the Great Recession.¹⁶ It was an economic calamity of stupendous proportions and perhaps the largest drain on black American wealth ever recorded.¹⁷ But this wealth death spiral failed to gain the attention of a nation as did police shootings of black men in many of the same affected neighborhoods in 2014 and 2015.¹⁸ #BlackLivesMatter and Community Health Activism On Black Friday 2015, thousands of #BlackLivesMatter demonstrators disrupted Christmas shopping on Michigan Avenue in response to a Chicago city hall cover-up of the police murder of teenager Laquan McDonald.¹⁹ McDonald's death was one of many well-publicized police shootings of young black men across the United States that spawned the #BlackLivesMatter movement in 2014.²⁰ McDonald, a troubled seventeen-year-old, was shot sixteen times by a police officer. A police conspiracy to cover up the murder ensued and eventually reached Mayor Rahm Emanuel at city hall. Fourteen months after the murder, an investigative reporter forced the city to release the video of it. It shocked the city and nation.²¹ Police homicide and brutality were not new phenomena. Police have enforced structural violence and the criminalization of black life across America for generations. What was new was video evidence of police brutality and the way it could now travel via viral social media. The invisible was now visible. The crowd of demonstrators included members of a South Side community organization named STOP, Southside Together Organizing for Power, and its youth organization, Fearless Leading by the Youth.²² STOP and FLY led fights for housing equity and access to health care. The connection between the national movement and the local issues 164 * CHAPTER TWELVE could not be any clearer to them. After all, the #BlackLives movement was not just about racist police violence. It was about long-standing structural violence and inequity. Race, Place, and Policing The tension between Chicago's black communities and the police had long simmered. For years Commander John Burge and his squad of detectives had tortured black prisoners into confessions in a South Side police station, yet the city defended him and other abusers in the face of lawsuits.²³ Between 2007 and 2012, Chicago police shot over four hundred people.²⁴ There were seventy police fatalities during that period, the most in the nation. Between 2004 and 2014, the cash-strapped city dished out \$662 million in police brutality settlements.²⁵ Imagine how those funds might have helped failing schools or the health-care safety net. In April 2016, an independent investigative report declared the Chicago Police Department to be systematically racist, an assertion that was no surprise to residents.²⁶ Three-quarters of the police shootings and 72 percent of the use of tasers have been directed at black people.²⁷ "The video that depicted the death of Laquan McDonald motivated a movement, and it was a tipping point, but really again the conversation about the narrative of the intersection of race and policing goes back decades," said Lori Lightfoot, chair of the Police Accountability Taskforce, which released the report.²⁸ Meanwhile, an epidemic of gun violence targeting teenagers and young adults plagued the same Chicago neighborhoods affected by racist policing practices. What the neighborhoods needed was safety. The violence epidemic in these high-poverty neighborhoods was a fivealarm public health emergency. While some teen violence prevention programs, such as Cure Violence, have reduced repeat gun violence by 40 to 71 percent in some neighborhoods, the scope of the crisis is far greater than these programs can handle.²⁹ The root of the violence epidemic is structural violence: the lack of jobs, limited educational opportunities, the loss of wealth, and the loss of hope and purpose in these neighborhoods. Community Activism against Structural Violence * 165 We can best understand the fight for a South Side trauma center in the context of this precipitous neighborhood decline, on top of generations of neighborhood neglect. In 2012 the city's decision to shutter six of twelve long-standing mental health clinics—four of them on the South Side—spawned wide protests and many arrests. County sheriff Tom Dart, who has described his jail as the state's "largest mental health provider," opposed the closings. "This is not higher math," Dart said. "If you reduce programs and remove funding, it isn't as if fairy dust will be spread throughout the clouds and these people's mental health issues will go away. They will still have them, and it's a question of where they will go from there. The majority are coming to the criminal justice system."³⁰ STOP and other groups protested the closings, which the city claimed would save \$3 million yearly.³¹ The need for mental health services in the community was enormous—and growing even as the funding evaporated. This tension between money and need would fuel the trauma debate. From the perspective of neighborhood leaders, the five-year battle for a Level 1 trauma center was not a one-issue battle. They had witnessed the besieging of their neighborhoods by losses of wealth and life, clinic and school closures, and the dimming of their children's prospects. The best efforts of the University of Chicago Hospitals to provide community health to the South Side was no match for the expectations of young black people who had to contend with the ravages of day-to-day violence in their communities. Damian Turner Is Shot A random shooting in 2010 triggered the demand for a South Side trauma center. Fifty-eight Chicagoans were shot that

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August, two fewer than the number of Americans killed in Iraq that entire year.³² Damian Turner was one of them. A stray bullet pierced his 18-year-old chest in a drive-by shooting just four blocks from the University of Chicago Hospital. Wounded and bleeding, he staggered to his sister's nearby apartment and collapsed on her doorstep. She raced to the phone and called 911. The paramedics arrived and transported Damian to North 66 * CHAPTER TWELVE western Memorial Hospital, the closest trauma center, ten miles away. He was pronounced dead an hour after arrival. His family and friends were left wondering whether his life could have been saved had he been taken just a few blocks, to the University of Chicago.³³ "Nobody on this earth deserves to die if they have a chance to live," Turner's mother, Sheila Rush, said to a reporter from *The Nation*. "My son did not even have a chance, because he was fighting for his life on the way in that ambulance on that long ride to the hospital."³⁴ The University of Chicago had closed down its adult trauma unit twenty-five years prior, when it was hemorrhaging \$2 million a year.³⁵ The university maintained a pediatric trauma center but admitted teenage trauma victims only up to the age of 15. Located in the middle-class Hyde Park neighborhood, the hospital is flanked by black neighborhoods where gun violence is rampant. Mistrust between the university and the black South Side had festered for seventy-five years because the community interpreted the university's urban development practices as a tool to blunt black intrusion into Hyde Park. In the 1930s, a Metropolitan Chicago Housing and Planning Council (MHP) composed of white real estate and banking interests was formed to address "urban blight" just as blacks were flowing into the city's neighborhoods. The council steered into law the Illinois Blighted Areas Redevelopment Act, which pioneered the concept of "urban renewal." The law created and empowered a Land Clearance Commission to use eminent domain to acquire land in "blighted" areas, demolish the existing buildings, then sell the land at steep discounts to private investors. Urban blight became a code phrase to justify the dismantling of black neighborhoods that encroached on white neighborhoods and business districts. Black neighborhoods were thus disproportionately targeted for redevelopment. The city council doubled down on this scheme by passing legislation to keep public housing that was open to black people from being located in white neighborhoods. These laws inspired federal urban-renewal legislation that replicated the Chicago plan across the United States, but also provided funding for black neighborhood destruction. Black people displaced by urban renewal and blocked from white wards were forced to take refuge in dense, overcrowded black neighborhoods. One neighborhood that attracted Community Activism against Structural Violence * 167 new black apartment dwellers and homeowners in the 1940s was Hyde Park.³⁶ In the late 1940s, University of Chicago officials feared that they might lose their student base if the neighborhood became black. Working with the MHP, they engineered a piece of state (and eventually federal) housing legislation that allowed neighborhoods that were not yet "blighted" to be razed by targeting what were euphemistically called "pockets of decay"—in other words, black neighborhoods. By 1958 the "conservation" of the Hyde Park neighborhood had destroyed perfectly fine housing in the black southwest side of the neighborhood. The urban renewal plan called for the destruction of 20 percent of Hyde Park's housing and the removal of 20,000 black residents without any relocation plans. Over the next fifty years university efforts to clear "blight" in the neighborhoods surrounding Hyde Park fanned the tension between neighborhood residents and the university.³⁷ While the University of Chicago Hospital officials thought they were making a simple business decision about whether to offer trauma services, some black neighbors interpreted the decision through the historical prism of mistrust and perceived racial discrimination by the university. In 2009 some claimed that the university was trying to deflect routine care of the local community to other institutions by limiting emergency room care, a move that was widely condemned.³⁸ The university hospital is the only major hospital on the South Side. It boasts a deep bench of medical and surgical specialists. The other hospitals are essentially small safety-net institutions with limited services and shaky finances. If you are sick on the South Side, the University of Chicago Hospital is the best place to go. When Damian Turner died, his murder awakened long-dormant grievances held by some black South Siders against the university. Turner was a popular community youth leader and a cofounder of FLY, an organization composed of high school and college-age students. At the time of his murder, the group had been working to improve the living conditions of kids detained in the city's Youth Detention Facility. When FLY leaders assembled to mourn Damian's death, they shared memories of other friends who had perished from gunshots. In these discussions they identified the lack of South Side trauma care as a 168 * CHAPTER TWELVE public health issue. They believed that if the University of Chicago had a trauma center, Damian would not have died. So FLY publicly asked the university to open a trauma center.³⁹ On what would have been Damian's nineteenth birthday, FLY activists held a demonstration in front of the university hospital to reiterate their demand and request a meeting with the university leadership. Five years passed before the medical center leader agreed to meet. Yet FLY leaders, undaunted by the challenge ahead and determined to honor the memory of their fallen leader, chanted at every rally and meeting, "I believe that we will win!" For its part, the university maintained that Chicago had no need for another trauma center and to build one would be cost-prohibitive. Both positions were accurate. There was plenty of trauma capacity at the regional trauma centers. As *The Nation* later described the situation: Chicago's four trauma centers are located on the city's west and north sides. The Southside of Chicago where most of the gunshot victims were being injured had no adult trauma center. Dr. Gary Merlotti, the chief of trauma at Sinai Health System on the Westside, noted that the city suffered from neither an insufficient quantity nor quality of trauma centers. "I don't think we have an inadequate number," Merlotti says. "We have a geographic maldistribution."⁴⁰ The finances of trauma care are dismal. Most trauma centers lose money, as many patients are uninsured. For FLY's new leader Darius Lightfoot, the issue was not revenue but the value of black lives. "Show us that you really care. Show us that you really value a black life," he said.⁴¹ FLY understood the issue as a crisis of morality and health justice, as well as a test of the university's commitment to the black South Side. The medical center leaders saw it as a question of resource utilization. But it was difficult to frame the debate as simply a resource question in light of the national #BlackLives movement and the depth of racial inequities in Chicago. FLY's demands extended beyond trauma care. FLY sought a broader program to address the health issue of greatest concern to the community: violence. Alex Goldenberg, executive director of STOP (FLY's parent organization), explained the connection: We definitely see gun violence cutting across a number of other issues. The fight for trauma care allows you to talk about these issues. We're not asking just for the care but we are really fighting to change the whole continuum of issues that violence is resulting in. At one end of the spectrum you have the trauma center, which is leading for the care for the injury. But you also have the violence interrupter that's there with the friends, family, relatives and the person who is injured. Then there are the services to follow up with the family and friends. Then you have all the other needed things like jobs and after school programs that support prevention. The coalition we are building is fighting for all of those things.⁴² The activists organized students, religious leaders, not-for-profits, physicians, and other health professionals under an umbrella Trauma Care Coalition. Change Starts to Come Over five years, three independent events contributed to the medical center's reversal of its position. The first was the 2013 grand opening of its \$700 million high-tech, gleaming hospital bed tower, the Center for Care and Discovery, in 2013. The tower's state-of-the-art magnificence contrasts with the poverty of surrounding neighborhoods. For community members who feel locked out, it symbolizes the wealth gaps and structural inequities that they experience every day. After the new hospital opened, the medical center found it difficult to use cost as an argument against building a trauma center. "The optics were kind of absurd," said Alex Goldenberg.⁴³ FLY disrupted the building's opening by signing up for a public tour and then holding a sit-in in the lobby Batons swinging. University of Chicago police cleared the demonstrators and arrested four people. Shortly afterward the medical center dean announced that the hospital would study a regional strategy for a trauma center—the first glimpse Community Activism against Structural Violence * 169 170 * CHAPTER TWELVE that a victory might be possible. Many demonstrations and prayer sessions followed, with police dragging protesters from a construction site in 2014 and clearing praying protesters from the hospital's lobby at other times. In June 2015, nine protesters were arrested after barricading themselves in a university building.⁴⁴ An influential study by Northwestern trauma surgeon Marie Crandall, in the June 2013 journal of the American Public Health Association, helped FLY's cause, calling Chicago's South Side a trauma care desert.⁴⁵ Crandall's study illuminated the extent to which the maldistribution of trauma care posed a deadly threat to a subset of patients. Studying gunshot wounds in Chicago, she found higher mortality among people who traveled more than five miles for trauma care than among those who traveled fewer than five miles—particularly patients with wounds like those of Damian Turner.⁴⁶ *The Nation* estimated that almost a fifth of Chicago residents live five or more miles away from a trauma center, most of them on the black South Side. More than a third of the city's homicides and shootings between 2001 to 2013 have unfolded more than five miles away from a trauma center.⁴⁷ Crandall's study provided evidence that sanctioned FLY's and Turner's family's suspicions that delay and distance might contribute to death. Studies beyond Chicago have not proved that distance factors in trauma mortality. But given that Crandall's study was specifically based on Chicago's data, it was hard to argue with her conclusions. The third factor that may have tipped the scales was the US president himself. In 2014 the University of Chicago and the City of Chicago lobbied for the Obama Presidential Library to be located near campus. Trauma-center protesters seized the opportunity, organizing events and chanting "No trauma, no Bama." Soon influential community leaders conditioned their support for the Obama Library on the building of a trauma center.⁴⁸ The university's pursuit of the Obama Library may have forced it to concede on the trauma center. The University of Chicago Medical Center faced internal pressure about trauma care as well. Many medical students, medical faculty, nurses, and staff supported the Trauma Coalition's demand and urged the administration to concede. The moral suasion of the university community was at the very least a factor in the eventual decision. Victory for the South Side in December 2014, the medical center leaders began stutter-stepping their way to a decision. They announced that the age for pediatric trauma treatment would be raised from 15 to 17. Then in September 2015, the university announced that it would partner with the Sinai Health System to build a trauma center five miles west of the university hospital on a Sinai hospital property. In December 2015, however, they scrapped the deal with Sinai and announced that they had decided to open an adult trauma center on their own campus as part of a larger commitment to expand health care services on the South Side.⁴⁹ Some viewed the expansion announcement as a cynical attempt by the university to improve its finances by providing lucrative cancer and other medical care in addition to trauma care.⁵⁰ But others saw it as a welcome and genuine about-face that will lead the medical center to focus more fully on the complex needs of communities beset by structural violence. The voice of the community had been heard. Members of FLY and STOP were cautiously optimistic that a trauma center would be built but will remain wary until it opens.⁵¹ On December 15, 2015, the Trauma Care Coalition released a statement: In this moment, the whole world is watching Chicago and its history and practice of institutional racism. The decision by President Robert Zimmer and Dean Kenneth Polonsky of the University of Chicago to listen to the community and concede to the demand to open a Level I Adult Trauma Center and save black lives shows that young black people can absolutely impact policy and influence political change for the betterment of the black community. We applaud the University of Chicago for taking responsibility as a member of the broader south side community. A Level I Adult Trauma Center at the University of Chicago will provide the best possible outcome for addressing the current lack of south side trauma care. It also signals a significant shift in the University's approach to responding to the needs of its predominantly Black South Side neighbors. This is a movement moment. We are winning and need to dream bigger and demand more to create a society where healthcare is a human right and all human rights are respected. We are calling on everyone who has struggled with us and all oppressed people to dream bigger. Let's do more, it's working, we can get the things that we want. The "I believe that we will win" chant is not just a chant, it is real.⁵² Community Activism against Structural Violence * 173 O BSERVUUDGUCT 13 Ultimately a great nation is a compassionate nation. America has not met its obligations and its responsibilities to the poor. One day we will have to stand before the God of history and we will talk in terms of things we've done. Yes, we will be able to say we built gargantuan bridges to span the seas, we built gigantic buildings to kiss the skies_____It seems that I can hear the God of history saying, "That was not enough! But I was hungry, and ye fed me not. I was naked, and ye clothed me not. I was devoid of a decent sanitary house to live in, and ye provided no shelter for me_____". This is America's opportunity to

help bridge the gulf between the haves and the have-nots. The question is whether America will do it.¹ MARTIN LUTHER KING JR. Observe, Judge, Act It would not suffice for me to diagnose inequality as a cause of America's premature mortality and death gaps without offering a prescription for cure, any more than it would suffice for a firefighter to witness a three-alarm blaze without grabbing a hose. For my prescription I turn to the insights of Dr. Paul Farmer, the humanitarian physician whose work in Haiti, Rwanda, Peru, and Russia with his human rights group, Partners in Health, has been at the forefront of treating the maladies of the poor caused by structural violence. In his book *Pathologies of Power*, Farmer wrote about three precepts that have guided his health justice work around the world: observe, judge, and act.² These precepts Observe, Judge, Act * 175 are critical to grasp to solve the problem of inequality as a cause of premature American death. Observe what is happening. Analyze it. Judge the reasons why people are dying prematurely. Then act. These three precepts were first introduced in 1930 by the

Belgian cardinal Joseph Cardijn, then promoted by Pope John XXIII in his encyclical letter *Mater et Magistra* in 1961.³ They were widely adopted in Latin America as a thread of liberation theology and in Chicago by antiracist priests fighting redlining, blockbusting, and other acts of structural violence.⁴ They are meant as a guide to follow to translate social justice principles into action.

Observe Medicine has a clear obligation to work on behalf of the poor but often falls short in the United States—indeed, across the world. With its focus on profit margins, the American health care system has directed the tools of biomedical technology to preferentially benefit the rich and middle class at the expense of the health needs of the poor. Because health care is a commodity and not considered a human right in the United States, the poor inevitably suffer. We have developed a polite vernacular that allows us to avoid the scandalous conditions of health inequality in our midst. Using euphemisms like “poor payer-mix” allows health system administrators to avoid delivering direct service to poor and minority neighborhoods. We tend to build clinics and high-technology centers in wealthier (and often white) neighborhoods. We avoid some of the Medicaid insurance plans that cover the poor, because they don’t pay us well. We limit the uninsured access to our clinics and technology. Our doctors and administrators are from largely white and privileged neighborhoods and often have little insight into the day-to-day lives of their poorest patients. While some of our institutions and many physicians do their best to serve the sick and poor, their service falls short of the need. We have too long tolerated rich-poor, white-minority inequities in treatments and health care outcomes. We have pretended that separate health care for the poor is equal to the care for the middle class and the rich. It is not. 176 * CHAPTER THIRTEEN Physicians are the “natural attorneys” for the poor, uniquely positioned to advocate on their behalf. Yet too often we have remained silent as our hospitals and insurance companies have pursued material gain over solving the health needs of patients in our most troubled communities. Most of us are uncomfortable acknowledging the brutal truth of life and death in America—that much suffering and early death stem from social and economic conditions and are preventable. Most of us, even if we acknowledge the unnecessary deaths, do not feel comfortable speaking up. It is uniquely the province of medicine to observe and ameliorate the conditions affecting populations suffering in ill health and poverty. One could argue that the disproportionate burden of disease and premature mortality inflicted on the poor obliges medicine to preferentially serve, care, and treat our most marginalized populations. To observe the state of health and low life expectancy in the poor requires that medicine not just heal the individual. It must address the social and economic conditions that elicit and aggravate illness. Take for instance, the visit of Mr. M to my office. A Suicide Attempt Mr. M is a 62-year-old black man. He looks ten years older, with cropped gray hair and a heavily wrinkled face with deep-set walnutcolored eyes and silver stubble on his cheeks and chin. He’s been my patient for a few years and suffers from diabetes, cirrhosis of the liver, emphysema, hypertension, and arthritis. An ex-offender, he is living a precarious hand-to-mouth existence in the inner city. Usually we discuss his diabetes or his chronic pain. But today he told me that he had tried to kill himself. I stopped typing into the electronic chart, slid back on my rolling stool, and turned to face him. As he told his story, the pained look on his face contrasted with the bright gleam of my examination room with its wall rack of trendy magazines and an examination table centered on an antiseptic white tile floor. My current office sits within one city block of the cubicle where I saw my first outpatient in the summer of 1978. In these almost four decades of practicing primary care in this one Chicago neighborhood, I have observed over and over again the trauma that a lifetime of structural violence inflicts on the human body and soul. Today was no exception. Mr. M had been acting erratically during the last month, and Megan, the nurse practitioner, thought that he might be using drugs. “What happened to you?” I ask. “We were worried that something was wrong.” I run through a standardized checklist of questions to assess whether Mr. M was depressed. When I ask him if he has thoughts of suicide, he nods. “I thought I needed to kill myself,” he says. “Forget this. I am outta here.” He described his physical pain and his shortness of breath. “Stuff is coming to me from everywhere. I can’t move like I used to. I am short of breath and in pain all the time. I need to leave here.” Mr. M is also homeless. He moves from shelter to shelter, from street to street, day in and day out. He was evicted from his last apartment and owes \$1,400 in back rent. There is not a stable housing option on his horizon anytime soon, so he wanders with his possessions from place to place. “So I went to a guy I knew who sold heroin, and I snorted some because I wanted to end it. Everything was too much for me. The way I was living. I’m sick, myself. Then I watched my mom have a heart attack. My brother is an alcoholic and all he wants to do is fight all the time. I did not want to live no more. Someone found me and called the ambulance. I was taken to Swedish [a Chicago hospital]. I came back to my senses after that.” “Why did you want to kill yourself?” I ask. “I have my own stress,” he says. “Then I have the stress in my family, trying to hold them together. Then there is the stress in the streets, trying to maneuver around to avoid this person or that street. The stress is so much sometimes that it makes me feel like my head is going to bust. It is the fear that I feel all the time. Sometimes I feel like giving up. I just want to lay down and die.” Doctors can be overwhelmed by the sheer magnitude of the distress and disease burdens that target the poor. Those of us who provide health care for the poor often encounter patients like Mr. M, living in the midst of despair. All of us have witnessed the crippling impact of grinding poverty on our patients. It’s not just the premature mortality. Observe, Judge, Act * 177 178 * CHAPTER THIRTEEN It’s the burden of living with disease and distress on a day-to-day basis. There is not a pill for Mr. M’s misery. However, safe and affordable housing might have prevented his suicide attempt. All I had to offer was a willing ear to listen, a social work referral, and an offer to see him again in a couple of weeks. I have been at this for a long time. It does not get easier. When one takes the time to peel back the doctor-patient

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relationship, a world is revealed that would be quite shocking to the average middle-class American. Yet we are all a bankruptcy, a job loss, a catastrophic illness away from a life of misery ourselves. I wish I could report that the lives of the poor have materially improved in my decades as a doctor in Chicago. By many measures they are worse. We recently analyzed the causes for hospitalizations in the West Side neighborhoods just beyond my hospital's portals. In most neighborhoods of concentrated advantage people go to the hospital to deliver babies or to get cardiac treatments and the like. But in the neighborhoods of high hardship, the top reason for hospitalization is mental illness. An epidemic of mental illness caused by the social and economic conditions in Chicago's inner-city neighborhoods. Mr. M is just the latest victim. Judge To judge requires we accurately assess the root cause of America's death gaps. I have named structural violence as a critical driver of health inequality. Not behaviors. Not biology. Not culture. Not bad luck. But deliberate public and economic policies that have allowed inequality to flourish at the cost of life itself. That is not to reject individual responsibility and accountability for health outcomes. Or to deny that diseases have biological manifestations. But individual behaviors, biology, and culture are insufficient explanations for the Observe, Judge, Act * 179 neighborhood-to-neighborhood gaps in illness and life expectancy. And they deflect attention from the social, political, and economic fault lines that create survival gaps. The Chicago Transit Authority Blue Line train has a stop just in front of my hospital. The life expectancy around the Blue Line stop in Chicago's Loop, just east of Rush University Hospital, is 85 years. Three stops down the Blue Line from Rush is Mr. M's neighborhood, where life expectancy plummets to less than 69. No measured assessment of the health conditions in America's neighborhoods could fail to connect the marginalized existence of so many and the economic structures and racial discrimination that have enriched many at the expense of the poor. Even if you don't agree that structural violence is the root cause of our neighborhood ills, there can be no doubt that something is dreadfully wrong. Neighborhood and life conditions have deteriorated to the point where they drive patients like Mr. M to madness and, worse, suicide. And yet we are anesthetized by these neighborhood conditions. We have tolerated the wickedness of inequity as if it were a natural condition of a modern capitalist society. We avert our gaze so we do not have to endure the jarring emotional dissonance created by the juxtaposition of great wealth and mammoth poverty. Despite the evidence that structural violence inflicts terrible psychological stress on the poor, the City of Chicago's Health Department closed its mental health clinics a few years ago.⁵ At the same time, Chicago's jails and emergency rooms overflow with the mentally ill. Under what measure of fairness and justice can this be justified? Concentrated poverty and distress are mushrooming in the United States. For those on the short end of the wealth stick, the system is rigged. The negative impact of structural violence has skyrocketed as jobs, opportunities, and wealth have deserted more and more American neighborhoods in the twenty-first century. The United States now boasts more high-poverty neighborhoods in any time since the 1960s.⁶ Since 2000, the number of people living in high-poverty ghettos and slums nearly doubled, from 7.2 million to 13.8 million, while poverty became more densely concentrated. More than one in four African Americans and more than one in three Latinos now live in neighborhoods of extreme poverty. Contrast this to white America. One in thirteen white Americans lives in this concentrated poverty—nothing to celebrate, but disproportionate to the US black and Latino experience.⁷ Because white poverty is more dispersed than black and Latino poverty, the death gaps within the white community can be difficult to discern. While white America experiences better health overall than black America, some neighborhoods in white America are not inoculated against the impact of structural violence. An analysis by the Washington Post found that since 2000, American white women have been dying at higher rates expiring in their 30s, 40s, and 50s, an invisible crisis driven by the impact of postglobalization job loss on small-town America. In one of the hardest-hit groups—rural white women in their late 40s—the death rate has risen by 30 percent. As life has evolved in rural America, as jobs have been dispatched overseas, as poverty has swelled, more white men and women are dying prematurely. A greater proportion of Americans lived in poverty in 2015—a staggering 45 million—than in the late 1960s. Children are the hardest hit, with almost half of them below five years old living in poverty.⁸ Chicago is an epicenter for child distress, with the highest child poverty rate in the nation. While black and Latino men have been imprisoned at unprecedented rates, black women and their children have faced an epidemic of evictions because of poverty and racism.⁹ The wealth gap between whites and minorities is the largest it has been since 1989.¹⁰ The wealth gap for single women in America is even starker. Single black and Hispanic women have a median wealth of \$100 and \$120 respectively; the median for single white women is \$41,500. Nearly half of all single black and Hispanic women have zero or negative wealth, meaning that their debts exceed their total assets. These statistics demonstrate graphic inequity, but we should not forget that the preponderance of poverty in the United States is among whites.¹¹

We have performed enough analyses. There are **no more observations or judgments to make.** If we were studying the **impact of structural violence on health and longevity** in a randomized clinical trial, the experiment would have been **halted long ago on ethical grounds.** **It is time to act.** It is time for healing. Observe, Judge, Act * 181 Act We can act on behalf of the poor. We can choose to neither objectify nor dismiss their experiences. We can insist on and pursue their right for health and longevity. We can speak up against structural violence. We can demand political and policy solutions to mitigate or eliminate the structures that impart violence. We can advocate for a fair and equitable health-care system organized around the precept of health as a human right. **We can expect our institutions to do more to serve the interests of America's high-poverty communities and their residents.** **We can expect our leaders and policy makers to hold all our institutions to greater accountability** for the lives of the poor. Finally, we can act personally to preferentially serve the poor. **To speak against** the forces of structural violence—**racism**; economic exploitation; mass incarceration; the lack of safety, good education, and decent-paying jobs—**requires us to make the invisible visible.** That means we have to **acknowledge and address** the **distress** in our high-hardship communities. **We can seek to understand** all the ways in which racial and anti-poor bias is explicitly and implicitly built into our institutions and then **work to overcome these biases.** To act against structural violence first requires us to **expose the conditions that curtail life** and

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hasten death in our midst. During the 1960 presidential campaign, when John F. Kennedy visited coal-mining country in eastern Kentucky, he was so jarred by what he witnessed—"the hungry children,... the old people who cannot pay their doctor's bills, the families forced to give up their farms"—that he pledged to take action.¹² At age eight, because of that visit, I confronted the faces of suffering and misery in the papers and on my living-room TV screen. The whole nation was moved to action, shocked by the abject poverty in the midst of American postwar prosperity. This revelation ultimately resulted in the War on Poverty, Medicare, Medicaid, Head Start, and other social programs that lifted the lives of millions of poor Americans and redistributed wealth back to the poor.¹³ Similarly, when #BlackLivesMatter activists descended on Ferguson, Missouri, and stood down law-enforcement officials in the summer of 2014, after the police murder of teenager Michael Brown, they made the invisible suffering within that community visible to the country and world.¹⁴ To break the silence about the structural causes of poverty and discrimination is a necessary first step toward cure. It requires that we talk openly about structural violence as a root cause of health inequity and premature mortality in our nation. Political and policy action are required as well. A restructuring of American society is necessary to reverse the corrosive impact of structural violence on mortality. These structural reforms could take many forms, from tax and job policy to the ending of mass incarceration. From the perspective of health care reform, the adoption of a single-payer health care system is the only way to create equity in health care.¹⁵ Single-payer health care will be vigorously opposed by the profit-driven private health insurers and by those who will insist it is too costly or not feasible. But those of us advocating for health and longevity for the poor must insist on an insurance system that is universal, free, and accessible to all. Such a system will also be a step toward a fairer distribution of wealth. But to achieve lasting equity will require more [but] than single-payer health care. It will require a massive reinvestment of new jobs and educational opportunities into the United States' most distressed neighborhoods. To challenge the structures that impart violence and perpetuate hardship is no easy task. After all, the forces of structural violence are mighty. They have deep historical roots. One cannot comprehend the misery experienced in inner-city black neighborhoods today without honoring the fact that that today's neighborhood conditions are historical products of a quarter of a millennium of brutal slavery, ninety years of Jim Crow peonage, decades of neighborhood segregation, discriminatory lending policies, poverty, and mass imprisonment.¹⁶ One cannot note the suicides, the alcoholism, and the sub-Saharan life expectancy on Native American reservations like Pine Ridge without acknowledging the historical connection to the genocide of millions of Native Americans, followed by the exile of their remnants to desolate regions. One cannot note the soaring mortality rates from drug overdoses, suicide, and cirrhosis among poor white Americans without acknowledging the historical growth of vast income inequality and job loss in rural America caused by globalization and tax policies.¹⁷ The contours of health and life expectancy in the United States are shaped by these destructive historical forces and events. As a nation, we have never reconciled or collectively grieved the sins of our history, national origins, and economic success. There are restorations and reparations to be made. There are more immediate ways medicine can act on behalf of the poor. We need to take these actions for a number of reasons.

First, a prescription for social and economic injustice is not readily to hand. The reshaping of the balance of equity in American society is necessary but not likely to happen soon. Reversing the structural conditions that have caused poverty rates to skyrocket will require long-term political and policy changes. Finally, the structural and political conditions that culminate in premature death have never been motivated by a desire to oppress people for the sake of doing so. These have always been the ways that powerful interests have maintained their rule and accumulated wealth. This will not change overnight, and not without a fight. But medicine can act, even in the face of such massive social and structural obstacles, to ameliorate suffering and even cure.

And as doctors and health professionals (and others) facing the maladies of the poor, we have an obligation and ability to heal now. Most doctors across the world take the Hippocratic Oath as a public rite of passage into medicine. In the aftermath of World War II and the revelations of genocide and sadistic medical experimentation by Nazi physicians, the oath was revised (and thus is now sometimes called the Declaration of Geneva, Physicians Oath): At the time of being admitted as a member of the medical profession: I solemnly pledge to consecrate my life to the service of humanity; I will give my teachers the respect and gratitude that is their due; I will practice my profession with conscience and dignity; The health of my patient will be my first consideration; I will respect the secrets that are confided in me, even after the patient has died; Observe, Judge, Act * 183 184 * CHAPTER THIRTEEN I will maintain by all the means in my power, the honor and noble traditions of the medical profession; My colleagues will be my brothers and sisters; I will not permit the considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing to intervene between my duty and my patient; I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat. I make these promises solemnly, freely and upon my honor.¹⁸ It is a doctor's oath but one we can all aspire to live by. If we choose to live and practice by this oath, then we have a special responsibility to preferentially prevent and treat the diseases that afflict the poor. To offer our personal services as caregivers in service to the poor is a critical action even in the absence of major structural changes in society. For doctors and nurses who treat those experiencing great social hardship and illness, the

simple act of healing is a way to create common cause and dispense hope. It is not a world-changing act but a powerful

statement of alignment between the profession and the most oppressed in our midst. While I focus on the responsibility of doctors under the Hippocratic Oath, this is not limited to doctors. We all, whether doctor, nurse, administrator, or layperson, have something we can do to mitigate suffering through personal advocacy. Unfortunately, there are many in the healing professions who are numbed to the suffering of the poor or grimace in uncomfortable silence when confronted with the harsh and seemingly unsolvable realities of life and death in America just beyond the four walls of their clinics. I am hopeful that one day the discussion of preventable premature deaths and their links to the social and economic conditions in American neighborhoods will be central to professional discourse and practice. There is something else that preferential care on behalf of the poor allows. It has the possibility to create hope and a sense of common purpose between ourselves, our institutions, our patients, and their communities. We know that individuals who feel that their life has purpose live 15 percent longer than those without purpose.¹⁹¹ do not want to overstate the impact of acting preferentially on behalf of the poor in creating purpose and hope, but honoring the views of the community is critical to building trust and effect cure. Paul Farmer calls this acting in pragmatic solidarity with our patients and communities. Farmer gives an example of pragmatic solidarity in describing the work of his organization, Partners in Health, in Haiti as he and his colleagues tried to understand why Haitian dirt farmers who had tuberculosis were resisting treatment. Some anthropologists thought these Haitians believed that tuberculosis was caused by spells cast by others and that their beliefs explained their refusal to take the medications. But Farmer found that the peasants themselves had a more logical explanation. When they took the tuberculosis medication, their condition improved, but they became very hungry. Since they had no food, they stopped taking the medications because the tuberculosis curbed their hunger. They explained their predicament regarding taking TB meds without food to Farmer in Creole, roughly translated this way: "It's like washing your hands and drying them in the dirt."²⁰ Once Partners in Health provided food with the medications, the patients were fully adherent. Farmer's point was that you did not have to change the Haitians' cultural beliefs to improve their health. But you did have to listen to them and solve the problem in a manner consistent with their needs. There were many times when Windora Bradley's diabetes and blood pressure were out of control because she cut back on her medications. I discovered that she could not afford her medication copays and also pay to feed her children. At times, in pragmatic solidarity, I arranged to get her bill paid so she could get back on track. If medicine can act in solidarity with the poor by understanding and treating their social as well as medical needs, suffering can be mitigated; diseases cured, Observe, Judge, Act * 185 | 86 * CHAPTER THIRTEEN lives extended. Sometimes, though, there is no treatment to offer, and listening itself is the only act of solidarity available. In the summer of 2012, three pre-med students and I visited a church in the Mexican American La Villita neighborhood, about a mile and a half from Rush. The congregants were all uninsured, undocumented immigrants in need of organ transplants. One after another they and their families pleaded their cases to me. Each story was more poignant than the one before. Marco was 19 and had developed renal failure at 17. He was tethered to dialysis three times a week. His life, his education, was on hold. His mother was with him and described through tears their family's anguish over Marco's illness. Blanca was 21 with a similar history. Gustavo was 38 on dialysis, and Maria was 54 with liver cirrhosis. I spent two hours with the students at the church, witnessing the testimonies and taking notes. I had no transplants to offer. I came emptyhanded even though there were three transplant centers within a few miles of the church. But as a doctor, I could listen. In the car driving back to the hospital, I asked the students to debrief their observations of the church visit with me. One of them broke into sobs. "It's so unfair!" she cried. And yes, it was so unfair. To witness the brutality of inequality can reduce one to tears. It is why medicine often opts to ignore the harsh reality of premature illness and death in high-poverty neighborhoods. It is difficult to witness misery without suffering oneself, especially when the solutions to health inequity are available but denied simply because of money. But sometimes the act of listening provides a little dose of hope to those in need. Two weeks after our visit to La Villita, the congregants, demanding transplant access, held a rally at the University of Illinois Hospital.²¹ My three students showed up to join the action. When the congregants recognized the students, they enveloped them with hugs and tears. The students' presence was an act of solidarity that validated the demonstrators' struggle. The students' witness was an affirmation that these undocumented patients and their hope for cure were not invisible. Hope and purpose can be transmitted like a vaccination, a booster against despair. Hope does not cure disease, but it is palliative. Three years later, many of these patients we encountered that afternoon at the church have received transplants. Family members or strangers donated organs for a number of them. Some have become my patients at my institution. Marco received a kidney donated by his brother and is now in college. His mother and brother are now my patients. Gustavo and another undocumented patient, Maria, each received a kidney transplant the same day at my hospital. The family of a dying patient in Houston saw a story about these undocumented transplant patients and directly donated both kidneys when the patient passed. The three students, now all in medical school, will carry the lesson of that visit in the church forward in their medical careers. But there is even more that we must do to act on behalf of the poor. It is our job to set the moral standards high for ourselves and our institutions. Too often our avoidance and passivity fails the poor. We do not speak up on their behalf. We do not allow the stories of our patients' privation and injustice to be amplified through our voices. If one solution to health inequality is a system of true universal health care as a fundamental human right, it starts when we make demands on our own practices and institutions to do more to serve the poor and uninsured. To do this is not that difficult. But it does require that we ask ourselves and institutional leaders at every critical medical center decision, How is this decision relevant to the suffering of the poor and to the relief of that suffering? If we can align our institutional practices to answer this question, we will make progress in eliminating neighborhood life-expectancy gaps. It is critical that doctors see their responsibility to be advocates for the human rights of their patients wherever they work. These conversations are necessary and uplifting for health care organizations, most of which were founded on moral grounds to serve those in need. But these organizations can lose their moorings in the murky world of health care finances and insurance politics. There is a business imperative to health care delivery, but hospitals that act as holding companies and profit centers while denying the poor the human right to health Observe, Judge, Act * 187 | 88 * CHAPTER THIRTEEN care have lost their way. Demands by doctors, health care workers, and the public on behalf of the poor can help redirect such organizations back to their healing missions to the benefit of all. Medicine is human rights work. It is what we took an oath to uphold. But only if we all act. As physicians, health care workers, or just everyday people interested in justice and fairness, we have an obligation to speak up politically to improve access to health care for all. At the time of this writing, there are nineteen

states into which the Affordable Care Act has not expanded. Because of this, the black uninsured rate is twice what would be otherwise.²² Because half of black America lives in nonexpansion states, 1.4 million blacks—23 percent of the nation's black uninsured population—have been prevented from getting insurance.²³ Meanwhile, the health care marketplaces are failing to reduce out-of-pocket costs for the middle class across the country. The system is a flawed, crazy mess. But we need to fight on our patients' behalf for full implementation of the Affordable Care Act while we campaign for a universal single-payer solution to replace it.

Judge the aff comparatively--perfect justice is both impossible and unknowable, evaluating actions empirically and experimentally develops an eclectic pluralism that's key to effective ethics

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Whatever readers are inclined to think about the "neutrality" issue, we argue that the pragmatist silence about justice can be accounted for, at least partially, in terms of three related and mutually reinforcing ideas to which virtually all pragmatists are committed. In no particular order, these are (1) A prioritization of concrete problems and real-world injustices ahead of abstract precepts (2) A distrust of a priori theorizing along with a corresponding fallibilism and methodological experimentalism (3) A deep and persistent pluralism, both in respect to what justice is and requires, and in respect to how real-world injustices are best recognized and remedied To see how these three large clusters of ideas inform a broadly pragmatist approach to justice and injustice, consider a distinction drawn recently by Amartya Sen (ironically, someone who has never self-identified with the pragmatist tradition). In his magisterial work *The Idea of Justice*, Sen distinguishes between two kinds of theoretical approaches to justice, both of which, he claims, have many eminent proponents in the history of moral and political philosophy. The first is a group of theories that Sen consolidates under the banner "transcendental institutionalism." Such theories are "transcendental" in that they aim "to offer resolutions of questions about the nature of perfect justice" (Sen 2009, ix); they tend to focus on the pure concept of justice—the unchanging and essential nature of "the just"—rather than on relative comparisons of justice and injustice. And they are "institutionalist" in that they concentrate on getting the institutions right, as it were, while neglecting (or ignoring altogether) questions that arise about the actual societies that would ultimately emerge from any given set of institutional arrangements. Sen cites Hobbes, Locke, Rousseau, Kant, and Rawls as paradigmatic examples of this kind of approach. "Transcendental" accounts of justice stand in contrast to what Sen calls "comparative" accounts. Comparative accounts abjure the search for perfect justice focusing instead on locating criteria for some alternative state of affairs being "less unjust" than another". Adam Smith, Condorcet, Wollstonecraft, Bentham, Marx, and John Stuart Mill are cited as exemplars. While Sen does not mention the names of any pragmatist philosophers in his discussion, we believe that pragmatists are far more likely to be "comparativists" than "transcendentalists." Like comparativists, pragmatists will be skeptical about the usefulness of trying to specify—absent some particular project, context, or specific complaint—what ideally just institutions would be like. They are likely to regard such attempts as emblematic of what Dewey criticized as "philosophy's search for the immutable" (LW 4:21), as yet further examples of philosophy's ambition for "finality and foreverness" (LW 2:357). Comparativists and pragmatists will agree that perfect and consummate justice—like perfect and consummate truth—is chimerical. Just as many of the beliefs we take to be true may turn out to be false, many of the laws, institutions, and behaviors we take to be just may turn out to contain hidden, previously undetected, injustices. In both

cases, a healthy commitment to **fallibilism** ensures that such possibilities can never be finally ruled out. From a pragmatist view, there are obvious advantages to conceiving of justice in "comparative" rather than "transcendental" terms. First, a comparative approach helps us make sense of real-world struggles for justice in a way that transcendental approaches simply cannot. "What moves us," Sen writes in his book's preface, "is not the realization that the world falls short of being completely just ... but that there are clearly remediable injustices around us which we want to eliminate" (2009, vii). This focus on "clearly remediable injustices" chimes with pragmatism's basic appreciation for **concrete problems**. Unlike the famous rationalists, for whom philosophy begins with disinterested contemplation, and unlike the famous empiricists, for whom it begins with passively receiving sensory stimuli, pragmatists believe that thinking and inquiry are fundamentally occasioned by problems. **Problems spur us into action.** They unsettle previously settled experience, disrupting the normal flow of things. When genuine problems arise, it is no longer possible for us to carry on as usual. While the language of "problems" is characteristically Deweyan — he preferred the clunky phrase "problematic situation" — the same basic idea underlies virtually all pragmatist thought. The pragmatist prioritization of "problems" goes hand in hand with an approach for which real-world struggles carried out in the name of justice, as opposed to abstract and idealized principles, will be given priority. **Pragmatists need not insist that abstract (idealized) philosophizing about justice is useless or always beside the point.** Minimally, perhaps, it can do no harm. Maximally, it can be useful to the extent that it moves people to see the present setup as one alternative among many, thus inspiring them to dream up new options (Rorty 2006, 58).⁴ Nevertheless, the kind of approach favored by pragmatists affords a certain **priority to questions about how injustice is actually experienced in the real world**, and to questions about the **specific problems** (political, moral, cultural, economic) to which this gives rise. Comparativists and pragmatists will agree that questions about the concepts and content of justice cannot be satisfactorily answered from the philosopher's armchair, in isolation from some **context, complaint, or problem**. They agree that **in the real world, demands for justice always reveal themselves as demands [are] made by specific people at specific times and places, and always for something specific**. There has never been a political movement that mobilized without an agenda or a set of demands — in the name of nothing but transcendental "justice" itself." As Dewey well summed up the point, "Men have constructed a strange dream-world when they have supposed that without a fixed ideal of remote good to inspire them, they have no enticement to get relief from present troubles, no desires for liberation from what oppresses and for clearing-up what confuses present action" (MW 14:195). Because pragmatists tend not to be involved in the search for "perfect justice" — because justice is not, they think, the sort of thing one "gets right" once and for all — they tend also not to be perturbed by the fact that judgments of justice and injustice suffer from a certain degree of vagueness and indeterminacy. Unlike conventional theories of justice, which aim to establish a set of principles from which all claims about justice can be understood to follow, pragmatists adopt the different (more modest) goal of trying to find better ways of meeting this or that complaint, solving this or that problem, overcoming this or that injustice. This is not a plea for simplifying or dumbing-down theoretical reflection about justice. Nor is it a plea to focus on the "practical" in place of the "theoretical." On the contrary, as C. I. Lewis writes, **Pragmatism could be characterized as the doctrine that ... there can be ultimately no valid distinction of theoretical and practical**, so there can be no final separation of questions of truth ... from questions of the justifiable ends of action" (Lewis 1970, 108). The aspiration rather is that theoretical reflection on justice and real-world struggles against injustice become correlated, integrated, aligned. The aspiration is born of the conviction that a philosophical theory of justice, no matter how intellectually alluring or elegant, must be modified or discarded if it cannot intelligently speak to the problems that men and women find themselves having to contend with. The pragmatist emphasis on concrete "problems" thus also goes hand in hand with a **methodological experimentalism**. Different problems can be dealt with in a variety of ways, some better and more intelligent than others. Solutions, in turn, are potentially as diverse and numerous as the problems they seek to address. No one can say in advance how a particular problem will best be resolved. Discovering that requires conducting experiments, and even then such knowledge is always tentative and revisable. Put differently, if we construe our fallibility in terms of the idea that improved habits and beliefs are always possible and desirable, then it becomes reasonable to view our theorizing about justice not as the search for absolute truth or unmovable certainty, but as a generic name for **problem solving**: as shorthand for

the activity, as Dewey put it, of generating hypotheses “to be used and tested in projects of reform” (MW 12:189). As Richard Rorty captures the thought, “Pragmatists are entirely at home with the idea that political theory should view itself as suggestions for future action emerging out of recent historical experience, rather than attempting to legitimate the outcome of that experience by reference to something ahistorical” (1999, 272). One of Sen’s central arguments is that there is no such thing as the one best approach to justice, one ideal form of reasoning, one privileged perspective, one procedure or rubric with which to make all decisions about justice. He emphasizes throughout his book “the need to accept the plurality of reasons that may be sensibly accommodated in an exercise of evaluation,” sensibly noting that “The fact that a person can reason his or her way into rejecting slavery ... does not indicate that the same person must be able to decide with certainty whether a 40 per cent top rate of income tax would be better than—or more just than—a top rate of 39 per cent” (2009, 394–396). Again, this pluralist outlook is one with which pragmatists are likely to be sympathetic. Pragmatists will agree that wisdom is to be potentially found in all corners. No one has a monopoly on insight, there are a variety of different ways of fruitfully proceeding. Here it is helpful to remember William James’s characterization of the pragmatist methodological temperament from the Pragmatism lectures: She [pragmatism] is willing ... to follow either logic or the senses and to count the humblest and most personal experiences. ... Her only test of probable truth is what works best in the way of leading us, what fits every part of life best and combines with the collectivity of experience’s demands, nothing being omitted ... [Y]ou see already how democratic she is. Her manners are as various and flexible, her resources as rich and endless, and her conclusions as friendly as those of mother nature. (WWJ 1:44) As we will see more clearly in the chapters ahead, pragmatism’s approach to questions of justice and injustice will be likewise open-minded, eclectic, and “completely genial.”

Our critical quantitative research method is key.

Lindsay McLaren 17. University of Calgary. 08/08/2017. “A Space for Critical Quantitative Public Health Research?” Critical Public Health, vol. 27, no. 4, pp. 391–393.

I jumped at the opportunity to join the Critical Public Health editorial board as Co-Editor, a position I started in January 2017. I am primarily a quantitative researcher, which is a departure from the journal’s typical content. For example, of the 40 research articles published in the journal in 2016 (Volume 26), only one could be described as quantitative (Ballantyne, Casey, O’Hagan, & Vienneau, 2016). In my application for the Co-Editor position, I somewhat hesitantly stated that I might be positioned to help increase critical quantitative research submissions to the journal. But that got me thinking, what is critical quantitative research? Does it [quantitative research] have a place in Critical Public Health, and what value does, or could, it bring? What are some of the challenges? Drawing from the journal’s website, ‘critical’ is about ‘exploring new ways of thinking about public health’. It is about ‘interdisciplinary’ and ‘innovative’ approaches to ‘exploring and debating issues of equity, power, social justice and oppression in health’. Although nothing in that description excludes quantitative methods, it would be remiss not to acknowledge that some features associated with a quantitative approach (e.g. beliefs about truth, bias and the role of values) seem epistemologically at odds with critical inquiry. Critical scholars working in social epidemiology (e.g. O’Campo & Dunn, 2012) have highlighted this tension between perceived objectivity of epidemiological research on the one hand and its ‘solution-oriented’ use in policy or advocacy on the other, as an important challenge to that field. Some have argued that there is no inherent incompatibility between quantitative methods and critical inquiry. In scholarship on higher education, Stage and Wells (2014), used the term ‘quantitative criticalist’ to describe quantitative scholars who ‘resisted the term positivist with its implications of fixed theoretical frameworks and prescriptive variable definitions’. Quantitative criticalists use quantitative data and methods to pursue research questions that, for example, reveal inequities and the social or institutional factors that create and perpetuate them. Critical quantitative scholarship may also question measures and analytic practices used in quantitative research, to ensure that they adequately represent circumstances and contexts, and do not themselves inadvertently perpetuate exclusion and hierarchy. A critique of social epidemiology (related to, but not the same as, critical quantitative inquiry) is that, despite being purportedly ‘social’, in practice it tends to be descriptive and downstream (O’Campo & Dunn, 2012). For example, it may focus on

associations between some social indicator and some health outcome without consideration of the **drivers of the association** and corresponding **implications for social change**. This is not an inherent feature of quantitative methods, but rather reflects – in part – **insufficient or non-explicit attention to theory**.

My quantitative mind leads me to think about ‘types’ of theories, ranging from intra- or individual level theories used in the behavioural sciences, such as the Health Belief Model, through community or organizational level theories, to large-scale social or critical theories such as Feminism or Marxism, which represent the outermost of the concentric circles. I recall my own ‘aha’ moment when I realized that the social and critical theories are where the action is, and where one can question and challenge the status quo. Over a decade ago, Frohlich, Mykhalovskiy, Miller, and Daniel (2004) helpfully outlined different ways in which those ‘outer’ theories can be integrated into population/public health research: to frame and orient an entire research endeavour; to interpret emerging findings as demanded by the data; and to critique the arguments and interpretations of others.

It seems reasonable that these different ways of using theory could be applied across methods. Critical quantitative scholarship offers a valuable complement to its qualitative counterpart.

Numbers can be powerful, as some of my favourite examples illustrate. A 2009 meta-analysis by Kondo, Sembajwe, Kawachi, van Dam, Subramanian and Yamagata estimated avoidable mortality attributable to income inequality.

To prompt attention to large-scale social and economic drivers of population health, we need ‘burden’ studies resembling those in other areas of public health, such as tobacco and alcohol.

In their 2013 book, The Body Economic, Stuckler and Basu illustrate, using descriptive quantitative methods, how the impact of global economic recession on population health outcomes depends on the degree to which a country implements austerity measures in response. This is a great example of work that goes beyond descriptive social epidemiology to identify the ‘causes of the causes’ (Marmot, 2005). A 2015 study by Sutin, Stephan and Terracciano observed an association between reported experiences of discrimination based on body weight, and mortality risk, even taking weight into account. Such work contributes a powerful counter-narrative to the dominant obesity discourse where weight itself is seen to be the problem. A 2016 study by Huisken, Orr, and Tarasuk (2017) demonstrated that household food insecurity in Canada is not associated with food skills (i.e. food preparation, cooking and shopping), thus exposing the limitations of individual or household-focused solutions to that problem. Finally, an upcoming paper in this journal (Mulinari, Wemrell, Rönneström, Subramanian, & Merlo, 2017) uses sophisticated statistical methods to examine and illustrate problems with (dominant) categorical approaches to identifying race/ethnic groupings in the United States. Their work has very important implications for targeted approaches in public health policy, which seem to be growing in popularity.

One can look to other disciplines to find excellent examples of critical quantitative scholarship.

Quantitative sociology, which I tend to think of as inherently critical because of the ‘outer’ level of theory used, comes to mind. An example is Bourdieusian-inspired **work** (Bourdieu himself used quantitative methods) **on social class and health outcomes** (e.g. McLaren, Godley, & MacNairn, 2009; Veenstra, 2007).

Scholarship in policy studies is also illustrative; **for example, the literature on termination of public policies**. **To complement case studies** that provide rich analysis of factors

contributing to policy termination in a particular circumstance, **recent ('large n') studies have tested and**

demonstrated a more general role of these factors across settings and/or time.

For example, across municipalities in the United States, Krause, Yi, and Feiock (2016) identified that political ideological factors (measured using indicators of Tea Party activity and Republican voters) played a significant role in predicting which settings terminated local policy on climate change, and which did not.

There are challenges with critical quantitative scholarship in public health. One has to do with available data.

Though primary data collection is always a good way to ensure that one’s critical theoretical questions are accommodated, existing data (e.g. national survey data) constitute an important and efficient source for quantitative researchers, including those with a critical perspective. One could argue that the onus is on critical quantitative scholars to use those data (which are used to inform policy, e.g.

<https://crdcn.org/about-crdcn>) and participate in its development. For example,

critical use of national survey data can help to identify gaps or implicit assumptions around the inclusion or exclusion of particular indicators, and

critical quantitative scholars are positioned to help ensure that survey methods and data collected are theoretically rigorous.

A second challenge, which is relevant across methods, is the continued influence of the ‘evidence hierarchy’.

It is ironic that when one searches ‘critical quantitative public health’ online, many of the top hits are about critical appraisal in a conventional epidemiological sense. This is highly problematic and remains an important challenge, as we found

during a recent experience with a Cochrane Systematic Review (McLaren et al., 2016). **Our aim to quantify effects of large-scale government interventions** (in this case, for dietary sodium reduction), **to demonstrate that healthy public policy at a national level has demonstrable benefits for population health and health equity**, was largely deflated by the

critical appraisal criteria, which left us no choice but to characterize the evidence as the very lowest level of quality.

We build movements by countering narratives of political ineffectiveness

Jennifer Cullen Loomis 15. Portland State University. 2015. Activist Doctors: Explaining Physician Activism in the Oregon Movement for Single-Payer Healthcare. Portland State University. Google Scholar, <http://search.proquest.com/openview/1698ec86b0abf84005237826b581c407/1?pq-origsite=gscholar&cbl=18750&diss=y>.

Feasibility Makes Single-payer Activism Unattractive Perhaps the most powerful deterrent to single-payer activism for the non-activists is the limited perceived feasibility of passing legislation to enact it. This acts as a formidable barrier.

the physicians must confront. This section will discuss how the nonactivists view these barriers as immutable resulting in the conclusion that single-payer "impossible" in America. Two of the most frequently cited reasons are that Americans would never support a plan that appears to give more control to the government and that even if Americans wanted single-payer, Congress would never be able to pass such reform. Given that these physicians do not see single-payer as an attainable solution, they see no point investing personal resources trying to attain it. For these reasons, if the physician does engage in activism, it is for other causes deemed more feasible. Americans' Distrust of Government The first main barrier the non-activists perceive is that of the American people and their focus on individualism and small government.

Single-payer systems are sometimes portrayed as a "government takeover" of medicine or increasing the size of "big government." This common perception runs counter to the ethos of individualism that is pervasive in American culture.

Non-activist physicians believe Americans in general are distrustful of the government and would not support an entitlement system where everyone is provided equal care because it runs

counter to values of individualism and the Protestant Work Ethic (Weber 2002[1920]; Skocpol 1996). Every non-activist physician cited this as a formidable obstacle to the passage of single-payer legislation. The following quote from a retired male whose specialty was critical care demonstrates the link he sees between American culture and single-payer. He said, "Considering the antagonism towards government that so many people have in this country. It runs deep and it runs strong and I just can't see us going in that direction politically in the near future." Doctors also mentioned that publicly-financed healthcare that is equally available to all is not attractive to the American people because of the belief that people must work for what they have and some people do not deserve access to high quality healthcare. In other words, they subscribe to the Protestant Work Ethic that says one must work hard to enjoy valuable goods like healthcare services. A retired, male, family practice doctor questioned, "Why don't we have systems like other countries do that actually take care of their citizens? It's because it's in the American culture. Really going back to the founding of the country, which is this kind of individualism and every person for themselves." He feels that American individualism is very strong and the public will not support a system where everyone is equal. Along these lines, a practicing female cardiologist expressed her doubt of the public supporting a single-payer system: "I think there's just no way because we're a society that's much more into 'I want everything for me right now' especially if I can pay for it. And you know, really, it'd be hard to follow a more socialized society that's thinking of the common good, so I just think it's never going to happen in my lifetime and kind of give up." We see how this sentiment influences activism. She surmises that it's never going to happen, which for her is the defining factor. Without being able to achieve the goal, she abstains from the process of activism. More evidence of American's hostility for them was seen as how some Americans want to repeal the few healthcare policies we currently have that seek to improve healthcare access for disadvantaged populations, like the Affordable Care Act (ACA) and Medicare. Non-activist doctors believed that if the American public doesn't like the small incremental changes in the ACA, they would never support the radical changes required by the establishment of a single-payer system. A retired, male, family-practice doctor explained it this way: "There's a fairly large number of tea-party Republicans, whatever, who actually think we should get rid of social security and Medicare, you know? So why would they support Medicare for all when they don't even support Medicare as it currently exists? There's still fighting the battles of the 1930s. So you know, that's just true. It's stupid, but it's true." The doctors do view these groups of Americans who want to roll back important social programs, as implacable foes of single-payer reform. They see this feature of American culture as unchanging; something that cannot be swayed with education and outreach. A male endocrinologist echoes this hostile public sentiment and the confusion among Americans about single-payer: "When you look at the right-wing reaction to the Affordable Care Act which is far from single-payer, which they're calling "socialized medicine" or "government medicine" and all that. There's so much hostility and anger and dishonesty and political power that whatever incremental improvement the Affordable Care Act brings is barely hanging on by its fingernails. To get from there to a true single-payer system, in our lifetime, I just don't see it." These sentiments reflect Skocpol's (1996) assessment that Americans fear any programs that appear to give the government more ability to regulate business. Some vocal factions of America want less government involvement in the market and react in a hostile manner to an incremental improvement like the Affordable Care Act. It is reasonable for the physicians to think that if incremental reforms are this controversial, then a more comprehensive reform is dead on arrival. Americans' distrust of government was the most frequently-mentioned theme among non-activists. They believe that the distrust of government and the commitment to individualism pervasive in American culture would prevent enough citizens from supporting a single-payer system, blocking its passage. And for the non-activists, if single-payer is an impossible outcome any effort designed to achieve such a system is done in vain. These non-activists have little hope for changing this sentiment in American culture.

Hence, they are unwilling to invest personal resources in the struggle if they do not think the outcome will be achieved. And they say the outcome will not be achieved due to the individualism prevalent in American culture and its preference for market solutions. Political Stalemate American culture was not the only obstacle to passing single-payer reform cited by non-activists.

Non-activist physicians were also concerned about the feasibility of passing single-payer legislation through the government. All respondents recognized that if we were to establish such a system, it would require a process that

involved our elected officials. All non-activists, though, were very pessimistic about the possibility of our elected officials cooperating to make a single-payer system happen, even if the American public was in support of it. For example, a retired female OB/GYN stated, "So, could it happen? Yes. Do I think it will happen? No, not yet. I don't think so. Because I don't think there's the political will." She goes on to say that resources are not a barrier to expanding care, but the resistance to single-payer more deeply reflects the lack of commitment our government has for helping its citizens. In the next quote, the "we" she is referring to is our government and elected officials. She said, "We have plenty of money. It's our priorities that are fucked up. We have plenty of money." In other words, we have the financial capacity to enact singlepayer, Congress simply refuses to do so. This is consistent with Mechanic's (2006:188) assessment of healthcare reform in the US: "Failure to overcome our health system dysfunctions is not a result of lack of knowledge or organizational capacity. It is an issue of will and commitment." This doctor's quote, again, illustrates how the unattainable outcome blocks her activism. Her perceived unwillingness of Congress to pass such a bill is a deciding factor in her choice to not become involved. Echoing the perceived ineptitude of Congress, a retired male in family medicine exclaimed, "It's just not gonna happen given Congress and the way it is. I mean they can't even do anything!" This sentiment is understandable given that during the course of these interviews, the federal government was "shut down" because Congress could not agree on a budget for the coming fiscal year. It is widely understood that contention over funding for the Affordable Care Act was a primary cause of the "shut down." Observing how contentious the ACA had become, even though it would bring only incremental improvements, colors the non-activists' views about achieving major healthcare reform. A statement made by a retired male whose specialty was critical care reflects this: "It's kind of hard to be super enthusiastic, and I love my friends who are super enthusiastic about single-payer, but realistically number one it isn't going to occur in this country with the political split that we have." The political split in the 113th Congress contributed to their notorious label as the "least productive Congress ever" (DeSilver 2013). Six out of seven mentioned the corrupting influence of money in politics and how this limits the possibility of passing the necessary legislation. They specifically mentioned the medical-industrial complex (MIC) and the vested interests that compose it which Relman (1980) first warned about. The MIC control massive financial resources and respondents discussed this undermines more progressive goals politics. Respondents said that these entities benefit from the current arrangement of healthcare and will use their resources to resist single-payer legislation. It appears that Relman's prescient warning that the MIC, whose interests are opposite those of patients and society, would rise to prominence and control healthcare reform has come true. A practicing female cardiologist explained the obstacles to single-payer legislation that she sees: "I think politics definitely [is an obstacle]. And I think capitalism definitely [is another obstacle]. I mean, there's so much money in healthcare. A lot of what I've been talking about is the physician-provider role, but there's just so much financial interest and so certainly big lobbying groups, Big PhRMA, insurance companies..." [limit the feasibility of passing single-payer.] She finds the amount of financial resources behind the

opposition to single-payer daunting and something that limits the efficacy of single-payer activism. Another female, a retired endocrinologist agreed, "I don't see it happening in my lifetime, I wish I did, among a lot of other things. Politics is, money and politics is in particular is interfering with everything. I'm not seeing that light at the end of the tunnel. [laughs] I don't know what to expect, I wish I could be more optimistic. Oh well." The non-activists view the quest for single-payer as a hopeless cause due to the big money interests that oppose single-payer. They think a grassroots movement will not be able to compete with the influence and reach of the MIC. Therefore, the non-activists view the political system necessary to pass and enact legislation as hopelessly corrupted by big money interests. The lack of passion for the issue is also clear in the last quote. Instead of reacting with outrage, she reluctantly accepts the situation by ending her discussion of these barriers with an "oh well." Given that all respondents felt a single-payer system would be better than what we have now and given the strong feeling that advocacy for single-payer does not result in meaningful change, it is not surprising that some non-activists were working to effect change in other areas of medicine. Three of these doctors had the mindset that, 'given that single-payer is not happening, what are other areas in which we could make improvements?' These doctors focused their efforts in areas that they felt were more likely to be successfully-reformed in the near future. There was a variety of other medical issues that non-activists were advocating for. For instance, a retired male family medicine doctor is involved in a physician organization that is working on issues related to gun violence, women's reproductive health issues, and eliminating gag laws related to the environmental practice of fracking. The female endocrinologist said she is concerned about what happens with patients' health information and privacy. She said, "That's the other thing I'm very concerned about, is patient privacy and what's happening with electronic records and all that kind of stuff." She has traveled to Salem and met with legislators and some nonprofit groups about this issue. She also wishes doctors would pay more attention to what patients have to pay for care. She said one of her goals is "...to craft a letter to the higherups at [a large HMO] here to push for that transparency between the doctor and patient about costs." A retired female in obstetrics and gynecology has chosen to focus her efforts on preserving access to safe abortion services. Speaking about her choice to focus in this area instead of single-payer she commented, "I mean, there's a limit. There was actually something refreshing about when I chose to become an activist in abortion care; it sort of frees up you up from having the responsibility of taking care of all the world's other problems. You know what I'm saying? Focus on one." The perceived futility in advocating for a single-payer system made activism for other issues more attractive. The doctors believed their activism in these areas was more likely to lead to changes that could be implemented relatively soon. In other words, they did not perceive there to be substantial barriers to enacting delivery reforms, but did view substantial barriers for attempting financing reforms. In addition, the last comment also demonstrates how there are limits to activism. The **doctors recognized that there are numerous areas that would benefit from advocacy and reform, but a person only has so much energy to devote to these causes and it can be a relief to limit what you advocate for** Due to this, the physicians chose to work for reform in **other areas of healthcare;** areas in which they felt they could effect change in a more reasonable time

Mental Health Care

Mentally ill are not receiving adequate treatment

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

The treatment gap is more like an enormous canyon for the mentally ill in our society. The latest national epidemiological study of diagnosable mental disorders revealed a 12-month prevalence rate of about 26% and a life-time rate of 46% of the total U.S. population. Among people with treatable mental disorders, only about 40% receive treatment from either our primary or specialty health care systems. Among those with any of the disorders who do report obtaining professional care, only 33% report service that meets criteria of minimally adequate care (Wang, Lane, Olfson, Pincus, Wells, & Kessler, 2005). These treatment gaps occur despite the report that about 1.4 million hospitalizations in 2006 involved patients who were admitted for mental illness, and another 7.1 million patients had a mental disorder in addition to the physical condition for which they were admitted. The total of 8.5 million hospitalizations involving patients with mental disorders represent about 22 percent of the total 39.5 million hospitalizations in 2006 (AHRQ, 2008, p. 23). By contrast, per capita expenditures in 2005 for mental health services were a mere \$99.55, which amounted to only two percent of the total per capita health expenditures of \$5,283 in 2004 (State Mental Health Agency [SMHA] 2005). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 851-853). AuthorHouse. Kindle Edition.

Mental health care included with universal care

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Protecting the Vulnerable Another implication of both principles of beneficence and nonmaleficence is that particularly vulnerable people should be protected from negligence and harm. Children and some adults such as mentally ill or retarded people, and elderly individuals with Alzheimer's or other dementias share in common a diminished capacity to make rational and practical decisions in their own best interests and welfare. Recognition of their special need for protection leads to surrogate decision-making by legally appointed guardians and conservators, or to civil commitments and criminal proceedings involving the insanity defense ("not guilty by reason of insanity" or "guilty, but insane"). The seriously and persistently mentally ill are particularly vulnerable. They are among the most underserved in health care systems throughout the world (WHO, 2001, pp. 25, 77). The World Health organization estimated that 450 million people world-wide suffered from neuropsychiatric disorders, a subset of all mental disorders, accounting for about 12% of the total burden of disease in 2000, yet one-third of countries had no mental health program of prevention, treatment, or rehabilitation, and a quarter had neither a mental health policy or program (p. 77). One-third of countries did not report a specific mental health budget, and half of the remaining two-thirds of countries allocated less than 1% of their public health budget to mental health (p. 77)

My own research with colleagues comparing the mental health systems of four industrialized countries revealed that the majority of citizens with mental disorders and psychological distress do not receive professional treatment (Olson, 2006a). Because the four countries varied from government financed and administered systems (England's national health service) through national insurance programs (Norway and Canada), to the market-maximized system in the United States, the failure to protect the mentally ill cannot be accounted for solely in terms of the systems of financing and organizing the delivery of mental health care. There appears to be a deeper stigmatization at work. To ensure universal access, much more needs to be done, such as parity legislation and development of a national workforce policy, which will distribute qualified mental health professionals geographically and according to regional prevalence rates. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3391-3393). AuthorHouse. Kindle Edition.

Disabled

Disabled do not receive adequate care

In addition to the mentally ill, the 44 million Americans in 2010 with physical disabilities are particularly susceptible to receiving substandard care. In the two decades since the Americans with Disabilities Act passed in 1990, people with disabilities remain disadvantaged partly because the U.S. health care system is not structured to care for them effectively (Iezzoni, 2011). Eliminating disparities in health care with this population should be given emphasis in health care reform, in addition to reducing "racial, ethnic, and socioeconomic disparities in the health care system. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 862-863). AuthorHouse. Kindle Edition.

There's a real impact – health disparities have severe negative impacts on persons with disability – we should change policies

Sager and Hams 15 (Josh Sager, Public Policy Intern at Community Catalyst, Marcia Hams, Senior Policy Analyst at Community Catalyst, November 2015. "Demographic Health Disparities and Health System Transformation: Drivers and Solutions." <https://www.communitycatalyst.org/resources/publications/document/Policy-Brief-Demographic-Health-Disparities-Final.pdf>)

Health and Health Care Disparities Across Demographics **Disparities in health and care stem from a wide range of demographic, social and cultural factors.** Many people also suffer the effects of **more than one disparity simultaneously** (e.g. **low-income, Black and LGBT**). Such experience, termed "**intersectionality**," is complex and is **not addressed by a focus on just one disparity**, as illustrated below

Socioeconomic Disparities
SES has a dramatic effect – health and access to quality care People with lower SES
19 percent had no healthcare while this number jumps to 32 percent for nonelderly adults in poverty Poverty makes it significantly harder to access health insurance and, by extension, affordable health care
Because of the above population and health care system dynamics, low-income populations are significantly more likely to suffer from certain chronic conditions than individuals in higher economic brackets
Racial and Ethnic Disparities Racial and ethnic disparities in health care are the result of a combination of social and economic factors Our nation's history of economic disenfranchising and segregating communities of color has resulted in a significant wealth gap the average net worth of a white household is 13 times larger than the average wealth of a Black household and 10 times larger than the average wealth of a Hispanic household, and reduced the accessibility of education, healthy living environments and health care within minority communities
Higher lifetime discrimination and burden of discrimination among African Americans are associated with greater hypertension
White Americans have significantly greater access to high-quality care than many minority groups One study by the Agency for Healthcare Research and Quality (AHRQ) found that whites received higher quality health care in 60 percent of core measures compared to Hispanic Americans, 40 percent of core measures when compared with African Americans, and 20 percent of core measures when compared with Asian Americans
Women having higher rates of depression and anxiety disorders than men, and men experiencing higher rates of substance abuse, antisocial behavior and suicide
Lesbian, Gay, Bisexual and Transgender Disparities LGBT populations suffer from several severe health disparities that significantly harm their health LGBT people experience discrimination, stigma, violence and rejection by their families
LGBT access to health insurance has been affected by being barred from marriage and the benefits of family health insurance as well as by unequal access to coverage through the workplace
Compared to heterosexuals, studies show that LGBT individuals are more likely to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities Specific health issues disproportionately affect LGBT people as a whole, including mental illness, substance use and sexual and physical violence
LGBT have higher rates of depression anxiety and substance misuse
LGBT youth in particular are at significantly higher risk of suicide and homelessness
Women having higher rates of depression and anxiety disorders than men, and men experiencing higher rates of substance abuse, antisocial behavior and suicide
Gender disparities in health care More women report forgoing care due to cost than do men
Women who are younger, Hispanic, low-income or uninsured are also more likely to lack connections to care As with racial and ethnic minorities, more women than men suffer discrimination and implicit bias in their relationships with health care providers
white women report ongoing health conditions that require monitoring, care or medication at higher rates than both Black and Hispanic women

for People with Disabilities xxxvi **Disparities in the health care for people with disabilities**. AHRQ has documented **access** and quality problems that **disproportionately affect people with disabilities** **People with disabilities were significantly less likely** than those without disabilities **to receive surgery** for early-stage, non-small cell lung cancer which was linked to survival discrepancies between people with and without disabilities. **Women with disabilities have much lower rates of screening mammography and Pap tests than women without disabilities**. Researchers suggest that disparities in treatment may be the result of patient preferences due to competing needs that result from their complex health conditions, as well as erroneous assumptions and stigmatizing attitudes among clinicians. In a Los Angeles County survey, 13-18 percent of those with disabilities reported being treated unfairly at their health care provider's office because of their disability. xxxvii Disparities in health status for people with disabilities. **People with disabilities are much more likely than the nondisabled to report being in fair or poor health**. One study found that only 3.4 percent of adults without disabilities reported fair or poor health, compared with 30.6 percent of those with difficulty seeing or hearing, 37.9 percent of those reporting movement difficulties, 51.8 percent of people with emotional difficulties and 63.8 percent of those with cognitive difficulties. For instance, a far larger percent of people with major difficulties

walking report being frequently depressed or anxious than of those without disabilities bias in their relationships with health care providers.^{xxxii} Among adults with a disability, reports of fair or poor health were highest among Hispanics, American Indians and Alaska Natives, and lowest among Asians. Finally, people with disabilities also have higher rates of risk factors that worsen overall health and lead to conditions such as heart disease and certain cancers. For instance, people ages 18-44 who have disabilities were more likely than those without disabilities to be obese, smoke cigarettes, and be physically inactive during leisure time.

Public Good

Health care should be treated as a public good, not a private one

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

A third example of an ethical perspective offered by an economist is Adam Oliver's description of the moral foundation of Britain's National Health Service. Dr. Oliver is a RCUK Academic Fellow in the health economics and policy department of the London School of Economics. Oliver (2008) suggested that access to health care is not a special private good, but a general public good, based on several moral premises: (a) everyone should be protected from adverse health situations beyond their control; (b) through universal access to health care, everyone should be enabled to flourish as human beings; (c) the fair distribution of health in a population is as important as the overall level of health in a population; and (d) choice of one's health care provider is good both as an end and as a means, whereas choice of a single versus plural payer is secondary. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 1249-1251). AuthorHouse. Kindle Edition.

Solidarity

Solidarity

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Another political scientist, Deborah A. Stone characterized social insurance programs like the U.S. Social Security system as “Good Samaritan ethics writ large.” She suggested that the “political magic” of a single, publicly financed health care system is that it enables us to help ourselves and others in the same way. The implicit ethical principles are beneficence and equality: “We value health care for others as well as ourselves” (Stone, 2008). In an earlier article, Stone (1993) expressed this as a communitarian ethic based on the principle of solidarity. Another presenter at the same conference, James A. Morone, suggested the health care debate is about what kind of society we want. He emphasized the importance of getting our philosophical grounding right, and mentioned specifically, the ethical principle of solidarity: “We’re all in this together” (Morone, 2008; 2010, pp. 1098-99). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 1286-1291). AuthorHouse. Kindle Edition.

Justice

Justice as Criterion

Justice is the highest value for a society

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

Healthcare is a commodity that concerns and affects all people. It can be observed that access to healthcare differs the world over. Some societies require that it be available to all while in others it is only accessible to those who can afford it. Nearly all societies strive for justice. The achievement of a just society is one of the highest human goals. As a whole we strive to act in an ethical manner whenever possible. Whether healthcare is necessary for a society to be considered just is an open question. It can only be answered in the framework of some coherent account of justice.

Justice is critical to a virtuous life

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

But why should we be just in our actions towards others, or in our relation to our society and its health care system? Adler's (1981) answer is based on the view that to be just is a virtue inseparable from others such as courage and temperance. All true virtues direct human conduct toward the ultimate end of a good life, which is also a common good. We ought to be just because it is a means to attaining the end of both our own happiness (a morally good life) and the happiness of others (p. 241). Thus, the virtue of being just is an essential trait of character which is prerequisite to acting justly, which in turn serves as a means to the good life that everyone desires and deserves. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 6402-6407). AuthorHouse. Kindle Edition.

Justice is a founding principle of the Constitution

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

According to the Preamble to the Constitution, the United States was formed as a constitutional democracy to promote the general welfare, to provide for common defense, to ensure domestic tranquility and the blessings of liberty, and to establish justice. This Constitution was ratified with ten

Amendments (called the Bill of Rights) December 15, 1791. It expresses Americans' original vision of the Federal Republic it wanted to become—a secure, peaceful, free and just society. The grievances listed by the American colonists against the British monarchy, included in the earlier Declaration of Independence of 1776, were expressed as violations of the principles of liberty and justice, and specifically violations of inalienable rights to life, liberty, and the pursuit of happiness. The central importance of justice to our vision of a good society was expressed subsequently in a statement attributed to Daniel Webster inscribed above the entrance to the Supreme Court in the Minnesota State Capitol building: Justice is the great interest of man on earth. It is the ligament which holds civilized beings and civilized nations together. Wherever her temple stands and so long as it is duly honored there is a foundation for social security, general happiness, and the improvement and progress of our race. Clearly, justice is an essential principle of American democracy and our common morality. The relevance of this principle of justice to health care was expressed by Martin Luther King, Jr.: "Of all forms of inequality, injustice in health care is the most shocking and inhumane." "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 4555-4558). AuthorHouse. Kindle Edition.

The pursuit of justice means there is a moral obligation to provide health care

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

A widely supported conception of justice is given by John Rawls in A Theory of Justice. I will use this as a starting point from which I will argue that universal access to healthcare is necessary for justice. It follows that all societies have a moral obligation to provide healthcare. All people have an interest in achieving and maintaining good health. Everyone has a personal conception of the good life and strives to achieve it. Healthcare helps maintain the level of human function which is necessary in this pursuit. Though healthcare is extremely valuable it can be cost prohibitive for some. Following the Rawlsian tradition I will argue that individuals unaware of their own situation in reality would assent to guiding principles that require universal access to healthcare

Types of Justice

There are several concepts and theories of justice which specify the preceding formal and general definitions. Each of the major ethical theories discussed in this book includes or implies a particular concept of justice. For example, the first formal definition expresses an egalitarian theory of justice, which emphasizes the concept and value of equality. This definition is different from a libertarian theory of justice, which emphasizes protection of individual liberties. The variety of views can be classified according to the types of justice emphasized in each theory. Among the types that have been identified are retributive, proportional, restitutive, reconciling, procedural, contributory, commutative, distributive and dialectical justice.

Retributive Justice

Sometimes referred to as criminal justice, retributive justice is based on the notion that people who harm others should be held accountable. More precisely, they should be punished or suffer retribution, hence the term, retributive justice. Retribution is distinct from rehabilitation, restitution, or reconciliation. Punitive damages won by victims of medical malpractice for gross negligence can be construed as applications of retributive justice.

Proportional Justice Implicit in the concept of retribution is the notion that the punishment must fit the crime. It must not be cruel and unusual punishment, but proportional to the severity of the crime. The ancient maxim, "an eye for an eye," was not merely a justification for retribution; it was also established to limit the response of the injured victim to reduce the likelihood of a perennial cycle of escalating revenge. The notion of proportional justice has been applied appropriately to financing health care. For example, by setting a standard upper limit on a health tax at 10% of income, the proportion paid for by people of lower and higher incomes would be equal, though the actual amount would vary with income. Proportional justice is also relevant to the delivery of health care. The type, "level, frequency, and duration of treatment received should be appropriate to (proportional to) the nature and severity of the individual's medical condition, and everyone with the same condition should have access to the same appropriate treatment. Proportionality is one of the elements defining medically necessary care. (See chapter three for further discussion.) Restitutive Justice Critics of retribution advocate restitution instead of, or in addition to punishment. R

Restitutive (or restorative) justice demands that the victim or injured party receive fair compensation from the perpetrator. Beauchamp and Childress (2001, p. 226) label this type as rectificatory justice, which refers to "... just compensation for transactional problems such as breaches of contract and malpractice." Restorative justice requires that all people who suffer loss or deterioration of their health due to medical malpractice deserve to receive compensation, including health care in order to restore their health.

Reconciling Justice

Real and perceived injustices are causes of alienation between people. If the primary goal of justice were to reconcile an estranged relationship resulting from one being wrongly harmed, we could speak of reconciling justice. Reconciling justice asks: "What does justice require to overcome alienation between people in order that they can be reconciled?" This concept appears infrequently in our

common parlance and writings about justice, in part because it constitutes a teleological approach to justice by virtue of its focus upon the goal of reconciliation as the desired end.

Deontological theories of justice require no such justification because what is just is viewed as independent of what is good. The lack of popularity of this concept of reconciling justice explains why we are surprised when it emerges. Archbishop Emeritus and Noble Peace Prize winner, Desmond Tutu conducted Truth and Reconciliation Commissions to help heal the traumas of genocide between African tribes in Rwanda, and to end the cycle of revenge. In some respects, reconciliation is an alternative to both revenge and retributive justice by virtue of its emphasis upon the elements of voluntary confession and forgiveness. The injured parties give up their claim to both revenge and punishment. One of Bishop Tutu's books describing this meaning of justice is entitled, *No Future Without Forgiveness* (Tutu, 1999).

Procedural Justice

Procedural justice addresses the questions of how decisions are made, altered, or appealed. This amounts to a focus on the decision-making process as the means by which certain ends or goals are pursued and policies are formulated and implemented. Procedural justice requires that the process be fair (Rawls, 2001). It is sometimes referred to as "due process." Although attention to process (means) should be given due consideration along with attention to desired outcomes (ends) in the formulation of health care policy, procedural justice becomes even more relevant when there are disagreements over the desired outcomes. For example, disagreements about what should be included in a decent minimum benefit set may not be resolvable except by the opposing parties agreeing to a fair procedure for determining which health care services will be included or given priority. They agree to abide by the outcome insofar as the decision-making process is just. By contrast, both laws and elections are contested when it appears there are irregularities in process and procedures. In the 2009-2010 health care debate, Republicans complained the process that eventuated in the Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 was not only unfair, but a violation of procedural rules and a bipartisan spirit. None of the Republicans voted for this comprehensive reform of the U.S. health care system.

Distributive Justice

Distributive justice addresses the fairness of allocations of benefits and burdens throughout a society determined by justified norms or rules expressed in public policies, laws, and regulations. Distributive justice is especially relevant to health care policy precisely because it addresses issues of equitable access, the allocation of health care resources, fair strategies for rationing of scarce resources, and fair financing. "R. Paul Olson Ph.D. MDiv.". *Moral Arguments for Universal Health Care: A Vision for Health Care Reform* (Kindle Locations 4689-4693). AuthorHouse. Kindle Edition.

Beauchamp and Childress (2001) provide the following definition of distributive justice: The term 'distributive justice' refers to fair, equitable, and appropriate distribution determined by justified norms that structure the terms of social cooperation. Its scope includes policies that allot diverse benefits and burdens such as property, resources, taxation, privileges, and opportunities. Distributive justice refers broadly to the distribution of all rights and responsibilities in society, including for example, civil and

political rights. (p. 226; with permission of Oxford University Press, Inc.) Four comments on this definition are in order. First, this definition requires that the distribution of social goods (such as health care) is determined by justified norms. By contrast, arbitrary and unequal distribution of social goods is unjust. Neither should access to health care be purely random—a matter of luck or a roll of the dice, especially since illnesses and injuries from accidents are unpredictable, and in many cases beyond the control of individuals affected. Finally, a just distribution is not to be determined by the distribution of power, but by norms. Might does not make right. Ethical considerations should supersede political calculations in determining health care policy, though both are relevant. Secondly, the justified norms are norms that structure the terms of social cooperation. In other words, the relevant norms are "those that contribute to social cohesiveness and harmony. These norms allow people to get along with one another peacefully and productively, securely and fairly. An ethical egoism that considers only the good of oneself is ruled out by the principle of distributive justice. Selfish people are not just. The term "social cooperation" implies people are helpful to one another as opposed to being hostile or indifferent toward one another. It connotes the coordination of people and processes to contribute in a joint effort toward a common purpose or shared goal. In its economic connotation, a "cooperative" is an association for producing goods in which members share profits and middlemen are eliminated. Ownership of private property is not excluded. For example, residents in a cooperative apartment complex own both their apartment and a share in the complex as a nonprofit entity in lieu of outside stockholders or an absentee landlord. In the national debate about health care reform in 2009 the notion of a nonprofit health care cooperative was proposed as an alternative to the government health care plan (the "public option") advocated by the Obama administration to achieve universal coverage and to compete with for-profit health plans. Both proposals were rejected at the federal level, but co-op health plans were permitted as an option for states with federal funding provided to establish non-profit, consumer-operated plans to be offered through the new, regulated health insurance exchanges. Moreover, states can include in their exchanges a nationwide, non-profit plan administered by the Federal Office of Personnel Management, in which members of Congress and their staff are required to enroll beginning in 2014 in lieu of the Federal Employee Benefits Program (Jacobs & Skocpol, 2010, p. 165). Still other states may cooperate with the new federal regulations by providing comparable coverage (after 2017) through a purely private health insurance system in lieu of the exchange framework required by the Affordable Care Act. A waiver from the federal Department of Health and Human Services might allow yet another alternative, namely a pluralistic, all-payer system managed either within a state's exchange or independent of it (Murray, 2009). The latter could contain costs like a single-payer system by regulating prices charged by health care providers and premiums charged by health insurance plans. Consequently, states have significant latitude in how they choose to cooperate to advance distributive justice in the health care system. My third comment on Beauchamp and Childress' formal definition of distributive justice is this: The structures of a society referenced in the definition of distributive justice include its policies, laws, and regulations as well as its institutions and organizations, which are all part of the social system or social order. The justified norms are the generally accepted values, rights, and responsibilities that define the structures of society as they should be, so institutions perform as the majority of people believe they ought to function. Society may be structured by the norm of competition, which is justified only as long as people value it and only if it functions fairly to distribute goods and services. In the definition of distributive justice, social cooperation for the sake of the common good trumps competition for the sake of individual advantage. Fourthly, what is to be distributed justly includes both the benefits and burdens of a society, both rights

and responsibilities. Thus, universal health care requires that everyone has the right of equal access to health care benefits, but also a fair share of responsibility for its burdens (such as financial costs). Needless to say, there is debate over what constitutes a fair financial burden. Proposals range from criteria based on merit such as the ability to pay, a value-based sales tax, a flat tax as a fixed percentage of income (with or without subsidies for the poor), to a progressive tax on both income and assets, or a surtax on wealthy individuals. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 4739-4741). AuthorHouse. Kindle Edition.

Contributory Justice Contributory justice claims that the individual has a right to contribute to society, especially (though not exclusively) through employment. This notion is grounded in the value of work and in the human dignity one derives from being a productive member of society insofar as one is able to contribute to the common good. Arguments for the right to work, to organize labor in unions, and for a social policy of full employment are sometimes justified by a principle of contributory justice. Appeals to contributory justice also support "support the growing awareness of the rights of disabled individuals and racial minorities to be gainfully employed. For example, the 1968 Kerner Commission report concluded that the destructive riots in 1965-1967 in urban cities such as Newark, Chicago, Los Angeles, and Detroit were due in part to the high rate of unemployed African-American men, whose ghettoized life of poverty, inadequate housing, and poor schools was itself a function of racism. The report warned that the U.S. was moving toward two societies—one black, one white—separate and unequal (Report of the National Advisory Commission on Civil Disorders, 1968). An individual's abilities and right to contribute through productive work is limited by conditions of illness and injury. Consequently, universal access to health care as a public policy can be justified by the principle of contributory justice. The Kerner Commission cited the lack of access to health care as one of an array of problems that fell with particular severity on African Americans. The persistence and degree of these ethnic disparities in both health status and health care suggests defacto discrimination in the U.S. health care system (Yancey, Bastani, & Glenn, 2007; Morales & Ortega, 2007), which is also evident in enormous gaps in wealth between Caucasians and minorities (Kochhar, Fry, & Taylor, 2011).

Commutative Justice

People make contributions to their economy through their labor and capital investments. In a capitalist system, both are generally bought and sold in the market place. Commutative justice addresses the question of whether or not these exchanges are fair. Does the worker receive a decent living wage for his labor? Does the investor receive a fair return for his risk? Is the individual receiving benefits commensurate with his premiums paid for health insurance? Should the benefits of public insurance programs be available for everyone whose taxes support the public health care system? While some would argue that the free market should determine what is a fair price based on economic forces of supply and demand, others suggest that government regulation is necessary to ensure both fair competition and commutative justice. These different perspectives are evident in health care reforms based on private sector solutions (e.g., managed competition, medical savings accounts) versus public sector solutions (e.g., single-payer or all-payer proposals for a national health insurance system). "R.

Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 4685-4688). AuthorHouse. Kindle Edition.

Current System is Unjust

The current system is unjust because it denies care to many

Furthermore, justice does not require that everyone be treated the same. In fact, insistence upon identical treatment may result in injustice. An example of an unjust financing policy is to charge the same premium for health insurance to everyone. The consequence is that the poor pay a higher proportion of their income for health insurance than the wealthy, and consequently suffer the harm of an excessive (disproportionate) burden to finance their access to health care through insurance. Even a fixed percentage of income to establish a maximum premium would require greater sacrifice by the poor unless they are exempt or subsidized, or the percentage of income paid for premiums decreases as income falls (and increases as income rises). The latter policy would be more progressive and distribute the burden of financing the health care system more proportionately and equitably precisely because people would not be treated identically. A policy is just provided it distributes costs in such a way that no one suffers a disproportionate burden. Possessing health insurance is a privilege the majority of Americans possess, but millions of uninsured, underinsured, and uninsurable have suffered harm in the U. S. health care system. Consequently, the American health care system must be judged as unjust. In my concluding chapter I address the question of whether justice has been achieved by the Affordable Care Act passed in 2010. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 4876-4881). AuthorHouse. Kindle Edition.

Justice (Rawls, Original Position)

Individuals in the original position (Rawls) would support access to health care

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

In order to answer this question I delve into the work of contemporary political philosopher John Rawls. His book *A Theory of Justice* is the preeminent voice in the current conversation on justice. From here I have borrowed Rawls' justice as fairness account, in which he imagines a hypothetical situation similar to the state of nature. These individuals in the original position exist behind what he calls the veil of ignorance; they have no knowledge of what their endowments, social status, or idea of the good will be in reality. Any guiding principles of justice which they agree to in this situation are thereby just. Utilizing his conception of justice I explore what status universal healthcare should have. As it seems individuals in the original position would assent to principles of justice that guarantee access to healthcare I conclude that universal healthcare is necessary for justice. Therefore as a society we are morally obligated to provide universal access to healthcare.

Original position explained in more detail

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

By choosing to come together as a society certain social benefits become available which otherwise would not exist. Principles of justice determine the division of social benefits and assign basic rights and duties (Rawls, 10). They are necessarily fair when chosen in the original position, a hypothetical situation prior to social cooperation. Individuals in the original position are behind what Rawls calls the veil of ignorance; they have no knowledge of what social status, distribution of natural assets and abilities, and conception of the good they will have in reality. This is in order to prevent anyone from attempting to tailor

principles of justice to his or her own benefit. By choosing behind the veil of ignorance individuals must consider what principles of justice they would want regardless of how well they are endowed in reality (Rawls, 11). Rawls assumes they are free, rational, and mutually disinterested in one another. As a result each individual will attempt to craft principles which give him or herself the greatest personal share of social benefits. The original position is of course a purely hypothetical situation and not meant to represent any historical event. However, Rawls' approach gives us a mechanism by which to determine whether a given society is just. If the society is built upon principles of justice which its members would assent to in the original position then it is just. If they would choose differently in the original position the principles of justice are unfair and the society is unjust (Rawls, 12). In *A Theory of Justice* Rawls proposes two principles which he believes free and rational people in the original position would accept, the principle of equality and the difference principle.

The principle of cooperation is necessary to support the proper functioning of society

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

Rawls proposes two radically different principles of justice, the principle of equality and the difference principle. The first requires equality in the assignment of rights and duties for all people. The second, the difference principle, breaks into two basic parts. The first holds that social and economic inequalities are just only when they result in compensating benefits for all and especially for those members of society who are least advantaged. One may notice that this principle is directly opposed to the principle of utility as it strictly prohibits some from having less so that others may have more. However, it is not unjust that some distinguish themselves in the social and economic realms so long as the situation of those less advantaged is improved (Rawls, 13). The second part of Rawls' difference principle is often referred to as the principle of fair equality of opportunity. It states, "Social and economic inequalities are to be arranged so that they are...attached to offices and positions open to

all under conditions of fair equality of opportunity” (Rawls, 72). There is nothing unfair about some jobs providing better compensation than others so long as they are open to all people of equal natural ability and the inequality in payment is to everyone’s benefit. Rawls’ adoption of the difference principle is based on the intuitive idea that the benefits of social cooperation depend upon the participation of all people, including those who are less well endowed. Therefore, a principle which proposes cooperation on fair terms such as the difference principle is necessary (Rawls, 13).

Individuals born into society based on the birth lottery

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

Individuals in the original position are situated behind the veil of ignorance. This hypothetical arrangement prevents them from knowing their actual state of affairs in reality as determined by the natural and social lotteries. Some are well endowed while others, poorly endowed, are destined to suffer. None can be said to deserve their allotment; the outcomes of the natural and social lotteries are neutral with respect to justice. The situation which one is born into is the result of these lotteries.

Cooperation benefits all individuals

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

The incentive to participate in social cooperation is that it provides additional benefits to each individual involved. The task of assigning these benefits fairly falls on the principles of justice which rational individuals would choose in the original position. Rawls puts forth two principles of justice, equality in the assignment of rights and duties and the difference principle. The latter states that social and economic inequalities are just only if they result in additional benefits for everyone participating under social cooperation. The major implication of the

difference principle is that the better endowed individuals in a just society can only flourish if in doing so they benefit the less well endowed. Social cooperation only becomes a reality if everyone, the better and less well endowed individuals, agree to participate. Rawls goes on to say that the less well endowed can only be expected to cooperate if the better endowed propose reasonable terms under which the division of advantages will occur. He believes that the difference principle satisfies this criterion and thus the less well advantaged will willingly join in (Rawls, 13).

Universal health care justified by Rawls' ethics

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Two Principles of Justice Applied to Health Care Policy

Rawls' social contract approach is a pluralistic deontology because he advocates two principles of justice: Equal liberty and the Difference Principle.

1. Equal Liberty: "Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all" (Lebacqz, 1986, p. 35).
2. Difference Principle: "Social and economic inequalities are to be arranged so that they are both (a) to the greatest benefit of the least advantaged, consistent with the just savings principles, and (b) attached to offices and positions open to all under conditions of fair equality of opportunity" (Lebacqz, 1986, p. 38) This theory affirms equal access to equal basic liberties, but also allows for inequalities under stipulated conditions. The conditions are not based on a utilitarian principle of the greatest good for the greatest number (total utility), not even upon an "average utility" or "utility floor;" rather Rawls' Difference Principle asserts that any inequality should favor those who are presently most disadvantaged and also future generations (the just savings of resources). Moreover everyone must have a fair equality of opportunity to privileged positions within a well-ordered society, and in any of its subsystems or institutions, which by implication, include the health care system and the privileged position of being among the insured in order to have equal access to health care. Universal health care can be justified by both of Rawls' principles because (1) universal health care secures access to health care as an equal right for every one to basic liberties (freedom from the burden of untreated injuries or disease, and freedom from financial impoverishment due to lack of insurance), and (2) the greatest benefit in universal health care would accrue to the least advantaged (the uninsured, underinsured, and uninsurable) and they would be provided fair equality of opportunity to participate in the health care system, which they did not have previously due largely to their inability to afford it. Rawls' principles would not necessitate identical treatment for everyone, but neither would they justify a two-tiered health care system in which only basic benefits are provided to some (viz., lower income people), while comprehensive benefits are accessible to others who can afford them. Instead, Rawls'

principles would be compatible with a health care system in which the same essential and comprehensive services are available to everyone. This is the “new universalism” adopted by several countries as reported by the World Health Organization (WHO, 2000, p. xiii). If health care resources are limited, any rationing required would be a restriction in benefits to which everyone would have equal access. Rationing would not occur according to people or groups (e.g., the poor or elderly receiving fewer benefits than the rest of the population). The duty is to ration benefits, not people (whether by age or income level). In this view, access to health care is secured as a basic equal liberty and protected against unequal distributions among groups for the sake of any other social or economic benefit as allowed in a utilitarian approach. According to Rawls’ two principles of justice, the American health care system is an example of an unjust social contract because about 16% of the population (47 million) is uninsured. The basic, equal freedom to participate in the health care system is effectively denied to some for the sake of freedom and economic gains by others obtained through the free enterprise system in the private health care sector. An expression of this type of rationalization of inequality is the way in which universal access to health care (via insurance coverage for all) has been held hostage to an imperative to contain costs (and thereby, to promote profits). Rawls’ equal liberty principle suggests a political political strategy for advocates of reform: If everyone experiences some restriction in benefits, the middle class (with its greater political clout) will have a much greater vested interest in providing the necessary funding for the health care system. An implication of Rawls’ second difference principle is that compensation paid to managers of health plans, insurance companies, hospitals, and to medical providers would be justified if and only if the greatest benefit of such a system of compensation accrues to the least advantaged in the health care system (viz., the uninsured, underinsured, and uninsurable Americans and lower wage health care providers). Clearly that principle of payments and rewards does not obtain in the case of the American health care system. system. The growing gap between rich and poor in American society is reflected in its health care system. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5579-5581). AuthorHouse. Kindle Edition.

Rawls’ theory supports health care as a positive right

Based on Daniel’s extension of Rawls’ theory to justify universal access to health care, Almgren asserts that Rawls’ theory establishes the right to health care as a positive right: “. . . something society owes the individual as either an implied or an overt provision of the social contract” (Almgren, 2006, p. 26). A positive right is distinguished from a negative right. The latter is known as a “liberty right” which is a protection by the state against violations of one’s freedom by others who might do something to us or take something from us. Almgren grants that a utilitarian view of justice could also justify health care as a positive right, though libertarian views deny such a right. Libertarians are more likely to view health care as a personal responsibility and a commodity produced, bought, and sold voluntarily in an unregulated “free” market. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5605-5608). AuthorHouse. Kindle Edition.

A2: Utilitarianism

An individual in the original position would not choose utilitarianism

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

In the original position, individuals would not be inclined to choose a principle of utility such that society is arranged, “to achieve the greatest net balance of satisfaction summed over all individuals belonging to it” (Rawls, 20). The consequence of such an arrangement is that some have less so that others may have more. Those in the original position see themselves as equals. Agreeing to a principle of justice which aims to maximize the net sum of happiness would be unlikely for individuals who hold this belief. In addition, each person in Rawls’ hypothetical situation is rational and self-interested. They will assent only to principles which protect their capacity to advance their conception of the good. One would not expect them to waive their own interests in order to achieve the greatest net satisfaction (Rawls, 13).

Benefitting the greatest number should be considered, but it alone cannot be the only moral foundation for a health care policy

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

The limitations of utilitarian arguments used to justify a policy of universal health care do not require us to ignore the goals and consequences of this policy. To do so would be both imprudent and unethical. Protecting and promoting the health of the greatest number possible is both a commendable and an essential goal. Moreover, the principle of utility (maximize the balance of good over harm) subsumes and is supported by the related ethical principles of beneficence (do the good) and nonmaleficence (do no harm). Additionally, the obligation to consider the benefits of a health care policy for the wider society is an antidote to the domination by private interests. Finally, most of the limitations of a utilitarian approach previously cited are addressed when this principle is balanced by other principles in guiding judgments about good health care policy. Stated in other terms, a utilitarian approach is good in what it affirms (maximize the good for the greatest number), but insufficient as the only fundamental ethical principle. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 2613-2614). AuthorHouse. Kindle Edition.

Utilitarianism excludes many and ignores the importance of moral action

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

8. The principle of utility does not ensure that everyone will be included as beneficiaries of health care, since it might be concluded that the greatest good for the greatest number that is possible or affordable is less than universal coverage. Consequently, the principle of utility may be advantageous to the majority at the expense of a significant minority (e.g., the 47 million uninsured Americans), so that what is good by the criterion of utility may be actually bad by another criterion of justice. An ethical theory that ignores the principle of justice is less than comprehensive. 9. A utilitarian approach tends to emphasize the value of efficiency estimated in terms of risk-reward or cost-benefit calculations. Unless cost-effectiveness is applied, there is a considerable risk that efficiency and cost-containment will supersede the values of both quality and access, or other procedural values such as democratic decision-making. There are also limitations to cost-benefit analyses as a decision-making strategy (Kling, 2006). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3675-3680). AuthorHouse. Kindle Edition.

Mill would agree that denying health care is a violation of justice

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Application to health care

The utilitarian, J. S. Mill suggested six circumstances which are generally agreed as unjust (as cited in Lebacqz, 1986, p. 19). Applied here to health care, violations of distributive justice occur (1) when people are deprived of a legal right to health care (e.g., based on a health insurance policy contract or civil law); (2) when people are deprived of a moral right to health care (as the human right to health care affirmed by the United Nations and World Health Organization); (3) when people do not obtain what they deserve, whether by right, merit or need; (4) when an insurance company or health plan breaks faith with an enrollee by either denying, delaying, reducing or rescinding benefits, or by altering the terms of the contract after enrollment (a "bait and switch"); (5) when a payer or provider is partial, that is, shows favor where exceptional consideration is not warranted; (6) when people are treated unequally. From a utilitarian perspective, all of these circumstances are violations of justice because of their consequences. That is, they all fail to maximize the greatest good for the greatest number. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 4953-4957). AuthorHouse. Kindle Edition.

Justice is more important than utility

Critique of the Utilitarian Theory of Justice

Despite its popularity, a utilitarian theory of distributive justice has limitations. Lebacqz (1986) discussed these under three concepts of total utility, average utility, and a utility floor, none of which necessarily produce justice defined as equality. From her perspective, equality supersedes utility as a standard, so the former serves as the criterion of the latter. In my view, a dialectical concept of justice, which balances equality and liberty, is a more comprehensive concept, and serves as a *prima facie* principle to balance other principles including utility. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5003-5007). AuthorHouse. Kindle Edition.

Utilitarianism shouldn't be used to justify racial discrimination and there is racial discrimination in health care

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Since the absence of health insurance or insufficient coverage reduces individuals' access to health care services, uninsured and underinsured Americans also suffer a disproportionate share in the burden of disease (Morales & Ortega, 2007). No money, no care; no care, no cure. This state of affairs makes the U. S. health care system unjust because it is an unfair distribution of both untreated diseases and financial burdens for medical services. With respect to insurance coverage, hence access to the health care system, the most blatant and pernicious form of injustice in the U. S. health care system is its unfairness due to racial discrimination. The overall rate of uninsured was reported by the U. S. Census Bureau (2006) as 15.8% of the total population for the year 2006. Note that one could claim a utilitarian argument that insuring 84% of the population is the greatest good for the greatest number we can afford to cover—a spurious argument, and contrary even to a utilitarian approach with a utility floor. The point here is that the statistic of about 16% uninsured overall does not reveal the pattern of defacto racial discrimination in the health care system. The latter is reflected in the statistics based on race: Twice as many black Americans (20.5%) and about three times as many Hispanics (34.1%) than nonHispanic whites (10.8%) were uninsured in 2006. Further evidence for ethnic disparities in both health status and health care has been reviewed recently by Anderson, Rice, and Kominski (2007) under the heading of access to health care. These racial disparities among the uninsured are sufficient to warrant the judgment that the U. S. health care system allows defacto discrimination against nonwhites. Because it discriminates based on irrelevant characteristics of people, the system is unfair and prejudiced, hence unjust and immoral. This disproportionate representation of nonwhite races among the uninsured is a moral stain of segregation upon the health care system. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5338-5343). AuthorHouse. Kindle Edition.

Justice (Nausbaum, Capabilities)

Lack of health care undermines human capabilities, making a lack of access unjust

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

Martha Nussbaum offers an alternative conception of justice which I also consider. The capabilities approach is founded on the idea that there are certain inalienable facets of human life that everyone should have access to. Some examples include living a life of normal length, bodily integrity, and the choice to participate in the various facets of society. It seems that justice is violated when one is denied access to any of these capabilities. Lack of healthcare seems to prevent the normal human functioning necessary for many of these experiences and therefore universal healthcare is necessary for justice. While I find this approach to have merit it is also problematic

[Note: In this article, the author concludes that the justice as capabilities approach is not the best one and argues for the original position. This “straw person” argument is included so that you can consider it and access other resources to support it].

Utilitarianism

Utilitarianism supports health care because, in principle, it protects health care for the greatest number of people

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

The previous discussions about cost-containment, medical and social utility, and quality of life suggest the principle of utility (maximize the good) is relevant to the formulation of health policy and supports a policy of universal health care. One of the merits of the principle of utility is that it focuses our attention on the question of what the good is that we should be striving to achieve. The focus on goals and outcomes encourages us to clarify what we value, hence, what we believe we ought to promote in order to achieve a good society. It also helps us avoid a myopic focus on means, and by distinguishing between them, it avoids confusing means with ends. For example, universal coverage is an end, whereas a single-payer system is only one of the means to achieving it. Additionally, utilitarian theory is an ethical approach compatible with both rational problem-solving and goal-oriented outcome evaluations in contrast to structural or process evaluations of health care delivery systems. In addition to focusing our attention upon the goals and outcomes of actions and policies, " policies, utilitarianism provides a general answer to the question of whose good we should promote. The answer is in terms of the public good. Utilitarianism is a social ethic. Thus, the primary justification for health care policy is whether it is designed and implemented for the welfare of everyone concerned. Conversely, we are not obligated to support policies that maximize benefits for private interests, whether individuals or groups (e.g., health care providers, health insurance companies, for-profit health plans, and their executives and investors, or only for people who can pay for health care). In this emphasis upon the greater good of the whole of society utilitarianism is similar to a communitarian approach and natural law ethics, which affirm both human dignity and the common good. According to both ethical ethical approaches and principles, health care must benefit the greatest number possible. The common good trumps private gain and human dignity requires equality as well as liberty. Within a finite population there is no number greater than everyone, hence the goal of universal access is justifiable and obligatory on utilitarian grounds.

Good Life

Health Care Protects the Good Life

Health is necessary to live a good, meaningful life

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Good health is fundamental in most conceptions of the good life. Health allows one to live a life that coincides with a normal human life span. However, this is not the only reason why health is important. Good health is generally necessary in order to participate in activities and be the subject of experiences. As Norman Daniels argues it is not the notion that good health is important for happiness that makes healthcare a special need but the importance of good health in opportunity (Daniels, 387). A lack of health limits one's function precluding the activities and experiences which are vital to the human experience. Healthcare is the best means by which to correct and prevent ill health. Though our treatments are not perfect in restoring health they are often effective in bringing back some degree of function, if only temporarily. Healthcare includes three categories of medical intervention: preventive, therapeutic, and palliative. None of the three is essential for all people; there are certainly individuals who never receive any sort of treatment and are of good health for the length of a normal human lifespan. Most, however, will experience all types of care to some extent. Preventive care can be as simple as education in healthful living, therapeutic care could just be setting a broken bone, and palliative care includes the administration of painkillers as basic as aspirin. Additionally, each category can be extended to include the most advanced procedures available. Most individuals will experience the need for a level of care between these two extremes dependent upon their allotment in the natural lottery. As a consequence of the social lottery, however, they may not be able to afford the necessary healthcare.

Health care protects basic human functioning and allow individuals to participate in the good life

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

Daniels finds the force of healthcare in protecting opportunity. Healthcare helps safeguard normal human functioning allowing individuals to participate in political, social, and economic life in their society. Each individual has a personal view of the good life which includes a certain range of function reasonable for their given society. Healthcare, as well as other social welfare programs, allows for them to live according to this plan (Daniels, 387). My view matches Daniels' in this regard. We both see the necessity of good health in opportunity. As I have argued, healthcare is the means by which good health is achieved and thus it is of central importance in protecting opportunity. Daniels' view and my own share additional pieces in common but differ in important ways.

According to Daniels, socioeconomic situation and health are inextricably linked. He provides empirical evidence to support his claim that, "inequality is strongly associated with population mortality and life expectancy across nations...wealthier countries with more equal income distributions, such as Sweden and Japan, have higher life expectancies" (Daniels, 389). Inequality in all forms, not just access to healthcare, correlates with poorer health. The best way to improve health then is to limit inequality in a given society. In order to do so Daniels appeals to the second part of Rawls' difference principle. The principle of fair equality of opportunity holds that positions and offices should be open to all and awarded on merit. Wrapped in this proposition is the notion that all should have an equal opportunity to acquire the skills upon which merit is based (Rawls, 72). This flattens the socioeconomic gradient in two respects: it assures equal basic liberties such as access to public education, childcare, and healthcare and it only permits inequalities in income when the inequalities work to advance the position of the least advantaged (Daniels, 390).

Can't meet the criteria of the good life without universal health care

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How each society attains this level of functioning for all people is up to its own discretion. In the case of certain capabilities, however, the approach should be more clear cut. Healthcare should play a substantial role in at least capabilities one and two, Life and Bodily Health, and be necessary in some capacity for many others. It seems inconceivable that a society could achieve threshold levels for capabilities three (Bodily Integrity), four (Senses, Imagination, and Thought), five (Emotions), six (Practical Reason), eight (Other Species), nine (Play), and ten (Control Over One's Environment) without the availability of healthcare. Of course, healthcare is not within reach for all members of some societies including the United States. Its cost can be prohibitive causing some individuals to forgo medical treatment in all but the most essential cases. In such a society threshold levels for many capabilities will not be within reach for some people and their lives will not be worthy of human dignity. By Nussbaum's account a society like the United States would not be at least minimally just. In order to be just such a state would need to provide universal healthcare.

Ensuring many of Nussbaum's core human capabilities to a threshold level requires the provision of universal healthcare. Without healthcare a minimum amount of functioning will not be attained for all but the luckiest individuals. Those who fall into the majority group and cannot afford adequate healthcare have no hope of achieving threshold levels of the core human capabilities. It is obvious that healthcare is vital to protecting capabilities such as Life and Bodily Health though its necessity for other capabilities may be less apparent. Bodily Integrity requires that the individual may freely move from place to place. Many treatable medical conditions prevent this freedom. Infections are usually treatable by standard medical procedures. Without treatment, however, infection can leave one bedridden and incapacitated. Senses,

Imagination, and Thought are also part of one's overall health. Mental disorders as well as a wide variety of illnesses and injuries, left untreated, can damage these faculties and limit one's ability to use and enjoy them. The Emotions can be similarly affected. Uncertainty and pain due to inadequate medical care can cause this capability to be unsatisfactorily provided for. Such a situation can cause "one's emotional development [to be] blighted by fear and anxiety" (Nussbaum, 77). A lack of care for mental and physical illnesses precludes any hope for exercising a minimum level of Practical Reason. Finally, lack of healthcare prevents full enjoyment of Other Species, Play, and Political Participation. While universal healthcare is most evidently necessary for Life and Bodily Health its absence prevents the attainment of a threshold level for almost every one of Nussbaum's ten core human capabilities. Healthcare is essential to justice under the capabilities approach. Ultimately, Martha Nussbaum's conception of justice provides a weaker impetus for universal healthcare than Rawls' approach, justice as fairness. While the capabilities approach makes a good case it is incomplete in some respects.

“The Good Life” Argument Explained in More Detail

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The capabilities approach is an alternative to the contractarian theory of justice presented by Rawls. In *Frontiers of Justice* Martha Nussbaum argues that her theory of justice “can take us further than social contract doctrines” while acting as an extension of a theory such as Rawls’ (Nussbaum, 69). However, she also believes that her approach is superior in providing guidance for public policy, an area in which healthcare is a major concern. In essence the capabilities approach is a list of the bare minimum human entitlements which all governments should ensure. Put another way, entitlements are what all humans should be able to do and be. Enumerating the vital capabilities is accomplished from, “an overlapping consensus among people who otherwise have very different comprehensive conceptions of the good” (Nussbaum, 70). Additionally, each capability has a threshold level below which true human functioning is impossible (Nussbaum, 71). Taken from *Frontiers of Justice*, Nussbaum presents the core human capabilities as follows.

1. Life. Being able to live to the end of a human life of normal length; not dying prematurely, or before one’s life is so reduced as to be not worth living.
2. Bodily Health. Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter
3. Bodily Integrity. Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and choice in matters of reproduction.
4. Senses, Imagination, and Thought. Being able to use the senses, to imagine, think, and reason – and to do these things in a “truly human” way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in

connection and experiencing and producing works and events of one's own choice, religious, literary, musical, and so forth. Being able to use one's mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to have pleasurable experiences and to avoid nonbeneficial pain.

5. Emotions. Being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by fear and anxiety. (Supporting this capability means supporting forms of human association that can be shown to be crucial in their development).

6. Practical Reason. Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. (This entails protection for the liberty of conscience and religious observance.)

7. Affiliation. A. Being able to live with and toward others, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another. (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation, and also protecting the freedom of assembly and political speech.)

B. Having the social bases of self-respect and nonhumiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails provisions of nondiscrimination on the basis of race, sex, sexual orientation, ethnicity, caste, religion, national origin.

8. Other Species. Being able to live with concern for and in relation to animals, plants, and the world of nature.

9. Play. Being able to laugh, to play, to enjoy recreational activities.

10. Control Over One's Environment. A. Political. Being able to

participate effectively in political choices that govern one's life; having the right of political participation, protections of free speech and association.

B. Material. Being able to hold property (both land and movable goods), and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others; having the freedom from unwarranted search and seizure. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers (Nussbaum, 78-80).

Her account is based upon what she calls the intuitive idea of a life worthy of human dignity. The list of central human capabilities, she finds, is implicit in the notion of human dignity (Nussbaum, 70). Such a notion is what requires each capability to be present in at least a threshold level. In order to flesh out her concept of human dignity Nussbaum borrows from the Marxian idea of true human functioning. He stresses the need for human beings to take part in "a totality of human life activities". We must have the opportunity for a wide variety of activities and experiences, not merely receive quantities of resources (Nussbaum, 74). Nussbaum's ten capabilities include all human activities which are essential in Marx's view. A just society ensures these capabilities for all its members.

"The Good Life" Critical for Justice and Dignity

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Universal healthcare seems to be an inevitable consequence of Nussbaum's capabilities approach. Like Rawls, it seems she would agree that such a provision is necessary in order for a society to be just. In *Frontiers of Justice* she puts forth the argument that a society is at least minimally just if all its members live lives worthy of human dignity. From her intuitive idea of human dignity and the Marxian conception of true human functioning she argues the necessity of ten central human capabilities. If any of these opportunities for activities and experiences is below a threshold level then human dignity is not achieved and the society is not just. Therefore, a just society will ensure these capabilities to at least the minimum level.

A2: “The Good Life” Is Anti-Disabled

No, the disabled live good lives. I’m just arguing they should have the appropriate health care to make that possible

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The notion that good health is necessary for a good life appears problematic

for my view in the case of individuals living with disability. Health seems valuable because it protects opportunity. Without good health one cannot participate in the range of opportunities that constitute one's view of the good life. Disabilities seem to preclude good health. Generally they are viewed as deviations from health because they impose limits on one's physical and mental capacity which causes worse than average functioning. It may seem implicit in my view that disabled individuals could not live good lives. Their health prevents them from participating in certain activities and experiences which make up the range of opportunities for a normal human life. Thus, they cannot live a good life. Obviously this conclusion is false. Most if not all individuals living with a disability would say they enjoy life. My premise must be reconciled with the empirical evidence in order for the argument to go through.

Examining the idea of one's personal conception of the good life clears up this discrepancy. One's personal conception of the good life is the manner in which one would like to live. This includes the activities that one would like to participate in and the experiences one would like to have. In order for a conception to be reasonable it must fall within the confines of one's personal situation. For example, my desire to breathe underwater is not a legitimate component of my conception of the good life. So is the case with an individual confined to wheelchair wishing to walk. While those living with disability can participate in most aspects of society they are aware that their personal circumstances limit their range of opportunities, as is the case for all people. Good health is the

level of function necessary to live one's personal conception of the good life. People with disabilities have different conceptions of the good life and thus different conceptions of good health.

A2: Costs Key

Costs are one consideration, but they are not the only consideration

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Like medical practice, economics is not an exact science. Neither are most doctors or patients familiar with sophisticated analytic procedures such as multilevel probability trees or marginal cost-benefit analyses applied to determine the relative cost-benefit ratios of alternative approaches. These technical procedures for determining the expected value of a medical procedure are complex to calculate and impractical for routine health care practitioners (Kling, 2006, p. 93, n.1). Moreover, they elevate both effectiveness and cost considerations as values paramount over other values such as responsiveness, responsiveness, fairness, human dignity, free and informed consent, and democratic, collaborative decision-making. Despite the limitations of the principle of utility and derivative procedures such as cost-effective analysis, a utilitarian ethic is both reasonable and relevant to the debate about health care reform. Utilitarianism is one of the rational, ethical principles to consider, but not the only one, nor the most fundamental one. Other teleological principles include beneficence and nonmaleficence. As I will illustrate in the next two chapters, both principles have important implications for health care policy, and both provide support for universal health care. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 2690-2695). AuthorHouse. Kindle Edition.

Many ways to reduce costs under a universal health care system

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

As Drake illustrates, the usual argument for restricting benefits (as well as access) is the rising cost of health care services. However, it is important to remember there are several other ways to contain costs, such as (a) reducing administrative waste in the current system due to over a thousand private insurance plans duplicating functions; (b) reducing excess capacity of medical technologies, hospital beds, and medical supplies; (c) setting limits on provider fees, hospital prices and insurance premiums; (d) reducing fraud and abuse; (e) investing in health promotion and disease prevention as well as disease management for chronic cases; (f) standardized claims forms and electronic medical records or "smart cards;" (g) improved quality of outcomes per dollar spent (value-based competition). In addition, new revenues could come from reallocating funds from other sources such as the burdensome military budget. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 6221-6224). AuthorHouse. Kindle Edition.

Beneficence

Beneficence requires cooperative care and universal coverage

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Beneficence Requires Cooperation and Universal Health Care Another explicit application of the principle of beneficence to health care reform is Weiner's (2006) principle of cooperative beneficence. This is an extension of the duty of individual beneficence, which Weiner suggests is supported by both deontologists such as Immanuel Kant, W.D. Ross, and John Rawls, and consequentialists like John Stuart Mill, Beauchamp & Childress, and Wm. Frankena (Weiner, 2006, p. 217, n. 20). The principle of cooperative beneficence makes cooperating for the benefit of others obligatory in order to secure shared vital interests such as the health of a population.

People can be (and should be) expected to fulfill their obligation to cooperate when they are given reasonable, well-defined, and equitable roles in a cooperative effort to establish and sustain a collective good such as universal health care. Herein lies a moral justification for the individual mandate to have health insurance as stipulated in the Affordable Care Act of 2010. To comply with the principle of cooperative beneficence, a health care system must meet a threefold design principle: The system must be simple, stable, and universal. These criteria would be met by a health insurance scheme that was affordable, universal, community rated, and portable, with uniform and comprehensive benefits available to everyone.

This threefold design principle implies two related principles to achieving a health care system that meets the moral standard and principle of cooperative beneficence: (a) a fair cooperative effort principle, and (b) a reasonable burden principle. When combined, these two principles require that the burdens (costs) of the health care system be distributed equitably and the amount of an individual's burden is limited. More specifically, these principles require fair financing by a progressive formula, so individuals and families with higher incomes pay more than those with lower-incomes. In Weiner's words: Because the cooperative beneficence approach uses the principle of beneficence, not justice (or fairness) to ground our social duty to cooperate in guaranteeing health care, it uses fairness to mean evaluating how the effort should distribute the burdens or sacrifices necessary to fulfill that social duty. (Weiner, 2006, p. 236; cf. p. 235, n.73) Weiner offered his approach to health care reform as an alternative to arguments for universal health care based on either (a) a positive moral right to health care or (b) on a charity approach which asserts only a negative right to be protected from being harmed by others (p. 213). He does not recommend a particular policy of health care reform, but his principles and criteria for evaluating proposals appear to this author to be met by a policy of universal health care as defined in chapter one of this book

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The principle of beneficence provides rational justification for the policy and system of universal health care as defined in chapter one. That system which is more beneficent will qualify as more justified morally than another which is less beneficent. In order to be practical, this general principle of beneficence must be further specified. Defining good health care as medically necessary care is one form of specification presented in this chapter. Weiner's (2006) principle of cooperative beneficence combined with his threefold design principle constitutes another example of specification. A third example of specification of beneficence is Charles Dougherty's middle axiom, " namely that we ought to render aid to those in need. Because the provision of health care is merely a specific form of rendering aid to those in need, it follows from his moral axiom that society has a moral obligation to recognize a moral right to some basic level of health care based upon both medical need. The burden of proof falls upon those who would deny both this societal duty and moral right of access to necessary health care (Dougherty, 1988, pp. 115-124). As a further specification of this middle axiom, Dougherty provides several arguments for the moral right to basic health care based on principles derived from utilitarian, egalitarian, libertarian, and contractarian theories. His approach illustrates how a teleological theory can lead to considerations of justice (rights), though the principle of beneficence " can be applied to justify universal health care without consideration of rights. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Location 3187). AuthorHouse. Kindle Edition.

Nonmalficence

Nonmalficence supports universal health care

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

THE PRINCIPLE of Nonmaleficence Do No Harm and Derivative Rules I have discussed the principle of utility and derivative rules related to the goals of medical and social utility, quality of life, and cost-containment. And from the ethical principle of beneficence I have derived and justified medically necessary care as the goal of the health care delivery system. Applications of both principles of utility and beneficence illustrate teleological ethics, which emphasize goals and outcomes. Another relevant teleological principle is nonmaleficence (do no harm). It is a basic principle of the Hippocratic Oath taken by most graduates of American medical schools (Miles, 2004). Two examples from the oath are the following statements: "I will use regimens for the benefit of the ill in accordance with my ability and my judgment, but from [what is] to their harm or injustice I will keep [them] . . . I will not give a drug that is deadly to anyone if asked [for it], nor will I suggest the way to such a counsel." (pp. xiii, xiv). Recall from chapter three that Frankena (1973) subsumed nonmaleficence (do no harm) under his primary principle of beneficence. He ranked doing no harm as above and prerequisite to three other obligations of beneficence, namely, to prevent harm, minimize or remove harm, and to do the good. Beauchamp and Childress (2001) view nonmaleficence (do no harm) as a separate *prima facie* principle, and specify rules derived from it relevant to the provision of health care services.. Examples of derivative moral rules can be stated as prohibitions: Do not cause pain or suffering, do not kill or incapacitate, do not cause offense, do not deprive others of the goods of life (p. 117). An illustration of the moral argument for universal access to health care based on a rule derived from a separate principle of nonmaleficence is as follows: MP: No one should be deprived access to medically necessary care (as one of the basic goods of life). "

mp: Universal health care deprives no one access to medically necessary care. C: Therefore we ought to promote universal health care. At first glance this syllogism seems to violate the rule that one cannot logically derive a conclusion from two negative propositions (Copi & Cohen, 2009, p. 247); however, the propositions that "no one should be deprived" (major premise) and "universal health care deprives no one" (minor premise) are logically equivalent to the positive assertions that everyone should or does receive health care. In this syllogism, the major premise is stated as a prohibition to be consistent with the principle of nonmaleficence and to conform to the derivative moral rule of not depriving others of the goods of life (in this case, medically necessary care). The minor premise is an assertion of fact. Universal health care is morally justified because in fact it does not deprive anyone of health care. The other moral rules derived by Beauchamp and Childress (2001) from the principle of nonmaleficence can be applied to support universal health care as well. One can commend universal health care because it does not cause pain or suffering; rather it prevents or removes the unnecessary pain and suffering experienced by those who lack insurance, hence have restricted or no access to optimal health care.

Moreover, universal health care saves lives and prevents or minimizes incapacities in people who receive primary and/or specialty care when it is needed. Finally, the failure to provide universal health care causes offense to those whose need for medical care is denied or delayed. It is an affront to human dignity and humiliating for someone to be unable to access the health care that they or their loved ones need because they are poor, and are consequently treated defacto as if they were undeserving or unworthy of receiving medically necessary care. Collectively these moral rules derived from the teleological principles of nonmaleficence and beneficence constitute reasons to support universal health care because it avoids, prevents, minimizes or removes the harm that occurs to people when their access to health care is restricted, delayed, or denied.

But we may ask, are people really harmed if their access to health care is restricted? The empirical answer to that question is affirmative. In my previous discussion of the principle of beneficence I cited studies documenting the poorer health and health care of the uninsured. A recent review of these studies has been conducted by Anderson, Rice, and Kominski (2007). These studies need to be placed in context by citing others which demonstrate that participation in the U.S. health care system actually causes harm to patients. Consequently, issues of safety and quality of care must be addressed; however, they must not be allowed to preempt the value and goal of universal access. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3231-3237). AuthorHouse. Kindle Edition.

The U.S. health care system fails to meet the basic ethical standard of nonmaleficence because thousands of Americans experience harm resulting from the occurrence of preventable medical errors. This is a quality-of-care issue: Unsafe care is poor quality of care. The issue of quality of care has been addressed in both international and national studies. In a landmark comparative study of the performance of health care systems among 191 member countries of the World Health Organization (WHO), the U.S. ranked 37th in overall health system performance (WHO, 2000, Annex Table 1, p. 155). On specific measures of quality, the U.S. ranked 24th on "the level of health and 32nd on the distribution of health throughout the population. It ranked even lower (54th) in fairness of financing, though it was ranked first in health care spending and in the level of responsiveness to the population's expectations. A combined rating of overall goal attainment was calculated based on three universal goals of health status, responsiveness, and fairness of financial contribution. The U.S. ranked 15th on overall goal attainment. Nine countries had child mortality rates lower than the U.S. in 1999 for male children under age five, and twelve countries' rates were lower than the U.S. for female children under age five. Eight countries had higher life expectancy rates at birth for both males and females (WHO, 2000, Annex Table 2, p. 163). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3252-3259). AuthorHouse. Kindle Edition.

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Due Care versus Negligence Obligations of nonmaleficence include not only inflicting no harm, but also an obligation to not impose risks of harm. A standard and rule of due care is a way of specifying the principle of nonmaleficence. "Due care is taking sufficient and appropriate care to avoid causing harm, as the circumstances demand of a reasonable and prudent person" (Beauchamp & Childress, 2001, p.

118). A moral argument for universal health care based on this standard (norm) is as follows: MP: A health care policy and system should ensure provision of due care sufficient to avoid causing harm. mp: As a policy and system, universal health care provides due care and avoids the general harm caused by limited access. C: Therefore we ought to promote universal health care. Stated negatively, one could argue that a system which provides less than universal access fails to provide due care, that is, it fails to provide sufficient and appropriate care based on medical need, and consequently, causes harm to those who are denied access to health care. Though applied generally in a legal context to the care provided by a health care professional, the concept of negligence could be applied morally to a health care policy that imposes risk of harm either intentionally (recklessly) or unintentionally but carelessly (inadvertently negligent) (Beauchamp & Childress, 2001, p. 118). The U.S. health care system is negligent of the nearly 50 million uninsured and 25 million underinsured Americans. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3327-3333). AuthorHouse. Kindle Edition.

Rights

The Constitution can be read to support a right to health care

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

For example, the 14th Amendment asserts that no State can deprive any person of life, liberty, or property without due process of law; nor deny to any person within its state jurisdiction equal protection of the laws. I will offer eight potential arguments based on existent constitutional rights, particularly those stipulated in the 14th, 8th, and 9th Amendments. The first five rights are related to, if not derived from the equal protection clause of the 14th Amendment. First, because an estimated 18,000 Americans die each year due to their lack of insurance (Institute of Medicine, 2000)—a more recent estimate is 45,000 (Wilper, et al., 2009)—the present health policies and health care system that permit this tragedy to occur violate the constitutional right to life "). guaranteed under the 14th Amendment. Assuming no change in the rate of mortality of the uninsured, over a decade the number deprived of their right to life would amount to a minimum of 180,000 Americans, which is more than three times the number of American soldiers who died in the Vietnam War. Second, lacking health insurance or being underinsured exposes individuals to insecurity and the risk of financial bankruptcy (Himmelstein et al., 2005). Consequently, an individuals' right to be free from such insecurity is denied contrary to the Preamble & Fourth Amendment. A denial of freedom is a denial of liberty. It is tantamount to a denial of their constitutional right to liberty guaranteed under the 14th Amendment. Third, as a consequence of suffering disproportionate risks of illness due to the absence of regular preventive and primary health care, and an unfair financial burden in the present health care system, the uninsured, underinsured and uninsurable are denied their constitutional right to equal protection under the law guaranteed under the 14 Amendment. The civil right to equal protection has been interpreted by the Supreme Court to mean a state must make sure all children regardless of race, have an equal opportunity for education. At the very least, given the racial disparities among the uninsured, the same argument could be applied to ensure equal opportunity to health care for minorities, if not for all uninsured who are sick and poor. Fourth, the 14th Amendment asserts the right to secure property of one's person, house, papers, and effects. Insofar as the same meaning of property in the 14th amendment is applied consistently in the Fifth Amendment, then employees who have made partial premium payments directly or indirectly through reduced wages or co-insurance, have a property right to health care services covered in the papers defining the health insurance policy. They are denied their property rights whenever private insurance companies and health plans delay, limit, or deny benefits by arbitrary exclusions (as "experimental" interventions), or by retrospective cancellations of their policy. In these actions, insurance companies deprive citizens of their private property rights, not merely contractual rights. Moreover, the concept of property rights extends to one's own person. Is not one's body and mind a valued, irreplaceable possession (property)? I have property rights to my own body and mind, and that includes care for both my physical and mental health. To be excluded from the health insurance system and health care services is consequently an unjust violation of my constitutional property right to secure my own well being. Fifth, the 14th Amendment also affirms the Constitutional right to due process. The exclusion of millions of Americans from the health insurance and health care system is not the outcome of due process. Quite the contrary, exclusions are often due to policies and

circumstances that effect people in arbitrary or discriminatory ways. The research on social determinants of health supports the view that health status as well as access to insurance and health care are factors associated with social class. In the American, employment-based health insurance system, loss of one's job often results in loss of health insurance, and many Americans cannot afford the COBRA extension with its higher out-of-pocket costs when they have lost their source of income. The outcome is not the result of due process, but a function of economic exigencies and employers' decisions, assuming the employer even offers health insurance to employees. Presently that is not mandated, not even by the Affordable Care Act of 2010. Sixth, strict constitutionalists assert that the absence of a specific amendment guaranteeing access to health care means it is not a civil right. In response, another rights-based argument could be offered based on the principle stated in the Ninth Amendment: "The enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people." In other words, the positive rights asserted in the Constitution cannot be used as grounds for denying or disparaging the right of access to health care retained by insured people as either a property right which is explicitly protected, or as a human right which should be protected. I make this inference based on the reference to "other" rights, which is generic, and not restricted to other constitutional rights explicitly and specifically affirmed. In fact this amendment was originally adopted to prevent an interpretation that rights not mentioned in the original ten Bill of Rights were not protected. Consequently, this argument might be used to advocate on behalf of the millions of Americans who are uninsured and underinsured. Seventh, one definition of punishment is the withdrawal of a positive value such as life itself or health care to protect one's life and health when sick and injured. Applying this definition, uninsured Americans are denied their right to be free from cruel and unusual punishment contrary to the Eighth Amendment. This situation is cruel because of the loss of life or unnecessary suffering that results, and unusual because it is a statistical outlier—nearly 50 million Americans are presently uninsured, and an estimated 23 million will remain uninsured after the Affordable Care Act is fully implemented in 2014. It is also capricious for people to lose their health insurance when for example, they lose their jobs, or to be denied coverage based on prior medical conditions, or to have their policy rescinded or cancelled when they become ill or injured, or when their insurance company raises their premiums so the policy becomes unaffordable. The eighth amendment was applied by the Supreme Court in the case of Furman v. Georgia to reject the death penalty as cruel and unusual punishment because it was not applied fairly and uniformly. Though not intended as punishment, neither has denial of access to health care been applied fairly and uniformly to all citizens. Moreover, according to the Institute of Medicine (IOM, 2002) an estimated 18,000 die each year due to their lack of health insurance. Is that not a cruel punishment? Eighth, people lacking access to health care are disparaged (contrary to the Ninth Amendment) because in the private sector of our health care system, access to health care is largely a function of one's ability to pay either out-of-pocket or through the purchase of an individual or group health insurance policy. Lower income and increasingly middle income Americans are being treated disparagingly. They suffer humiliation and a personal sense of failure because they cannot afford the coverage for the condition for which they (and their loved ones) need medical care. Add to that the humiliation experienced by the poor who are means tested to qualify for the federal-state government insurance (Medicaid), and are often herded into private managed care plans, and it becomes difficult to imagine a more demoralizing and disparaging system. The preceding arguments for a civil right to health care for every U. S. citizen are based on my own inferences from the U.S. Constitution. Weiner (2002) provided an analysis of how health care advocates and legislators could use state constitutional law to defend a universal legal right to health care under

the equal protection clause of the federal constitution asserted in the 14th Amendment (as cited in Weiner, 2006, p. 212, n. 12). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5845-5851). AuthorHouse. Kindle Edition.....

The preceding discussion expresses my conviction that injustice in health care remains a civil rights issue of our time. As Martin Luther King, Jr. wrote: "Of all the forms of injustice, inequality in health care " is the most shocking and inhumane." It falls disproportionately on minorities, women, children, and those who are poor and sick; it violates their inalienable rights to life, liberty, and the pursuit of happiness declared in our Declaration of Independence; and it denies them equal protection under the law. It is cruel and unusual punishment to be denied the right to life and the human dignity of equal access to health care based on medical need, resulting in disparagement of their value and worth as human beings. It is equally a violation of the moral purposes of our Union, which are declared in the Preamble to the Constitution of the United States of America: to "... establish justice, domestic tranquility, provide for the common defense, promote the general welfare, and secure the blessings of liberty... ." Common sense suggests " suggests that health care is one of the blessings of liberty (freedom from preventable disease, pain, and suffering), and universal health care promotes the general welfare, including promotion of a healthy, productive workforce. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5868-5870). AuthorHouse. Kindle Edition.

Government is morally obligated to prevent discrimination in health care rights

Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

The human right to health care implies a corollary duty of a democratic government to ensure this right is not denied nor restricted by discriminatory (unfair) policies and practices. The government is the appropriate institution to fulfill this obligation because it is most representative—at least in principle—and because stewardship of the common good and the public trust is a primary function of government. Moreover, the American government is structured with legislative, executive, and judicial branches to disperse and balance power, which is required to achieve justice among competing and conflicting interests. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5392-5394). AuthorHouse. Kindle Edition.

Markets/Morality

Universal access to basic healthcare is a moral and cultural right – proclaiming these rights is necessary to implement legal policies. Even if these legal policies are not perfect, their advocacy of healthcare as a right can overcome pure theoretical abstraction.

Menzel 11 — Paul T. Menzel, Ph.D., is a Professor of Philosophy Emeritus at Pacific Lutheran University, xx-xx-xxxx ("The Cultural Moral Right to a Basic Minimum of Accessible Health Care" Kennedy Institute of Ethics Journal, Volume 21, Number 1, March 2011, pp. 79-119)

In the United States, amid the fractious politics of attempting to achieve something close to universal access to basic health care, two impressions are likely to feed skepticism about the status of a right to universal access: the moral principles that underlie any right to universal access may seem incredibly "ideal," not well rooted in the society's actual fabric, and the necessary practical and political attempts to limit the scope of universally accessible care to make its achievement realistic may seem marked less by moral rhyme and reason than by the pull of conflicting interests. I try to directly dispel the first of these impressions and to obliquely question [End Page 79] the second. The immense political barriers to achieving universal access to basic care should not be underestimated, but the moral landscape in which reform can work is not unpromising. The essential elements that imply a moral right to basic care already exist in U.S. culture, and those same elements give considerable shape to limits on the basic minimum of care that such a right covers. The Conception of a Cultural Moral Right The first of my larger claims is that as a cultural moral right, the right to universal access to basic care already exists in the United States.¹ The right that exists is not a legal right but a moral one, carrying the same capacity to criticize existing legal arrangements that all moral rights carry. This right is, however, a socially embedded moral fact, present in real aspects of U.S. law and culture. The first step in explaining and justifying this claim is to unpack the conception of a "cultural moral right." "Natural rights" or "human rights"—any rights that are not culturally relative—are claims people are justified in making to their fellow human beings and citizens regardless of the typical beliefs about morality that happen to be prevalent in their society. Such rights, which we might call transcendent, may appear to give the people who hold them the greatest moral power of any rights, for they are not contingent on the vagaries of moral opinion in the society in which they are asserted. Such rights, however, are often difficult to assert persuasively in actual social life precisely because conceptually they transcend the moral beliefs of people surrounding the claimant and rights holder. By contrast, nontranscendent senses of a moral right can give rights holders more persuasive power in making claims on their government and fellow citizens. Contractual rights and legislated rights, which refer to legal rights, are nontranscendent, but there is a nontranscendent sense of moral rights as well: moral claims on others that are logically implied by the combination of some already existing legal elements with various noncontractual, nonlegislated moral commitments and principles widely held in a given society.² Moral rights in this sense I call "cultural" moral rights, to call attention to the fact that they are embedded in a particular moral culture.³ Cultural moral rights may appear fragile, for they are contingent on the moral culture in which they exist and can be asserted. Moreover, since they are not legal rights, the surrounding members of society can usually, with impunity, refuse to recognize them. But in another respect they are powerful: insofar as they really do "exist"—that is, they really are implied [End Page 80] by various legal elements and widespread moral beliefs of people in that society—those who assert them are not fighting as uphill a battle as people asserting natural rights often are. The assertion of a cultural moral right, based on principles and values already prevalent in one's society, is an instance of what Michael Walzer calls "immanent" social criticism. Just as in the most effective personal criticism we measure friends and colleagues "against their own pretended ideals," charging them with hypocrisy or bad faith, the most effective social critics "hold up a mirror to society as a whole" (Walzer 1994, pp. 41–42). "Immanent" criticism, including the assertion of cultural moral rights, has special moral leverage with fellow citizens and can be a powerful source of social change.⁴ Like natural moral rights, cultural moral rights are often much harder to discern than legal rights (contractual or legislated). But just as the difficulty of discernment does not justify dismissing the possibility of the existence of natural moral rights, so also we should not dismiss the possibility of cultural moral rights. If the argument of this

paper is correct, failing to think in terms of cultural moral rights—failing even to look for them—is one of the reasons people typically fail to recognize that there is already operable in U.S. society a kind of right of universal access to basic health care. Because this right does not provide its holders with legal claims and protections, of course, one might think "so what?" Such a reaction to the prospect that a cultural moral right already exists would be premature. A cultural moral right is a "claim-right," and in the particular instance of the right to universal access to basic health care, it is partly an "affirmative" or "positive" right.⁵ It shares in the standard conceptual characteristics of both these kinds of rights. By definition a moral claim-right obtains in a society if and only if it is held by all individuals in that society. In turn, such a right in the case of health care access is held by all if and only if each and every person in the society can justifiably claim that morally they ought to be guaranteed access to basic health services. That moral claim to access is exercised either through purchase with one's own realistically available resources or, if one does not have such resources, through means of access provided by others. This last component is the "positive right" part, and it is crucial if the right is to real universal access. That said, however, it would be confusing and mistaken to think of the entire right as a positive right. The positive element characterizes the right for only some people covered by it. The scope of the right also includes persons who can gain access by purchasing insurance with resources of [End Page 81] their own that are adequate to the purpose and realistically available—as I demonstrate in the next section, that is the case for the cultural moral right to universal access to basic care as it is embedded in the U.S. social situation. For these other persons the practical import of the cultural moral right to basic health care is that it constitutes a moral obligation to insure themselves for basic care. Moreover, when bolstered by other moral principles widely held in the society, particularly an anti-free-riding principle, the state is justified in mandating the fulfillment of this obligation. Thus, part of the right to health care and the universal aspect of its content is compulsory health insurance. We are entirely accurate if we refer to this right not only as "the right to health care" but as "compulsory (affordable) health insurance." One portion of the right's demographic is "positive"—some people ought to be provided resources by others so they can gain access. The other portion is different: the holders of the right are morally obligated to obtain insurance for themselves (though they have this moral obligation only if insurers' ability to vary premiums by likelihood of illness is sharply limited). This two-dimensional right-and-obligation character of the moral situation is the correct way to state the matter in a multipayer health system in which individuals and sponsoring groups (such as employers) choose their insurer. The way the moral right to a basic minimum of accessible care is articulated in the context of a single-payer system will need to be somewhat different. The essential moral claims will still apply, with the "obligation" to purchase insurance shifting to an obligation to pay the taxes supporting the single-payer insurance. I have chosen to develop the argument for the moral right to universal access to basic care in a manner that applies explicitly to multipayer systems. For one thing, that is the immediate context of the United States. Another reason is that change to a multipayer insurance-mandate system is arguably a shorter, less difficult step to take within existing U.S. moral culture than change to a single-payer system. To be sure, even in the U.S. context considerations of efficiency and fairness beyond those that contribute to generating the basic moral right itself may ultimately pull the society toward a single-payer arrangement for providing universal access, but consideration of that possibility is beyond the scope of this paper.⁶ Before leaving this preliminary discussion, I need to address a major fundamental challenge to the notion of a cultural moral right. Cultural moral rights are alleged to work at a median level that is not transcendent but that is not institutional either. If they really are moral rights that, like [End Page 82] transcendent rights, retain the capacity to criticize existing arrangements in a society, how can they be anchored in the very factual elements of the society that make them cultural moral rights with a capacity for immanent social criticism? The elements that logically generate the right, after all, are just contingent facts in a society. What is their moral foundation and justification? Without one, the right implied is no moral right at all but only a cultural one at best. There are two plausible replies to this objection. (1) The societal elements that generate a particular cultural moral right—in this case, already existing universal access to emergency care and widely shared principles about unfair free riding and just sharing of costs between well and ill—may themselves have sound moral justification. In fact, I would claim, in this case they actually do, though articulating that foundation is largely outside the scope of this paper (for an account that lays out such a justification, consult Menzel forthcoming a). (2) Even if these societal elements are without a sound moral justification themselves, they provide the context in which morally poignant claims of consistency can be made. Immanent criticism works off the power of alleged inconsistency. The person asserting a cultural moral right is proclaiming to the society: "You are apparently committed to w ..., x ..., and y.... But you cannot be, authentically and with integrity, unless you also accept my claim z.... Either give up w, x, and y (which you likely won't), or acknowledge z." Consistency and integrity themselves carry moral weight (as a matter of both societal fact and rational justification, I suspect, though I do not provide the evidence and reasoning to back up such a claim here). Moral philosophers on the "purist" end of the discipline may continue to be suspicious, but others (like Walzer, e.g.) whose work speaks to actual social change and not merely ideal theory will readily avail themselves of such a "median" notion as cultural moral rights.

Single Payer is concrete proposal that would restructure conditions of healthcare and reduce burden on poor

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We have traced much of what ails people in the United States to the conditions in which people live and work. These problems are exacerbated by the expensive, inefficient US healthcare system dominated by the MIC. The cure for these illnesses may not be easy to achieve. In fact, it may be politically extremely difficult, involving a profound restructuring of power relationships between classes in the United States. Yet conceptually, the solutions are fairly straightforward. Many are successfully in place in other countries. This chapter puts forward three ambitious yet realistic changes to US political economy and healthcare that would drastically improve people's health. The policies are ambitious because they would mark a profound restructuring of the conditions in which people live and work and in their system of healthcare. They are also realistic, having been enacted in other nations. These already existing alternatives are more effective, efficient and egalitarian than the policies currently in place in the United States. ... UNIVERSAL, SINGLE-PAYER, PUBLIC HEALTH INSURANCE IN CANADA

The US healthcare system relies more on private, for-profit delivery of both insurance and services than other developed countries. The disappointing results of this approach were highlighted in Chapter 5. It has historically not guaranteed access to millions of its citizens who are uninsured, and even under the ACA, people will still be deterred from seeking medical care because of the payments associated with private insurance. It is also a very expensive system. Similar health results have been achieved with much lower costs in systems that rely less on for-profit delivery within the United States and in other nations. There are a wide variety of alternative mixtures of public and private, profit and non-profit ownership models in different countries, but one of the starker contrasts with the US system comes from its neighbor, Canada. Canadian health insurance (Medicare) is paid for out of tax revenue and administered by the government of each province. Comprehensive coverage—which essentially means all necessary hospital and physicians' costs—is provided to all citizens, who also have the option of purchasing supplemental private insurance. Unlike the US system, there is no cost sharing at the point of service. Canadians purchase supplementary private insurance because, depending on the specific provisions in each province, Medicare does not cover some drug costs, dental care, home care, and vision care. Single-payer national health insurance for the United States as envisioned by the Physicians for a National Health Program Single-payer national health insurance is a system in which a single public or quasi-public agency organizes health financing, but delivery of care remains largely private. Currently, the U.S. health care system is outrageously expensive, yet inadequate. Under a single-payer system, all Americans would be covered for all medically necessary services, including: doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs. Patients would retain free choice of doctor and hospital, and doctors would regain autonomy over patient care. Physicians would be paid fee-for-service according to a negotiated formulary or receive salary from a hospital or nonprofit HMO/group practice. Hospitals would receive a global budget for operating expenses. Health facilities and expensive equipment purchases would be managed by regional health planning boards. A single-payer system would be financed by eliminating private insurers and recapturing their administrative waste. Modest new taxes would replace premiums and out-of-pocket payments currently paid by individuals and business. Costs would be controlled through negotiated fees, global budgeting and bulk purchasing. (PHNP, n.d.) Service delivery in Canada is also heavily influenced by provincial governments. The ministers of health control hospital costs by approving and funding global operating budgets for individual hospitals. New facilities and equipment must also be approved and largely funded centrally from the same authority. This institutional arrangement has enabled Canada to contain the escalation of hospital costs relative to the United States. Physicians' fees are determined by means of bilateral monopoly negotiations between provincial medical associations and the ministries of health. Canadian physicians are not permitted to charge patients for anything extra: in other words the government fees represent payment in full. With the price fixed, provincial governments have set up committees to review the patterns of practice so as to identify physicians, and possibly regulate the activities of those who have practices significantly larger than the norm. In addition, some provinces have negotiated aggregate limits on physician billings. In demonstrating the shortcomings of the current US health system, we provided some evidence on its inefficiency and lack of access in Chapter 5. The private, for-profit portion of the US system fares poorly in comparison with both the public portion of the US system and the Canadian system described above. A single-payer public health system is generally viewed to be Superior to a multi-payer private system in terms of both efficiency and equity. Single-payer public systems can raise financing, administer claims, and spread risks over the population more efficiently than a multi-payer private system (Evans, 2000). A tax-financed single-payer system "combines in one authority both the incentive and

capacity to contain costs, to a greater degree that is possible in any of the other financing mechanism" (Evans, 2002: 17). Moreover, there are no "marketing expenses, no cost of estimating risk status in order to set differential premiums or decide whom to cover, and no allocations for shareholder profits" (Evans et al., 1989: 573). A comparative analysis of the healthcare costs in the OECD countries found that total healthcare expenditures are lower on average in systems predominantly funded through general taxation (OECD, 2002). We have already seen that overall healthcare costs are lower in countries with universal public insurance. Part of the reason for this decreased overall cost is reduced spending on healthcare administration. A study comparing the administrative costs (the amount above that paid out for medical care) of the US and Canadian healthcare systems found that 5.9 percent of total healthcare costs in the United States went to insurance administration compared with 1.9 percent in Canada. Further, within the United States, the overhead of private insurance was 11.7 percent compared with 3.6 percent for Medicare and 6.8 percent for Medicaid (Woolhandler, Campbell, and Himmelstein, 2003; see also Himmelstein and Woolhandler, 2008). Other studies have found that administrative costs account for nearly half of the difference between the share of resources allocated to the health sector in the two countries (Himmelstein and Woolhandler, 1986; Fuchs and Hahn, 1990; Himmelstein, Lewontin, and Woolhandler, 1996). There are additional costs to having private insurance as well. Businesses have to dedicate time and effort to administering healthcare plans. US businesses spent \$57 [dollars] per capita on healthcare consultants and the administrative costs of running their healthcare plans. Canadian firms spent a much more modest \$8 per capita on administering health benefits and supplemental private insurance (Woolhandler et al., 2003). Not only is a shift in the financing mix towards a multi-payer private system and away from a tax-financed systems associated with higher costs, it also means a more regressive distribution of payment burden. To the extent that insurance premiums are related to the risk of illness and that the users of care are required to make some financial contributions in the form of deductibles and co-insurance, such a shift in the financing mix involves some transfer of funds from the unhealthy and poor to the healthy and wealthy (Evans, 2000). In 1991, the CBO released two reports on the feasibility of implementing a single-payer public health insurance system. One compared the saving from two alternative reforms to US healthcare. Both reforms would apply Medicare's rates for all medical services and provide universal insurance. The first would do so while retaining the US system of multiple public and private insurance providers. The second would do so under a single-payer system. Under either reform, "all US residents might be covered by health insurance for roughly the current level of spending or even somewhat less, because of savings in administrative costs and lower payment rates for services used by the privately insured" (CBO, 1991a: 39). Further, the CBO found that, of the two reforms, a single-payer plan would create greater savings. The major drawback of the single-payer system was the possibility that "high-income people would probably pay more for coverage that might be less comprehensive than their current plans," which lays bare the distributional consequences of the health insurance debate (CBO, 1991a: 37). The second study explicitly drew lessons for the United States from Canada's experience with health insurance. It concluded that "If the US were to shift to a system of universal coverage and a single payer, as in Canada, the savings in administrative costs would be more than enough to offset the expense of universal coverage" (CBO, 1991b: 6). This included not only expanding coverage to those without insurance but also eliminating co-payments and deductibles.

Single-payer consolidates leftist political infrastructure and whets the appetite for future socialist victories

Schwartz and Sunkara 17 [Joseph M. Schwartz is the national vice-chair of the Democratic Socialists of America, and professor of political science at Temple, Bhaskar Sunkara is the founding editor of Jacobin, "What Should Socialists Do?", August 1, 2017, Jacobin, <https://jacobinmag.com/2017/08/socialist-left-democratic-socialists-america-dsa>]

Fighting for "Non-Reformist Reforms" For socialists, theory and practice must be joined at the hip. Socialists work for reforms that weaken the power of capital and enhance the power of working people, with the aim of winning further demands — what André Gorz called "non-reformist reforms." We want to move towards a complete break with the capitalist system. Socialists, unlike single-issue activists, know that democratic victories must be followed by more democratic victories, or they will be rolled back. Single-payer health care is a classic

example of a “non-reformist” reform, one that would pry our health system free from capital’s iron grip and empower the working class by nationalizing the private health insurance industry. But socialists conceive of this struggle differently than single-issue advocates of Medicare for All. Socialists understand that single payer alone cannot deal with the cost spiral driven by for-profit hospital and pharmaceutical companies. If we do achieve a national (or state-level) single-payer system, the fight wouldn’t be over; socialists would then fight for nationalization of the pharmaceutical industry. A truly socialized health care system (as in Britain and Sweden) would nationalize hospitals and clinics staffed by well-paid, unionized health care workers. Socialists can and should be at the forefront of fights like this today. To do so, we must gain the skills needed to define who holds power in a given sector and how to organize those who have a stake in taking it away from them. But we can’t simply be the best activists in mass struggles. Single-issue groups too often attack a few particularly bad corporate actors without also arguing that a given crisis cannot be solved without curtailing capitalist power. Socialists not only have to be the most competent organizers in struggle, but they have to offer an analysis that reveals the systemic roots of a particular crisis and offer reforms that challenge the logic of capitalism. Building a Majority As socialists, our analysis of capitalism leads us to not just a moral and ethical critique of the system, but to seeing workers as the central agents of winning change. This isn’t a random fetishizing of workers — it’s based on their structural position in the economy. Workers have the ability to disrupt production and exchange, and they have an interest in banding together and articulating collective demands. This makes them the key agents of change under capitalism. This view can be caricatured as ignoring struggles for racial justice, immigrant rights, reproductive freedom, and more. But nothing could be further from the truth. The working class is majority women and disproportionately brown and black and immigrant; fighting for the working class means fighting on precisely these issues, as well as for the rights of children, the elderly, and all those who cannot participate in the paid labor market. Socialists must also fight on the ideological front. We must combat the dominant ideology of market individualism with a compelling vision of democracy and freedom, and show how only in a society characterized by democratic decision-making and universal political, civil, and social rights can individuals truly flourish. If socialist activists cannot articulate an attractive vision of socialist freedom, we will not be able to overcome popular suspicion that socialism would be a drab, pseudo-egalitarian, authoritarian society. Thus we must model in our own socialist organizations the democratic debate, peaceful conflict, and social solidarity that would characterize a socialist world. A democratic socialist organization that doesn’t have a rich and accessible internal educational life will not develop an activist core who can be public tribunes for socialism. Activists don’t stay committed to building a socialist organization unless they can articulate to themselves and others why even a reformed capitalism remains a flawed, undemocratic society. The Power of a Minority But socialists must also be front and center in struggles to win the short-term victories that empower people and lead them to demand more. Socialists today are a minority building and pushing forward a potential, progressive anti-corporate majority. We have no illusions that the dominant wing of the Democrats are our friends. Of course, most levels of government are now run by Republicans well to the right of them. But taking on neoliberal Democrats must be part of a strategy to defeat the far right. Take the Democrats, who are showing what woeful supposed leaders of “the resistance” they are every day. Contrary to the party leadership’s single-note insistence, the Russians did not steal the election for Trump; rather, a tepid Democratic candidate who ran on expertise and competence lost because her corporate ties precluded her articulation of a program that would aid the working class — a \$15 minimum wage, Medicare for All, free public higher education. Clinton failed to gain enough working-class votes of all races to win the key states in the former industrial heartland; she ended up losing to the most disliked, buffoonish presidential candidate in history. If we remain enthralled to Democratic politics-as-usual, we’re going to continue being stuck with cretins like Donald Trump. Of course, progressive and socialist candidates who openly reject the neoliberal mainstream Democratic agenda may choose for pragmatic reasons to use the Democratic Party ballot line in partisan races. But whatever ballot line the movement chooses to use, we must always be working to increase the independent power of labor and the Left. Sanders provides an example: it’s hard to imagine him offering a radical opening to using the “s” word in American politics for his openly independent campaign if he had run on an independent line. Bernie also showed the strength of socialists using coalition politics to build a short-term progressive majority and to win people over to a

Medicare For All Master File

social-democratic program and, sometimes, to socialism. Sanders gained the support of six major unions; if we had real social movement unionism in this country, he would have carried the banner of the entire organized working-class movement. Bernie's weaker performance than Clinton among voters of color – though not among millennials of color – derived mostly from his being a less known commodity. But it also demonstrated that socialists need deeper social roots among older women and communities of color. That means developing the organizing strategies that will better implant us in the labor movement and working-class communities, as well as struggles for racial justice and gender and sexual emancipation. Socialists have the incumbent obligation to broaden out the post-Sanders, anti-corporate trend in US politics into a working-class "rainbow coalition." We must also fight our government's imperialist foreign policy and push to massively cut wasteful "defense" spending. We should be involved in multiracial coalitions, fighting for reforms like equitable public education and affordable housing. Democratic socialists can be the glue that brings together disparate social movement that share an interest in democratizing corporate power. We can see the class relations that pervade society and how they offer common avenues of struggle. But at 25,000 members, we can't substitute ourselves for the broader currents needed to break the power of both far-right nativist Republicans and pro-corporate neoliberal Democrats. We have to work together with broader movements that may not be anti-capitalist but remain committed to reforms. These movements have the potential to win material improvements for workers' lives. If we stay isolated from them, we will slide into sectarian irrelevance. Of course, Socialists should endeavor to build their own organizational strength and to operate as an independent political force. We cannot mute our criticism against business unionist trends in the labor movement and the middle-class professional leadership of many advocacy groups. But in the here and now, we must also help win those victories that will empower workers to conceive of more radical democratic gains. Our members are disproportionately highly educated, young, male, and white. To win victories, we must pursue a strategy and orientation that makes us more representative of the working class.

Movements snowball and empowers left since we free them of collective bargaining time suck

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CLASS INTERESTS: THE EVOLUTION OF THE MEDICAL INDUSTRIAL COMPLEX A private health-care industry of huge proportions could be a powerful political force in the country and could exert considerable influence on national health policy. A broad national health-insurance program, with the inevitable federal regulation of costs, would be anathema to the medical-industrial complex, just as a national disarmament policy is to the military-industrial complex. (Relman, 1980: 969) Like the conditions of work and the state of the environment, the healthcare system is influenced by the outcome of the conflict between groups with opposing interests. US healthcare has been shaped by the conflict between the general public's dissatisfaction with the private system and those who have a vested interest in that system. As we shall see in the following section, the specific mechanisms through which this conflict played out, and the specific groups that took the lead for each side, changed over time. However, this did not change the constant that a weak working class failed to win universal public health insurance in the face of a well-organized, powerful medical industry. In this conflict between US citizens and a specific faction of US industry, the broader business class, which once sided with the medical industry, has become more ambivalent in its support in recent years because of changing economic circumstances. The domination of US healthcare by the medical industry has resulted in an unresolved contradiction. What is desired by the industry has not been satisfactory to the general public. This has manifested itself in serious demands for universal health insurance five times in the 1900s. The early years: the AMA In the early decades of the 1900s, the forces of progressive reform called for expanded access to healthcare. In Europe, workers, their union organizations and the political parties that represented them were the driving force behind universal public insurance (see Table 5.1). Between 1883 and 1910 every Western European nation passed some form of sickness insurance (Hacker, 2002: 193). In these nations, the labor movement pressed for universal, healthcare systems with very specific characteristics. First, they wanted a universal, as opposed to means tested, or targeted, system. Second, they insisted on labor movement input into the direction of the healthcare system. Third, the state was to be in financial control of the system. Finally, it should be funded through a system of progressive income tax (Navarro, 1989). This structure contained two important principles for European workers: solidarity and redistribution. By making a uniform level of benefits available to the entire population, the unity of the labor movement was strengthened. Simultaneously, it strengthened the populations' commitment to public healthcare since the benefits did not only go to an unfortunate (or undeserving) minority of poor families, but to the entire population. Funding through progressive income tax was a deliberate strategy to redistribute income from high-earning business owners to lower-earning workers. Why were European workers able to get their demands for public health insurance implemented while US workers repeatedly failed in the United States? Table 5.1 Establishment of major trade union federations, socialist parties and first social (including health) insurance: selected European countries Source: (Navarro 1989: 140). It was not as though there was no pressure for health insurance in the United States. In 1912, Theodore Roosevelt endorsed compulsory health insurance. In 1916, the American Association for

Labor Legislation pushed for health insurance at the state level. Both of these proposals failed, while similar proposals in Europe succeeded. Vicente Navarro (1989) makes a convincing case that one of the major reasons for this difference is that, despite the increased strength of **the working class** in the United States during the Progressive period, it **was still relatively much weaker than European labor**. The percentage of unionized workers in the United States is lower than in Europe. **For much of US history, unions were organized along weaker, more conservative craft lines**, as opposed to industrial unions, and had no centralized bargaining process. **US labor has never had a significant political party to represent working-class interests. As a result, any popular demands for a universal public system could not be channeled through established union organizations or political parties.** In fact, the AFL, the largest union organization in the late 1800s and early 1900s, openly opposed any kind of publicly funded healthcare. The notoriously conservative president of the AFL, Samuel Gompers, was concerned that public healthcare (and any other government protection for that matter, from minimum wage to unemployment insurance) would diminish the influence of unions, since one of the principal benefits that unions could offer their members would be removed from the negotiating table and placed in the hands of the state (Starr, 1982: 250). While the US population did not have a ready vehicle to push forward its demands for health insurance, **the opposition was unified and well organized**. In contrast to workers' compensation, where employers were divided because many could see a potential benefit through a reduction in legal settlements arising from injuries at work, business could see no similar gains from public health insurance. **Business groups were opposed** to a public system because they were against public intervention in principle, **concerned about being forced to pay for a public program**, predicted it would create an increase in employee "malingering," **and because they were worried that it would decrease employee loyalty** to the firm that was created by employer-funded insurance (Hoffman, 2001: 113–14). **From the workers' perspective, this "employee loyalty" was generated by the additional insecurity that came with losing health coverage along with their job.**

Universal public insurance that would guarantee coverage even to those without work would reduce employers' power in the labor market.

The medical industry provided the vanguard of the opposition to compulsory health insurance. Although health insurance was in its infancy at this time, the insurance companies of Prudential and Metropolitan lobbied to prevent a national insurance program, worried that it would cut into their lucrative trade in life insurance which offered the working class a way of avoiding the dreaded "pauper's burial." During this period the drug companies also lined up in opposition out of concern that a government-run program would have considerable bargaining power over the price of pharmaceutical products. The most vocal opposition to health insurance came from the American Medical Association (AMA). Although it originally provided tentative support for the social reformers who wanted a national universal health insurance program in the 1910s, support was withdrawn over concerns that it eliminated doctors' discretion over their fees, and that fees for services would be changed to a salary or capitation system (a fixed sum per patient per year) under national insurance. One Buffalo doctor claimed that health insurance would create a "heartless, overworked, 15 cent-a-call contract physician" (Hoffman, 2001: 89). After its early flirtation with universal healthcare, the AMA led the opposition to any intrusion into its professional domain. As we saw in Chapter 2, the early decades of the twentieth century witnessed the formalization of the medical profession, part of which was the growing strength of its association. By 1930, 65 percent of doctors belonged to the AMA. By 1920, it issued a declaration opposed to any "system of compulsory contribution insurance" that was "provided, controlled or regulated" by the government (Hacker, 2002: 198). Indeed, at this point, doctors were also opposed to private, voluntary insurance, which they feared would interfere with their professional purview. Similar class alignments thwarted the next wave of health insurance proposals in the 1930s and 1940s. In 1935, health insurance was proposed as part of the New Deal that ushered in Social Security but was left out of the final Act. In the late 1940s the Wagner–Murray–Dingwall Bill, which would have introduced public universal insurance, also failed. The two major changes of this period were the growing strength of US workers and the fledgling development of the private health insurance industry. The pressure for reform again came from popular demands to ensure access to healthcare as the costs of medical care began to increase, in part because of the formalization and direction imposed by the Flexner Report (see Chapter 2). In 1943, 85 percent of people in the United States favored a system of healthcare modeled on Social Security. As organized labor moved to a more inclusive form of industrial unionism, it supported universal public health. However, this support was not unequivocal. Although the Congress of Industrial Organizations (CIO) decried voluntary insurance in 1949, and provided surface support for public insurance in the 1930s and 1940s, it made little concrete effort to win public, universal health insurance through political means. This was especially true after the Taft Hartley Act of 1947 purged unions of their more radical leaders, tactics, and ambitions. Public insurance would strip one of the fringe benefits that bread and butter unionism could use to attract workers in the more hostile post-Taft Hartley environment (Quadagno, 2004: 31).

While the union movement was the driving force behind universal public insurance in other nations, in the United States its efforts were channeled into getting private insurance through collective bargaining. Without the driving force of a fully committed union movement, public desire for universal public health insurance could not overcome entrenched opposition spearheaded by the AMA,

which followed a two-pronged approach. The first was to decry any public insurance. The AMA levied a \$25 fee on its members for an unprecedented multi-million-dollar campaign in the late 1940s, billing public insurance as a communist plot to bring "socialism" to the United States which would result in "low-grade assembly line medicine" (Quadagno, 2004: 30). It communicated its position through letter-writing campaigns, newspaper ads, and personal letters from doctors to their patients. In addition to shaping public opinion, it directly campaigned against politicians who were proposing public plans (Hacker, 2002: 225; Quadagno, 2004: 30). The AMA drew support from the other medical industry groups like the American Hospital Association (AHA), insurance companies, and drug manufacturers. Organizations representing the broader business class, like the Chamber of Commerce, also publicly opposed any government intrusion into private healthcare profits. The second prong was to offer **private insurance** as a deliberate tactic to ease the political pressure for the more odious, as far as the AMA was concerned, public alternative. In 1940 only 6 million people in the United States had any kind of medical insurance, but the figure expanded over 12 times, to 75 million by the end of the decade (Quadagno, 2004). Private insurance was palatable to doctors, in part because the medical profession was in control of early insurance organizations. First, the AHA (Blue Cross) and then the AMA (Blue Shield) set up non-profit organizations that offered early forms of voluntary insurance, but in a manner that avoided the medical profession's concern about third-party intervention in its professional decisions (Quadagno, 2004: 30). In some ways, hospitals even benefited from insurance. Early Blue Cross policies were, in effect, a preparation for hospital services, where families would pay a monthly fee in exchange for free hospital stays of a certain length. For hospitals, this increased the number of patients that could use their services and created a smooth,

predictable revenue flow. While business was not keen on the increasing costs of employer-based health insurance, it preferred the voluntary private form of insurance over the public option. Like the paternalistic corporate efforts implemented in the Progressive period, firms felt that it would increase employee loyalty. This was especially true during the Second World War when wage controls encouraged firms to offer fringe benefits to attract employees in a tight labor market (Quadagno, 2004: 31). The failure of public insurance did not mean that government was not involved in healthcare spending. Rather, it was heavily involved, but in a manner that was amenable to the profitability of the private healthcare sector. In 1946, the Hospital Survey and Construction Act (or Hill-Burton Act) provided grants and loans for healthcare facility construction and modernization (Hoffman, 2001: 183). In exchange for this financial help, facilities had to offer a "reasonable volume" of services to area residents who would not otherwise be able to pay for medical care. The enforcement of the reasonable volume provisions was virtually nonexistent in the early years of this Act, meaning that those who could not pay did not necessarily get access to Hill-Burton funded hospitals. Yet the bill did permit the medical establishment to claim that it was increasing access for poorer members of the community, while increasing the supply of medical facilities in the country. After the defeat of Wagner-Murray-Dingwall, the employer-based system was firmly entrenched as the dominant method of insurance. Doctors,

hospitals, insurance companies, and employers all benefited from private insurance. **On top of this it had the added political bonus of neutralizing the demand for public insurance. Unions may have paid lip service to a public option, but their energies were dedicated to expanding private insurance to their members.** The supremacy of private insurance was further supported by the 1954 tax code change that made employer contributions to worker health plans tax exempt, a policy supported by the AMA and AHA. It was also supported by the CIO despite the fact that it would clearly benefit rich workers more than poor, and only those workers with employer coverage (Hacker, 2002: 204). As a result of these changes, the percentage of people covered by private insurance in the United States grew from 10 percent in 1940 to 70 percent in 1960 (Hacker, 2002: 214).

States will always be a neoliberal tool to protect commerce; they fail to protect the poor

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Despite the important shifts in constitutional law during the 20th century that Justice Ginsburg draws upon in Sebelius, the Constitution of the United States is no friend of democracy. The Constitution deliberately thwarts the coming together of democratic power by dispersing it temporally and institutionally, and it secures these anti-democratic tendencies by erecting high barriers to constitutional change via normal democratic processes.²⁶ Thus it is no surprise that Milton Friedman turns to the US Constitution as a model for protecting neoliberal “freedom” from the unfreedom heralded by the presence of democratic political power: How can we benefit from the promise of government while avoiding the threat to freedom? Two broad principles embodied in our Constitution give an answer that has preserved our freedom so far . . . First, the scope of government must be limited. Its major function must be to protect our freedom both from the enemies outside our gates and from our fellow citizens . . . The second broad principle is **that government power must be dispersed**. If government is to exercise power, better in the county than in the state, better in the state than in Washington.²⁷ In their dissenting opinion, Justices Kennedy, Scalia, Alito, and Thomas sought to nullify the ACA in its entirety and vindicate these two constitutional principles. They repeatedly returned to the “structural protections” of liberty, “notably the restraints imposed by federalism and the separation of powers.”²⁸ For them, the mandate was unconstitutional because it compelled economic activity rather than regulated it, and thus portended the transformation of the Commerce Clause into a general power to solve national problems.²⁹ The threat to withhold all federal Medicaid funding from States that did not agree to expand their programs in accord with the federal statute raised the specter of Congress “trampling on State’s sovereignty” and degenerating into a dreaded “parliament of the whole people.”³⁰ Rather than defer to democratic power in the realm of social and economic welfare legislation, the dissent imagined the role of the Court as stern schoolmaster of the Republic: Structural protections . . . are less romantic and have less obvious a connection to personal freedom than the Bill of Rights of the Civil War Amendments. Hence they tend to be undervalued or even forgotten by our citizens. It should be the responsibility of the Court to teach otherwise . . . Today’s decision should have vindicated, should have taught, this truth.³¹ **Neoliberal citizens are**, apparently, ignorant and stubborn, and **in need of constant reminders** and tutorials **that the acquisition of** their individual **freedom demands the surrender of** their political power. . . In light of the dissent’s constitutional theory, **how then does this constitute a departure from neoliberal ends?** Recall that Milton Friedman’s hostility to centralized political power offered a gradation of judgment about governmental power when governmental power was called for: county rather than state, state rather than federal. Unlike Medicare, which **is administered by the Federal Government**, Medicaid is a joint-project between the States and Federal Government, an example of “cooperative Federalism.”³² **Any State could withdraw from Medicaid and leave the poor in grave distress; no action by this or that State can threaten the distribution of health coverage provided by Medicare.** And as Justice

Ginsburg pointed out, the constitutionality of Medicare is on sound constitutional footing; it does not prod the States, it bypasses them via the Taxing and Spending power. By rendering federal attachments to federal funds constitutionally suspect, the dissent comes near to creating an either/or logic with respect to future Federal action: spend directly or do nothing. When doing nothing ceases to be a political option, nationalized public health care will be the surest legal path; after all, why risk the constitutional challenge when you can simply avoid it? Ironically, the dissent undermines federalism in the name of federalism and thus turns neoliberalism against itself. ... Individual liberty and limited government are considered to be neoliberal virtues, but limited government in neoliberal governance in fact means limits in some domains but real and robust power in others. As Wendy Brown has astutely noted, neoliberalism does not fight state power per se, but turns state power toward the creation of new neoliberal orders: "the state is not without a project in the making of the neoliberal subject."³³ Chile's simultaneous experience of neoliberalization and right-wing dictatorship helped set the historical mold for realizing Friedman's ordering of economic freedom as preceding and grounding other practices of freedom, and for unleashing the state as a productive force in building a marketized society. Following Brown's lead, we can see that the Pinochet dictatorship did not represent the emergence of a libertarian order of the state policing a naturally functioning market, but instead signaled an active neoliberal state of intervention and social engineering. A key policy triumph of the neoliberals in Chile was the privatization of the public pension system under the Pinochet dictatorship. The minister of labor in charge of that project, José Piñera, would also come to co-chair the Cato Institute's Project on Social Security Privatization in the United States. Chile replaced public pensions with "individually-owned, private investment accounts." The law established a "mandatory minimum savings level of 10% of wages" and all "new entrants to the labor force were required to enter the PSA system."³⁴ Workers, however, were 'free to choose' which financial services company they wanted to manage their mandatory individual pension savings account. To translate this into the language of the Sebelius case, the State has issued an individual mandate that all workers must purchase financial services products. The State does not disappear here; it simply appears in neoliberal form. But this appearance is precisely what the right-wing dissent in Sebelius held to be constitutionally impermissible. If the State can not only regulate economic "activity" but in fact can compel it, have we not then crossed the Rubicon from limited government into its very opposite? As the dissent put it, if the power of regulation includes the power to compel that which is regulated, "then the idea of a limited government power is at an end."³⁵ The capacity of the Federal Government to privatize Social Security along Chilean lines is thus constitutionally blocked. The dissenting opinion sings with neoliberal poetry only to potentially thwart a longstanding neoliberal dream. It has wandered into that vexing predicament where neoliberals have never been able to live with, or without, the state."³⁶

Natives

Native disparities in health-care are massive—Universal health-care solves

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Senate Republicans campaigned against “Obamacare” for seven years. Yet there was never an alternative that had support from a majority of their own party. The problem is simple: Many (not all) Republicans see health care programs that help people — the Affordable Care Act, Medicaid, etc. — as welfare. Others look at the evidence and see these programs that are effective: Insuring people, creating jobs, supporting a rural economy, and actually resulting in better health outcomes. Evidence-based success stories. Of course Indian Country is squarely in the middle of this debate. Congress has never even considered, let alone acted, to fully fund Indian health programs. But the Affordable Care Act basically defined the Indian Health Service (and tribal, nonprofit, and urban operations) as health care delivery vehicles. And one way to pay for that delivery was by providing health insurance through an expanded Medicaid, no-cost insurance that tribal members could get through exchanges and employers. The ACA with all its faults sets out a plan to fully fund the Indian Health Service. That's the challenge now. Making sure that every American Indian and Alaska Native has insurance of some kind. Because of what happened (or, more accurately, what did not happen) in the Senate this week the money remains on autopilot. If you are eligible, the funding is there. Yet the uninsured rate for American Indians and Alaska Natives remains high, as a Kaiser Family Foundation report noted a couple of months ago. “The Affordable Care Act’s Medicaid expansion provides an opportunity to enhance this role by increasing coverage among American Indians and Alaska Natives and providing additional revenue to IHS- and Tribally-operated facilities,” The Kaiser report said. In states that do not expand Medicaid, American Indians and Alaska Natives will continue to face gaps in coverage and growing inequities. This is a problem that will grow because of congressional inaction. Nineteen states including Oklahoma, South Dakota, Wyoming, Idaho, Kansas, Nebraska, Florida, and Maine, have rejected Medicaid expansion. So a tribal citizen in those states gets fewer dollars for healthcare than some Indian health patients in North Dakota, Montana, Alaska, Arizona, New Mexico, or any other state that took advantage of the expansion. As Kaiser notes: “American Indians and Alaska Natives will continue to face gaps in coverage and growing inequities in states that do not expand Medicaid. In states that do not expand Medicaid, many poor adults remain without an affordable coverage option and will likely remain uninsured. Similarly, IHS providers in these states will not realize gains in Medicaid revenue.” This is the what's next? How does the country manage this divide, especially in Indian Country. (And, just as important, we also need to see the gap measured. What are the differences in treatment and outcome between Montana and Idaho or North Dakota and South Dakota? Data, please.) This is critical because under current law, third-party billing (including Medicaid) remains at the local service unit. There is now a funding inequity that needs to be addressed by state legislatures. Recently Rep. Tom Cole, R-Oklahoma, said he knows these states and they won’t expand Medicaid. (Back to the welfare, thinking.) I hope not. The Trump administration recently made it easier for states to get a 100 percent reimbursement for Indian health patients (enticing South Dakota to reconsider joining the ranks of expansion states.) So it's possible, and a challenge, to make sure that the law is implemented, and that innovation continues. The ACA gives much power to an administration to a state to change the rules. You will see a lot of that now. Indian Country needs to keep a sharp eye on that process and raise objections if the result is unsatisfactory. Allocation of Indian Health Service Program Funding, in Billions, FY2016. Source: Kaiser Family Foundation So why did the Senate bill fail? Sure, full credit should go to the heroic stands by Sen. Susan Collins, R-Maine, and Sen. Lisa Murkowski, R-Alaska. From the very beginning of the debate they were the party advocates for a Medicaid system that does produce better healthcare outcomes. And Alaska is a great example of that because nearly a quarter of the state’s population is served. This is how it should be across Indian Country and the nation. And, of course, there was Sen. John McCain’s dramatic late night thumb’s down. The Arizona Republican was a no vote when it counted. But that's not why the bill failed. Fact is it's remarkable that such nonsense got so far. It’s inconceivable that a plan was written at lunch the day before the vote. The bill failed because the Republicans, as a group, do not know where they want to lead the country on health care. They know they don’t want Obamacare (even though it’s based on conservative, market-based ideas). They sure as hell know they don't want universal health insurance, either Single Payer such as Medicare for All or a government health service like Great Britain’s. Yet when I listened to the debate yesterday so many of the complaints about insurance and costs could be solved by such a path. The problem here is that the United States made a huge mistake

with employer-based insurance and that left out people who work for themselves or small businesses.

The only way to fix that is a large pool of people spreading the costs, so that healthy people pay for sick people. The ACA tried to do that with mandates. Most countries

accomplish that goal with universal insurance. Another factor in the Republican plans — and another reason for the bill's failure — is their absolute certainty in a market-based solution. Healthcare delivery and free markets do not play well together. The proof of that is simple: How much is an empty hospital bed worth to a business? Yet that should be the goal. And how much is it worth to a hospital-as-a-business to help a patient not need surgery? What market incentives are there for people to eat better? Seven years ago, when I started writing a lot about health care, I did so because I saw the Indian Health Service as a fascinating example of government-run and managed healthcare. As we began this debate, I thought, let's

figure out what works and what needs work. But I was way wrong. IHS is no longer only a government-run system. Much of the agency is now a funding mechanism for tribal, nonprofit, and urban operations). And that's where so much of the innovation and

excellence in Indian health exists. We need to learn more about what's working and why. Yet Congress (and the public narrative) continue to think of an IHS that no longer exists. At least entirely. This might be a moment to focus on the latter part of what the agency does, improving the flow of funds, and adding more of our people to insurance rolls.

Here's the thing: We cannot do anything about universal health care. At least not yet. But we can have universal health care for Indian Country. It's a huge task, but the ACA remains the law and it's only a matter of execution (not a policy debate). Third-party collections now account for about \$1.8 billion out of the IHS' budget. The dollars Congress appropriates is \$4.8 billion. The third-party portion can grow through more insurance coverage. The

appropriations side will require hard fights in Congress and the outcome is uncertain. Back to the Senate. Texas Sen. John Cornyn, a member of the Republican leadership, joked that perhaps it's time for a new way of doing business. "I guess we ought to go back to Schoolhouse Rock," he said. That's been a clear message from both Republicans and Democrats throughout this messy project. Get a bill. Hold hearings. Let a committee debate alternatives. Then let the bill come to the floor. Regular order. Schoolhouse rock.

Health Care Key to Equality

Equal access to health care is critical to equality

Newsweek, September 11, 2009, Universal Health Care is a Moral Choice,
<http://www.newsweek.com/universal-health-care-moral-choice-79223>

Those Americans who die or go broke because they happened to get sick represent a basic moral decision our country has made. All the other rich countries have made a different decision: they cover everybody. A French physician, Dr. Valerie Newman, explained it this way: "You Americans say that everybody is equal," she said. "But this is not so. Some are beautiful, some aren't. Some are brilliant, some aren't. But when we get sick—then, yes: everybody is equal. That is something we can deal with on an equal basis. This rule seems so basic to the French: we should all have the same access to care when it comes to life and death."

Other nations adhere to the same principle, with slightly different explanations. For Switzerland—a rich, capitalist country that didn't create a universal health-care system until 1994—the underlying rationale is the concept of **solidarité**. That's a crucial word in the Swiss vocabulary, freighted with meanings that include "community," "equal treatment," and "despite our differences, we're all in this together."

"To have a great sense of **solidarité** among the people," former Swiss president Pascal Couchepin told me, "all must have an equal right—and particularly, a right to medical care. Because it is a profound need for people to be sure, if they are struck by the stroke of destiny, they can have a good health system."

That principle seems so obvious to people in Europe, Canada, and the East Asian democracies that health officials asked me over and over to explain why it isn't obvious to Americans as well. "The formula is so simple: health care for everybody, paid for by everybody," a deputy health minister in Sweden told me. "You Americans are so clever. Why haven't you figured that out?"

If inequality exists, the least advantaged should be treated first

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

John Rawls' Difference Principle is illustrated by the concept of vertical equity cited by the World Health Organization (WHO). The WHO concept of equity is twofold: Horizontal equity requires that all those who face the same health need will be treated alike; vertical equity obligates preferential treatment to those with the greatest need " p. 55). The latter concept seems compatible with John Rawls' Difference Principle, namely, if there is unequal distribution of social goods, it must favor the most disadvantaged (in this case, those with greatest health care needs). The concept is also similar to the notion of medical triage, which consists in assessing the severity of patients' conditions, hence urgency for priority treatment. The WHO also justifies public financing to achieve cross-subsidies: the wealthy subsidize the poor, and the healthy subsidize the sick (as any prepayment system will achieve in part) (WHO, 2000, p. 55; cf. viii). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5650-5655). AuthorHouse. Kindle Edition.

A2: Liberty More Important

Note: These are also useful libertarianism answers

Justice requires equality

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

It is important to recognize that while justice is distinct from both liberty and equality, it includes both. Liberty and equality are both necessary constituents of justice construed as a nonmoral value or desired good. This means that justice cannot exist apart from either liberty or equality. A satisfactory ethic based on justice includes both as indispensable elements held in balance so that neither value is affirmed exclusively or absolutely. Justice Requires Equality The idea of equality is central to many concepts of justice. It was emphasized in the previous formal definition of justice justice by Beauchamp and Childress (2001, p. 227). Three additional illustrations cited by Frankena (1973) will be sufficient to express this egalitarian concept of justice. One example of the principle of justice (expressed rather abstractly) is Sidgwick's *prima facie* principle: It cannot be right for A to treat B in a manner in which it would be wrong for B to treat A, merely on the ground that they are two different individuals, and without there being any difference between the natures or circumstances of the two which can be stated as a reasonable ground for difference of treatment. (As cited in Frankena, 1973, p. 17) A second example of an egalitarian view of justice is Rasdall's axiom of equity: "I ought " to regard the good of one man as of equal intrinsic value with the good of any one else." (p. 27). A third illustration from the Judeo-Christian tradition is the egalitarian principle expressed in the Golden Rule (Mt.7.12). Gensler (2002) used symbolic logic to establish the validity of his paraphrase of the Golden Rule: "Treat others only as you consent to be treated in the same situation" (pp. 235, 250f). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 4780-4784). AuthorHouse. Kindle Edition.

Unregulated liberty undermines justice for others, it is not unlimited

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

It is through just laws that the liberties of a people are secured and defended. But unlimited liberty becomes a license to deny the liberties of others, hence liberty must be regulated by balancing liberty with equality. The principle and value of justice implies everyone should have only as much liberty as justice allows, and no more than that... [and] a society should seek to achieve only as much of an equality of conditions as justice requires, and no more than that" (Adler, 1981, pp. 138-139). Justice both promotes and limits liberty and equality. A quote attributed to Jefferson Davis expresses the point: "Liberty consists in the right of each individual to exercise the greatest freedom of action up to, and not beyond, that point where it impinges upon the like exercise of freedom of action of every other man." In terms of the above syllogism, my freedom to choose my own health care provider must not prevent others from choosing theirs, nor must my freedom to access health care services deny or limit others freedom of access. To participate in, and to benefit from a health care system which denies others

freedom to access necessary services is a violation of the principle of liberty as well as equality. It is unjust. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 4807-4809). AuthorHouse. Kindle Edition.

Justice is more important than liberty

We act upon all three values in governing our social, political, and economic affairs: liberty, equality, and justice. From a teleological perspective, all three are considered as highly desirable goods, that is, they are "... real goods that we need to lead decent human lives in the pursuit of happiness" (Adler, 1981, p. 136). These are values that define a democratic society and constitute principles of good government. A good government is a just government. Nevertheless, liberty and equality are also limited goods.

Attempts to maximize one will minimize the other. Both must be limited by justice. Hence, of the three values, justice is the greater good because it synthesizes and balances the other two. Justice regulates our thinking about both liberty and equality. Moreover, unlike the latter two, justice is an unlimited good. "No society can be too just; no individual can act more justly than is good for him and for his fellowmen" (Adler, 1981, p. 137). The reader might note that this is an example of relating ethical principles and moral values by balancing and ranking them relative to each other. One way of ranking justice as sovereign is to argue that whereas liberty and equality are *prima facie* obligations, justice is a categorical imperative. We must act justly, do justice at all times, everywhere, with everyone.

Alternatively, all three values could be considered as *prima facie* principles, that is, principles we are obligated to always fulfill unless overridden by another *prima facie* principle such as beneficence. But a ranking among the three is also justified because justice itself includes, regulates, and balances principles of liberty and equality. Hence, justice is sovereign and the greater good because it reconciles what liberty allows and equality requires. Above all, a health care system must be just. Expressed in the categories of dialectical reasoning, we can consider maximizing liberty as the thesis, and maximizing equality as the antithesis. Justice is the synthesis that gives due regard for both. Justice is a dialectical dialectical concept which balances the other two. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Location 4827). AuthorHouse. Kindle Edition.

Equality of Opportunity

There must be fair equality of opportunity

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

In her essay “Universal Access to Healthcare” Lesley Jacobs examines whether an egalitarian such as Daniels or myself can justify universal care. Specifically she deals with Daniels’ argument for universal healthcare which she refers to as “the minimalist egalitarian strategy” (Jacobs, 333). In this approach Daniels argues for universal access to care on the grounds that it is a requirement of fair equality of opportunity. Also known as the second part of the difference principle, fair equality of opportunity was introduced by John Rawls as an alternative to formal equality of opportunity. Rawls considered the former to be an improvement on the latter in one important sense. Formal equality of opportunity holds that individuals with equal talents and motivations must have equal legal access to advantaged social positions. Rawls recognizes that this view is incomplete without taking into account the different socioeconomic starting points which individuals come from. This uneven footing is the reason that people of similar merit do not reach the same advantaged positions even though everyone has equal legal access. Fair equality of opportunity seeks to remedy this problem as it holds that people of equal merit should have equal prospects of success regardless of socioeconomic position. To this end Rawls argues everyone must have access to a system of education that serves to minimize the effects of one's socioeconomic class on ambitions and natural talents. The desired effect is a flattening of the socioeconomic gradient.

Health care needed to be provided to sustain a fair equality of opportunity

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

Daniels' strategy is to extend fair equality of opportunity to healthcare. He argues that choosing fair equality of opportunity over formal equality of opportunity in addition to public education requires access to healthcare. Ill health, like socioeconomic class, is a random circumstance of birth and should not affect one's ability to realize one's merit.

General Morality

Universal Care Key

Need universal care to fulfill moral obligations

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

The way health care is now delivered (or not delivered) to individuals shows little or no respect for a positive moral right to health care. To meet this moral demand in a minimal sense will require a health program providing universal coverage. And in a stronger sense of egalitarianism and the value of human life, a suitable health care reform proposal should provide not only for access to minimal health care, but rather for the highest quality health care available.

Universal health care consistent with all moral theories

In addition to the above theories and material criteria, Lebacqz (1986) discussed the social contract theory of John Rawls, and three faith-based theories by the National Conference of Catholic Bishops, a Protestant theory by Reinhold Niebuhr, and a Christian liberation theory of justice. All of these eight theories of justice can be applied to formulate material principles and rules for the distribution of benefits to justify universal health care (UHC). Thus, distributing health care universally is morally justified because:

1. UHC maximizes the greatest good for the greatest number (utilitarian ethics).
2. UHC provides choice (libertarian ethics).
3. UHC affirms the common good and social solidarity (communitarian ethics).
4. UHC provides an equal share and fair opportunity opportunity (egalitarian ethics).
5. UHC ensures equal opportunity to basic liberties, yet benefits most the least advantaged (J. Rawls' fairness-based justice and difference principle).
6. UHC respects human dignity and contributes to the common good (Catholic social ethics; contributory justice).
7. UHC honors both freedom and equality as elements of justice (Christian realism; dialectical justice).
8. UHC liberates the poor and oppressed (liberation ethics). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5306-5313). AuthorHouse. Kindle Edition.

"R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5299-5306). AuthorHouse. Kindle Edition.

Moral benefits outweigh any moral disadvantages

A summary of the teleological arguments presented in the previous chapters is that a policy and system of universal health care (as defined in chapter one) should be adopted and implemented because it is supported by ethical principles of beneficence, utility, and nonmaleficence. Universal health care promotes the good of our population's health, establishes the greatest good for the greatest number (everyone), and avoids, removes, minimizes, and prevents the harms caused by the present American health care system, which excludes millions from medically necessary care. These moral justifications for universal health care outweigh moral reasons not to change the health care system. In subsequent chapters, additional arguments will be provided. I turn now to an evaluation of teleological theories to note both their strengths and limitations. I will discuss both under the criteria of a good ethical theory as clear and coherent, logical and verifiable, comprehensive and parsimonious, important, relevant, and practical. I have italicized key words for emphasis. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3548-3553). AuthorHouse. Kindle Edition.

Multiple justifications for access to health care as a moral right

Justifications for a General Moral Right to Health Care

The moral obligation to distribute health care fairly is grounded in a positive right of individuals to receive a "fair share of health care" when it is needed. This right constitutes a claim based on need, regardless of gender, race, age, current or pre-existing medical condition, or on the ability to pay. Consequently any policy, procedure, or system that strives to contain costs by excluding individuals or categories of people (those with high risk for disease, or the poor) violates their right and is therefore unjust. A more just approach would be to limit the set of benefits to which everyone has equitable access. One such approach is based on the right to a decent minimum of health care. The latter presupposes a general moral right to health care just as the utilitarian principle "maximize the good" presupposes the principle of beneficence (do the good). I will address the general moral right first. Beauchamp and Childress (2001, pp. 242-243) present two arguments for a general moral right to health care. One is primarily rights-based and the other is fairness-based. Their first argument is based on precedent, specifically the precedent of collective social protection, to which all individuals have a right. It is predicated on the similarities of threats to health with other threats to well-being from fire, crime, pollution, or natural disasters. Since the government assumes responsibility for the latter four threats, consistency requires that collective action and resources should be allocated for the protection of health as well. This argument assumes that health is a public good and its protection is a proper function of government, not a private commodity bought and sold in the market place for the benefit of some but not for all. Their first argument is also an appeal to a fairness-based justice. The reasoning is as follows. Revenue for government expenditures comes largely from individual citizens who are required to pay taxes. The government in turn allocates money for medical research and training. Citizens have a right to claim a decent return on their investment (taxes), consistent with the principle of commutative justice (requiring a fair exchange). Thus, even if health care is considered a private good as libertarians construe it, individuals can claim a right as citizens to the benefit of health care justified by their taxes allocated to support the health care system through public funding of medical research, the

Medicare For All Master File

development of medical technologies, and through public subsidies to educate physicians, nurses, and other health care professionals. At the very least, everyone should be eligible for publicly financed insurance because the absence of insurance is the primary economic barrier to receiving health care in the U. S. system, and private insurance and health plans have failed for decades to achieve universal access. Moreover, based on both the history and economic self-interests involved, it is very difficult to believe that the private sector can, or ever will achieve universal access apart from government oversight and intervention. The United States is the only industrialized democracy with less than half of its population eligible for public health insurance (Beauchamp & Childress, 2001, p. 240). The second argument for a general moral right to health care is an appeal to the fair opportunity rule derived from the principle of distributive justice. People deserve a fair chance to utilize their abilities to function fully. Their functioning is impaired by injury, disease, or disability, placing them in a condition of undeserved disadvantage. Society has an obligation to compensate and/or restore their functioning by providing health care so their opportunity is more equalized and fair. This argument for a general moral right to health care is very similar to John Rawls' principle of justice as fair equality of opportunity. "It is important to note that in contrast to the first argument for a moral right to health care, this second argument does not restrict the financing of health care to the public sector. In fact, Beauchamp and Childress state that "... a more efficient and equitable system is needed, but not necessarily a system exclusively featuring either public or private insurance, and not necessarily an egalitarian system" (Beauchamp & Childress, 2001, p. 244). A third argument in support of a general moral right to health care is M. Adler's (1981) theory of natural rights based on natural (human) needs previously discussed. To reiterate briefly, health is a real good based on a natural need, not merely an acquired want. Since we are morally obligated to desire, seek, and acquire that which is really good for us (Adler's categorical imperative), ensuring access to effective health care is also a moral obligation. Health care is instrumentally good as a means necessary to restore or maintain health when we are seriously ill or injured. Consequently, health care is a real good and also a human right. Fourthly, Dougherty (1988) derives the general moral right to health care from the presumptive moral obligation to render aid to persons in need. He affirms this fundamental duty as a categorical imperative. It is "... a virtually self-evident moral intuition which cannot be derived from any other more basic or primary principles of obligation" (p. 118). This duty to aid persons in need is a universal and essential principle based upon the mutual and reciprocal needs that humans experience by virtue of their social relatedness, because they are by nature, social beings. This duty to aid those in need is so fundamental that the burden of proof rests upon those who would deny it. And since persons who are ill or injured are in need of assistance, claiming a right to medically necessary care is a reasonable application of the self-evident, primary moral duty to render aid to those in need. Although Dougherty asserts one primary moral principle, his overall argument is pluralistic, and based on three premises (which I have numbered below): In sum, a pluralistic account of the right to health care recommends itself on the basis of three considerations. [1] If it is admitted that there is a general duty to aid others in need, then the moral case for a right to health care does not have to be proved, but only made reasonable. This can be done without developing one line of argument from one theory of justice. It can be done by employing many arguments and various theories of justice. [2] Second, the multiplicity of goods, services, and intangibles to be distributed in society, in general, and in health care in particular, makes it likely that more than one conception of justice will be necessary. [3] Third, each of the theories of justice under consideration relies on a concept of what it is to be a person. But these alternate conceptions of the nature of persons include creative elements that are not appropriately judged true or false. Instead, each brings

important insights and alternative ways of regarding persons. Therefore an adequate account of justice and the right to health care will have to take insights from each of these major and influential theories. The conclusion of these considerations is pluralistic in substance and method. The case for a right to health care can be best made by drawing the most important insights and arguments from utilitarianism, egalitarianism, libertarianism, and contractarianism. And there is one more virtue of a pluralistic approach: disparate strands of arguments provide enhanced rhetorical strength. The single view may be thought of as a chain—only as strong as its weakest link. The plural view, by contrast, is like a cable—as strong as the number of intertwined and mutually supportive threads. (Dougherty, 1988, 123-124; by permission of Oxford University Press, Inc.) Dougherty applies the four theories of justice as moral arguments to interpret and specify the singular and most fundamental principle that there is a general moral duty to render aid to persons in need. “Together, these four arguments drawn from four theories of justice, provide the pluralistic foundations for a moral right to health care” (p. 124). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 6149-6153). AuthorHouse. Kindle Edition.

...

I have illustrated four ethical arguments for the general moral right to health care: (a) the precedent of collective social protection based on commutative justice, (b) a fair opportunity rule derived from distributive justice, (c) a natural rights argument, and (d) the duty to render aid to persons in need expressed in a modified contractarian theory. Additional arguments for a positive moral right to health care have been cited by Weiner (2006) based on egalitarian and communitarian conceptions of justice, arguments based on natural rights, enlightened self-interest, fairness and social contract. The accumulated arguments provide a compelling case for the general moral right to health care. In addition to Dougherty (1988), Buchanan (1989) showed how a moral right to health care is deduced from various ethical theories: Utilitarian, egalitarian, libertarian, and contractarian ethics. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 6174-6180). AuthorHouse. Kindle Edition.

Goal oriented and rule oriented moral systems prove the need for universal health care

Moral Arguments for Universal Health Care The justification for adopting universal health care as a health care policy is provided by the middle level axioms deduced from both ethical and systems theories. Stated another way, universal health care is justified because it meets all eight normative-system standards (axioms) of a good health care system. These eight axioms are in turn justified by multiple principles derived from several ethical theories. The ethical theories can be classified in two general types: goal-oriented (teleological) ethics and rule-oriented (deontological) ethics.

From the perspective of goal-oriented ethics, universal health care is justified by principles of utility, beneficence, and nonmaleficence. These principles also constitute moral reasons to support several specific elements of universal health care. The principle of utility (maximize the good) provides a

rationale for medical and social utility, concern for quality of life, cost-containment, and cost-benefit calculations; the principle of beneficence (do the good) is a warrant for medically necessary care; and the principle of nonmaleficence (do no harm) justifies considerations of safety and quality of care, due care versus negligence or maltreatment, and protection of the vulnerable in the health care system. From rule-oriented ethics, universal health care is justified by principles of universality and respect for human dignity (Kant's categorical imperative and corollary), theological voluntarism, fairness-based justice, and rights-based justice (civil, human, and moral rights to health care). Though derived from divergent ethical theories, the plurality of principles converge to provide a persuasive moral argument for universal health care. I have expressed specific moral arguments in support of universal health care in the logical form of normative syllogisms. In each of these deductive arguments, one or more ethical principles or midlevel axioms function as a major premise. In the minor premise I have made a factual claim that universal health care conforms to the principle(s) affirmed in the major premise. By deducing a normative conclusion from both premises, I have constructed several valid arguments in support of the vision of universal health care and the elements defining it. My own informal count of these arguments and others cited in this volume yields more than twenty specific reasons for supporting universal health care as a morally justified health care policy. More reasons are given below for affirming universal health care as the desired end of health care policy, including arguments listed from theological ethics. Solely on moral grounds, this vision for health care reform is better than others which have fewer arguments in their favor, or which lack one or more of the eight standards and elements which define universal health care. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 6822-6828). AuthorHouse. Kindle Edition.

Current System Immoral

Many reasons the current system is immoral

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Teleological arguments advocating health care reform based on ethical principles of utility, beneficence, and nonmaleficence assert that the present health care system in the United States is not morally justified because of its harmful consequences to millions of Americans. These arguments are based partly upon attention to the empirical outcomes and consequences of the health care system as well as the other ethical principles. Proposals for reform, including the policy and system of universal health care, are supported by claims that these reforms will avoid, remove, minimize, or prevent the negative consequences (harms) of the present health care system and promote greater good for a greater number of Americans. The litany of documented harmful consequences is substantial and disturbing to know. They include medical, financial, and moral harms. Quality problems have been categorized as overuse, underuse, and misuse. The most distressing outcome is loss of life and physical injury to patients due to preventable medical errors, cited previously by the Institute of Medicine (IOM, 2000, 2001). Bodenheimer and Grumbach (2009, p. 111) cited these and other clinical consequences. Selected statements from their summary are provided below. The reader is referred to their text for the references.

- An estimated 32,000 people die in US hospitals each year as a result of preventable medical errors. In addition, an estimated 57,000 people in the United States die because they are not receiving appropriate health care.
- The number of deaths and injuries caused by preventable errors in outpatient settings is unknown. Prescribing errors occur in 7.6% of outpatient prescriptions, which amounts to 228 million errors in 2004.
- Forty-five percent of adults do not receive recommended chronic and preventive care, and 30% seeking care for acute problems receive treatment that is contraindicated.
- A number of studies indicate that racial-ethnic minority patients and low income patients experience an inferior quality of care compared with white affluent patients.

Aside from these harmful clinical outcomes, Haase and Reiner (2006) noted the following five deficiencies in the U.S. voluntary employment-based system of health insurance:

- Insurance: Employees in small businesses are much less likely to be offered coverage than those who work for large companies (businesses with more than two hundred employees). The cost per employee of health insurance is generally lower for large companies because risk is spread among a broader pool of workers. More than a quarter of all working-age Americans in companies with fewer than twenty-five employees are uninsured. These workers account for almost half the total number of uninsured Americans who are employed.
- Layoffs and job switching lead to irregular and episodic insurance coverage. The Congressional Budget Office estimates that 21 million to 31 million Americans go without coverage for a full year or more, while 57 million to 59 million are without coverage at some point during a given year.
- Part-time and temporary workers are more likely to be uninsured. According to the Kaiser Commission on Medicaid and the Uninsured, 31 percent of Americans in households with only part-time workers are uninsured, compared to 18 percent in households with one full-time worker.

and just 8 percent in households with two full-time workers. This situation looks even more troubling in light of the growing trend for companies to hire temporary workers and consultants to whom they do not offer health and other job benefits • Nearly one in three young adults between the ages of nineteen and twenty-four lack health insurance. Younger Americans are most likely to be uninsured because they either are unemployed, have episodic employment, or forgo coverage since they expect to be in good health. • A substantial percentage of minorities do not have health benefits. Hispanics (7.7 percent) and African Americans (10.8 percent) have higher unemployment rates than whites (5.2 percent) and are more likely to be employed in jobs without benefits. Their employment status is one reason minorities are more likely to lack health care coverage than whites. (Haase & Reiner, 2006, pp. 64-65) "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3478-3483). AuthorHouse. Kindle Edition.

The above deficiencies in providing reliable and sustained access to health insurance insurance and appropriate health care are negative consequences of the present employment-based insurance system. Collectively, these deficiencies constitute compelling moral justification for comprehensive health care reform envisioned as universal health care. The Affordable Care Act of 2010 was a significant step toward that goal, but remains subject to challenge and threats to repeal it, or to prevent annual allocations of the funds necessary to sustain it (Skocpol, 2010). "

Bartlett and Steele (2006) provided another summary of the negative and harmful consequences of the fragmented health care system dominated by special interests, none of which represents what is best for American health care overall. And that explains why U.S. health care is second-rate at the start of the twenty-first century and destined to get a lot worse and much more expensive. It's why some people must hold garage sales to pay their medical bills, why almost no one knows what their health insurance will pay for until it's too late. It's why many Americans are forced to make job choices based not on what they might like to do in life, or what's in their best interest, but on the health insurance packages offered by employers. It's why U.S. corporations are at a disadvantage in a global economy, forced to divert ever more revenue and resources to administering health care plans. It's why some diseases such as colon cancer or attention deficit disorder, which capture the media's attention, get a substantial share of government research and treatment dollars, while other diseases that receive less attention, such as amyotrophic lateral sclerosis (Lou Gehrig's disease) and cystic fibrosis, receive far fewer dollars. It's why millions of Americans are forced to agonize over how to care for aging parents with Alzheimer's disease, or how to pay the bills for children with a catastrophic illness—and do so without depriving siblings of their needs. It's why millions of Americans needlessly consume expensive medications that enrich pharmaceutical companies and Wall Street, but that contribute little or nothing to a longer, healthier life. Finally, it explains why Americans are the most over treated, undertreated, and mistreated health care patients on the earth. It need not be this way. (Bartlett & Steele, 2006, pp. 236-237) "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3498-3503). AuthorHouse. Kindle Edition.

The litany of harmful medical and financial effects experienced by an increasing number of Americans makes the U.S. health care system morally unjustified according to ethical principles of beneficence and nonmaleficence, and on utilitarian grounds: It does not achieve the greatest good for the greatest number, nor the greatest possible balance of benefits over harms. More specific moral deficiencies of

the American health care system have been cited by Robison (2006). His conclusion is that the U.S. health care system is immoral on several grounds. In his words [numbering added]:

[1] It deprives innocents of the goods of health care. What did the infants do to deserve such treatment [i.e., neglect] in such a rich country? [2] It creates moral dilemmas for those within the system. Why should parents have to lie about their children's health in order to compete for a job? [3] It is not rational. It puts those who want to be health practitioners through the rigors of what is clearly one of the best educational systems in the world and then allows those with no expertise at all in health care to substitute their judgment for the judgments of the experts—all for profit to an insurance company, not for the health of patients. And it is [morally] perverse in so many ways—[4] harming the innocent through exclusion from the health care system, [5] harming all, innocent or not, by failing to act decisively to prevent such catastrophes as the recent upsurge in tuberculosis from developing, and so putting all at risk, and [6] costing all, as tax payers, enormous sums for something that would have been far less expensive had it been prevented.... . Other perversities in the system [are] [7] those features that force financial disaster on the old so that they can receive medical care when they are vulnerable as the infants we exclude from the system, [8] those that make it impossible for any of us to make rational decisions about health care coverage because the details are hidden from us and the 'best' choice is determined by what creates the most profit for insurers, not what provides the best service. All these are moral faults in the system. All are contingent features of our system, features that can be changed.... . We have a moral obligation to change the system because its current configuration causes unnecessary harms to all " of us, and what ought to drive the changes is that a new system rectify, not replicate, the moral failings of this system. (Robison, 2006, p. 39). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3521-3522). AuthorHouse. Kindle Edition.

Robison (2006) offered another summary of moral deficiencies of the present health care system in the United States as reasons to reform it: That our health care system [a] fails to satisfy the minimally basic goods of any health care system, [b] it distributes what goods it does provide in a way that cuts through the population to exclude many of those most in need of health care, [c] puts at risk what health care it provides to those who can afford it because [d] it tends to subordinate medical decisions to economic imperatives, [e] makes rational what is immoral, and [f] makes impossible what is rational—all these are moral reasons for changing our health care system. (p. 34; cf. White, 2006) Of course, a second important question to address is whether a proposed change will correct the deficiencies of the present system without causing more moral (or other) harms than the present system causes. Opponents of change with vested economic interests will often argue that any reforms, whether incremental or comprehensive, will only do more harm or produce other feared consequences, imagined or real. In either case, the debate is framed in utilitarian terms. Robison argues rightly that: The only way to object [to change] is to show that we have a weightier moral obligation obligation not to make the change—that some other moral values that produce those harmful features or consequences as unfortunate but essential side effects are so morally important that they must be retained despite the harms. Arguments that everyone is used to the system or that it would be expensive to change it or that changing it would produce inefficiencies are irrelevant morally, unless one can show sufficient moral harm attached to any change to outweigh the harm the system already produces. (Robison, 2006, pp. 38-39) Thus, Robison asserts a moral obligation to change the present health care system in the United States because (a) the present system is immoral, (b) there are no moral reasons not to change it, and (c) there are persuasive

moral reasons in favor of changing it. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3538-3539). AuthorHouse. Kindle Edition.

Moral Obligation

Health care is a moral obligation because it is critical to human flourishing

Frank G. Kirkpatrick Author, 'The Episcopal Church in Crisis: How Sex, the Bible and Authority are Dividing the Faithful, June 4, 2013, Huffington Post, The Missing Moral Dimension in the Health Care Debate, http://www.huffingtonpost.com/frank-g-kirkpatrick/the-missing-moral-dimension-in-the-health-care-debate_b_3383194.html

Addressing health needs is a moral obligation because health is essential to the well-being and flourishing of all persons. And it is more than a personal good; it is a social good. The best health care possible should be provided to all members of any society that claims to be looking after the common good or the general welfare of the people. That is why its partial provision through a society-based program, Medicare, is called an entitlement. An entitlement, despite the bad odor the conservatives believe emanates from that word, is a moral term derived from a socially accepted moral obligation. As such, it ought not to be treated as a "discretionary" economic expenditure. It is shocking that a political party that has clothed itself in the mantle of morality has failed utterly to articulate the moral basis of health care or to offer any moral justification for overturning Obamacare or any alternative moral vision for what would replace it. Leaving millions uninsured, as the state of Texas continues to do, is a moral scandal. A political party that cannot address the provision of health care in moral terms has forfeited its right to speak for moral values in America. Once our moral obligation to provide health care to all has been accepted the way will be clear to figuring out as realistically as possible how to provide it efficiently and effectively. But if the moral dimension of the debate is ignored, health care will be treated as having no more moral claim on our resources than does the demand that social taxes pay for my desire for a month's vacation in the Alps.

Health care services deserving moral consideration

Leonard M. Fleck, Ethics Professor, Michigan State University, 2009, Just Caring: Health Care Rationing and Democratic Deliberation, p. 39

I start with the assumption that therapeutically effective health care is morally special. Access to effective medically needed care today often makes the difference between life and premature death. It often makes functional recovery from otherwise permanently disabling injury possible. It often relieves symptomatic suffering associated with acute

or chronic disease that would otherwise grossly interfere with our ability to work (earn a living) or simply enjoy the ordinary pleasures of life. These facts alone attach some degree of moral significance to health care that cannot be meaningfully attached to the vast majority of other products and services generated by our economy.

Denying access to care based on ability to pay is unjust

Leonard M. Fleck, Ethics Professor, Michigan State University, 2009, Just Caring: Health Care Rationing and Democratic Deliberation, p. 40

The point of the preceding paragraph is that the health care rationing issue would not be an issue deserving public attention unless there was something morally special about access to needed health care. If someone were denied access to a new refrigerator or new iPod or new television because they were unable to pay for these products, no one sees this sort of rationing as being morally problematic. But being denied access to a hospital emergency room (in great pain) because one's blocked small intestine (due to cancer) is not imminently life-threatening (and one has no money or health insurance to cover the cost) will strike most of us as being morally criticizable (both unkind and unjust).

Health capabilities are morally important

Jennifer Prah Ruger, Law Professor-Yale, 2010, Health and Social Justice, p. 43

Part II of this book argues from an Aristotelian/capability perspective that what are here called health capabilities should be the central focal variable for assessing the justness and efficiency of health policy. This part proceeds in four stages. The first, in Chapter 2, draws on moral and political philosophy to argue that the Aristotelian/Capability view provides the basis for the special moral importance of health capabilities as the central focal variable for assessing equality and efficiency in health policy. These lines of thought take a universal view of humans' capability to flourish as an end of political activity and provide an analytical framework to address questions of justice and human rights in a way that other philosophical schools do not. More specifically, it is argued that in certain evaluative exercises, universal attention to central health capabilities—people's capacity to avert premature mortality and escape morbidity—should be the morally central on prior objective of health policy, to which we have a special social obligation above and beyond our obligation to the provision of non-central health capabilities. This obligation is universal, applying to all human lives, irrespective of class, gender, race, ethnicity, or community. The focus in some evaluative exercises on central health capabilities as morally central in the evaluation of health policy stems from the need to separate out the ability to satisfy certain critically important functioning up to certain minimally adequate levels. Central health capabilities are indisputable categories of moral and practical importance. The application of the central health capabilities idea, in terms of what premature mortality and escapable morbidity mean, is taken up in Chapter 4.

Justice requires us to care about everyone's access to health care

Leonard M. Fleck, Ethics Professor, Michigan State University, 2009, Just Caring: Health Care Rationing and Democratic Deliberation, p. viii-vix

We are too quick to blame overzealous lawyers, overpaid CEOs of health care institutions, and greedy insurance companies for the fiscal shortfalls in our health care system. Each of us should be "looking within" instead. We are very much of a divided mind in regard to our health care system. We want for our future possible selves as patients

everything contemporary medical technology can offer that will improve the length or quality of our lives. But as presently healthy taxpayers/insurance premium payers we want health care costs controlled. We tell Congress that; we tell Aetna that. We do not want “others” to be spending “our money” on these extremely expensive cancer drugs or other “last-chance therapies.” We expect these “others” to be good citizens and good patients, accept their deaths with equanimity, and die cheaply. These “others” have no right to waste “our money.” Of course, what we avoid giving any thought to is the fact that we are just another one of those “others” from the point of view of our fellow citizens. This captures in a nutshell the “Just Caring” problem: Why should anyone else pay attention to my demands for justice in meeting my health care needs when I refuse to pay attention to their demands for justice in meeting their health care needs.

Ethical commitment to redistribute resources to cover health

Jennifer Prah Ruger, Law Professor-Yale, 2010, Health and Social Justice, p. 5-6

Fifth, because the achievement of equity in health requires social organization in the form of a redistribution of resources, and related legislation and regulation, this obligation requires an ethical commitment on the part of everyone, those most fortunate and those in need, to the end goal of providing health capability to all. Without this ethical commitment, redistributing resources from the wealthy to those less fortunate and from the well to the sick will not be possible, because the effort to do so must be voluntary, not coercive. As such, individuals must internalize the public moral norm that health is worthy of social recognition, investment and regulation to the point of successfully operationalizing it. The ethical imperative of health equity provides strong grounding for individual and state action to respect, protect, and fulfill health equity through institutional change. The primary means for achieving justice and actualizing a right to health are both legal and non-legal instruments. This ethical commitment to health equity is an ethical claim, in this case on all individuals, especially the wealthier, to redistribute some of their resources to help meet our own needs and those of others, today in the future.

Government Role Justified: Unique Moral Status of Health Care

Justifies

Moral status of health care justifies government involvement

Leonard M. Fleck, Ethics Professor, Michigan State University, 2009, Just Caring: Health Care Rationing and Democratic Deliberation, p. 103

When the question is raised as to whether or not health care resources are morally special, the intent is to suggest that health care ought to be distributed in accord with norms of justice as opposed to market norms (i.e., ability to pay). Two preliminary considerations would suggest that health care ought to be distributed in accord with norms of justice: its effectiveness in matters of life and death, and the massive public investments that yielded effectiveness.

Moral significance of health care means it can't be left to the market

Leonard M. Fleck, Ethics Professor, Michigan State University, 2009, Just Caring: Health Care Rationing and Democratic Deliberation, p. 103

Health care today is often very effective in reversing or substantially ameliorating the effects of illness or accident. That is, needed health care can often make the difference between life and a very premature death, or between a serious temporary injury and a serious permanently disabling injury. These are morally significant outcomes. It is hard to imagine any consumer good or service distributed on the basis of the ability to pay that has comparable consequences. Further, what would seem to be a related and relevant moral norm would be a "duty to rescue."

Society has a moral obligation to promote health and human flourishing

Jennifer Prah Ruger, Law Professor-Yale, 2010, Health and Social Justice, p. 2-3

In this view, the ethical principle of "human flourishing" underlies society's obligation to maintain and improve health capabilities. This principle holds that society should enable human beings to live flourishing lives. Flourishing and health are essential to the human condition. Certain aspects of health, in particular, undergird other areas of human flourishing, because without life itself, no other human functioning is possible. Therefore public policy should focus on individuals' ability to function. Health policy should support individuals' capability for health functioning, enabling individuals to meet health needs, and creating conditions for health agency. From this perspective, expanding freedom is both the primary end and principle means of public policy consequently, public policy should focus on removing barriers to freedom that leave people with little choice to exercise their reasoned agency. Freedom entails both processes of action and decision-making and actual opportunities available to people, given their personal and social circumstances. In what follows, I will argue that both the process and opportunity aspects of freedom are essential to developing individuals; health capabilities and a just health system. Public policy should be efficient, requiring the wide and prudent use of resources. The primary goal for health systems is to reduce disparities in health capabilities using the fewest resources. Therefore, some limits must be set in allocating resources, and individuals and experts must decide how to make these trade-offs.

Health Care Costs

Medicare Costs Increasing

Costs are rising and deaths are increasing

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

Ironically, efforts to restrain healthcare spending by restricting access have failed catastrophically to restrain costs even while killing Americans. Americans pay much more for healthcare than do residents of other countries, and the gap has grown over the past decades while health insurers have been restricting access to care. Healthcare spending in the United States, about \$10,000 per person, is twice as much as in the rest of the OECD. Spending has also risen faster in the US: since 1971, it has increased as a share of gross domestic product nearly twice as fast as in the rest of the OECD. We might be happy to pay this price if it came with commensurate improvements in healthcare, but, as mentioned above, our life expectancy gains have been among the lowest in the OECD. We have paid nearly \$1300 per person for every one-year increase in life expectancy since 1971, triple the price paid in the rest of the OECD (\$399 per person). At this rate, to equal the life expectancy of other affluent countries, we would have to raise our spending to over \$14,000 per person, almost triple the average of other affluent OECD countries. This \$9000 margin per person per year—the gap between what we would need to spend to reach the same life expectancy as other countries and what they actually spend—is one measure of the dollar cost of our inefficient health care system. Friedman , Gerald. The Case for Medicare for All (p. 15). Wiley. Kindle Edition.

High health care costs undermine wage growth

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

The rising cost of healthcare is interfering with everything else that we try to do. Instead of raising wages, employers have been paying more and more for their workers' rising health insurance costs. Real spending on private health insurance per employee has soared since 2007, absorbing an additional \$5000 per employee in family plans—money unavailable to pay workers so that they can pay for housing, vacations, schooling for their children, or to put food on the table. From 2007 to 2014, healthcare spending by middle-class households climbed by 25% even while spending on housing fell by 6%, on food by 8%, and on clothing by 19% (see Figure 4).²⁵ The rising cost of healthcare is not only killing Americans and undermining their children's education, it is also bankrupting them. Around 20% of Americans had medical debt in 2014, leading in too many cases to bankruptcy. Nearly a million Americans went bankrupt in 2017, and as many as 60% of these bankruptcies were due to medical debt.²⁶ Over half a million bankruptcies is a steep price to pay for private health insurance.

Medicare for All Reduces Costs

Medicare for All reduces health care costs

Pollin, 2018, Robert Pollin is Distinguished University Professor of Economics and Co-Director of the Political Economy Research Institute (PERI) at the University of Massachusetts Amherst. He is also the founder and President of PEAR (Pollin Energy and Retrofits), an Amherst, MA-based green energy company operating throughout the United States, Economic Analysis of Medicare for All, [file:///Users/stefanbauschard/Downloads/Medicare_For_All_12.5.18%20\(1\).pdf](file:///Users/stefanbauschard/Downloads/Medicare_For_All_12.5.18%20(1).pdf)

Medicare for All has the potential to achieve major cost savings in its operations relative to the existing U.S. health care system. We estimate that, through implementation of Medicare for All, overall U.S. health care costs could fall by about 19 percent relative to the existing system. The most significant sources of cost saving will be in the areas of: 1) administration (9.0 percent savings in total system costs); 2) pharmaceutical pricing (5.9 percent savings in system costs); and 3) establishing uniform Medicare rates for hospitals, physicians, and clinics (2.8 percent savings in system costs). An additional, more modest source of cost savings, at least in the initial years under Medicare for All, would be to reduce the high levels of waste and fraud that currently prevail in service provision. As a low-end figure, we assume that achievable cost savings in these areas would be about 1.5 percent of total system costs in the first year of full operations. We also assume that further gains in waste reduction and fraud control are achievable in later years, at a rate of about 1 percent per year for roughly a decade. As of 2017, the U.S. is spending \$3.24 trillion on Health Consumption Expenditures (other than public health programs). With Medicare for All generating both increased overall demand in the range of 12.0 percent and cost savings of about 19.2 percent, total Health Consumption Expenditures would fall to \$2.93 trillion. We therefore estimate that Medicare for All could reduce U.S. Health Consumption Expenditures by about 9.6 percent while also providing decent health care coverage for all U.S. residents.

Health care costs will decline for middle income families

Sally Pipes, 2020, *False Promise: The Disastrous Reality of Medicare for All*, Pipes is the President & CEO, Pacific Research Institute .

Under the transitional program featuring the 8 percent premium reductions for covered employees, businesses that have been providing coverage for their employees will see their health care costs fall by between about 8 – 13 percent, after accounting for administrative savings as well as their premium reductions. For families, our results show that Medicare for All can promote both lower average costs and greater equity in financing health care. For example, we find that for middle-income families, the net costs of health care will fall sharply under Medicare for All, by between 2.6 and 14.0 percent of income. By contrast, with high-income families, health care costs will rise, but still only to an average of 3.7 percent of income for those in the top 20 percent income grouping and to 4.7 percent of income for the top 5 percent income group

Medicare for All reduces costs

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

Working from the relevant research literature, we estimate that, through implementation of Medicare for All, overall costs of providing full health care coverage to all U.S. residents could fall by about 19 percent in the first year of full operations relative to spending levels under the existing system. The most significant source of cost saving under Medicare for All ECONOMIC ANALYSIS OF MEDICARE FOR ALL / PERI 2018 6 will be a series of structural changes. These will be in the areas of: 1) administration (9.0 percent savings in total system costs); 2) pharmaceutical pricing (5.9 percent savings in system costs); and 3) establishing uniform Medicare rates for hospitals, physicians, and clinics (2.8 percent savings in system costs). We therefore estimate that these three areas of structural change under Medicare for All can achieve, overall, about 17.7 percent in total system cost savings relative to the existing U.S. health care system. A second, more modest source of cost savings, at least in the initial years under Medicare for All, would be to reduce the high level of waste that currently prevails in service provision. A major 2010 study by the IOM found that, as a lower-bound estimate, wasteful expenditures in four major areas of service delivery amounted to about 19 percent of total system costs. These four areas are: 1) unnecessary services; 2) inefficiently delivered services; 3) missed prevention opportunities; and 4) fraud. In line with the IOM's own analysis, we assume that achievable cost savings in these areas through Medicare for All would be only about 1.5 percent of total system costs in the first year of full operations. But we do also estimate that additional efficiency gains in the range of 1 percent per year would be attainable thereafter for roughly a decade. A major factor here will be to establish an effective global budgeting system under Medicare for All.

Multiple sources of savings

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Structural Sources of Cost Savings Administration Under the current system, the overall costs—including time, money and personnel—dedicated to billing and insurance-related (BIR) activities are substantial.³² It is widely recognized that the existing system operates with widespread inefficiencies and redundancies. The areas of inefficiency and redundancy include: contracting, claims processing, credentialing providers and payment validation. These high administrative costs result from all parties operating in the system having to deal with a large number of insurance providers with their own sets of rules and claims-processing requirements. Creating a single payment channel has the potential to reduce these inefficiencies and excess costs significantly. There are two broad sources of administrative savings: 1) the reduced administrative costs for providers associated with a move towards a single payer

system; and 2) reduced administrative costs and mark-ups associated with the provision of health insurance. Savings for Providers Studies of health care administrative costs estimate that the cost of BIR related activities are between 10 and 20 percent of total revenues for physicians and between 4.8 and 10.8 percent of revenues for hospitals.³³ Following the estimation methodology from a 2010 report of the Institute of Medicine (IOM), *The Healthcare Imperative: Lowering Costs and Improving Outcomes* (IOM, 2010), we assume that BIR administrative costs represent 13 percent of the revenues of physicians, clinics, and dentists and 8.5 percent of the revenues of hospitals and of other institutions providing health services (apart from physician and clinical services).³⁴ We show these figures in Table 9. The savings that can be achieved by eliminating administrative inefficiencies for providers are potentially very high. Some estimates suggest the amount of excess BIR costs for physicians and hospitals operating in the U.S. to be on the order of 80 percent.³⁵ The IOM study estimates lower potential cost savings associated with streamlining BIR activities, on the order of 50 percent.³⁶ For the purposes of estimating the savings associated with reducing the inefficiencies of BIR activities under Medicare for All, we assume a mid-range estimate of 65 percent. We show this figure in column 3 of Table 9. Savings through Insurance Provision Cost savings can also be achieved by reducing administrative overhead costs associated with providing health insurance. As we show in Table 9, the costs of administering the U.S. health insurance system—both public and private insurance—amount to 8.5 percent of all health care spending at present. By contrast, estimates of the administrative costs of Medicare are significantly lower—on the order of 2 percent of spending or less. According to the 2018 Medicare Trustees Report data for the calendar year 2017, the administrative expenses of Medicare Parts A, B, and D totaled \$8.1 billion out of \$710.2 billion in total spending—that is, administration amounted to about 1.1 percent of total spending.³⁷ The average figure is slightly higher between 2010 – 2015 at 1.8 percent.³⁸ These percentages for Medicare administrative expenses derived from the Medicare Trustees Report are likely to be somewhat lower than the actual administrative shares of total expenses. This is because they do not include the net cost of insurance for the private plans administering Medicare Parts C and D. If we adjust for this consideration, the full administrative costs for Medicare Parts A, B, and D is likely to be about 2.0 percent.³⁹ A study of insurance administrative costs in other high-income countries shows that insurance administration costs as a share of total expenditures were lower compared to the U.S.: 1.9 percent in Finland, 2.8 percent in Australia, 3.3 percent in the U.K., 4.1 percent in Canada, and 5.6 percent in Germany.⁴⁰ The average administrative costs as a share of total health care expenditures for these five comparison countries is 3.5 percent. It is also useful here to consider the trend for health insurance administrative costs over time within the U.S. economy itself. In 1980, the administration of private plus public health insurance in the U.S. accounted for 5.1 percent of total health consumption expenditures. As of 2017, the administration of private plus public health insurance in the U.S. accounted for 8.5 percent of health consumption expenditures with more than 80 percent of the growth in administration and insurance expenditure occurring in the private health insurance sector.⁴¹ All else equal, it would be reasonable to expect that the relative costs of the purely administrative functions should fall over time, given that the costs of information processing have declined dramatically between 1980 and the present. If the cost of private insurance had grown only as fast as GDP (not even assuming a relative improvement in information processing), then public plus private health insurance administrative costs would be at 3.5 percent of U.S. health consumption expenditures at present.⁴² If the functions of private insurance could be delivered at an expense equal to the current expenditure on Government Administration then public plus private health insurance administrative costs would be at 2.9 percent of total health care expenditures at present,⁴³ a reduction of \$167.5 billion. Given this range of evidence, both for the U.S. and comparison countries, it is reasonable to assume, as a low-end estimate, that moving to Medicare for All in the U.S. could reduce the administrative costs of insurance to 3.5 percent of total

spending. We report this conclusion in Table 9, column 3, in which we show the saving potential in administrative costs to be 58 percent (i.e. the share of administrative costs falls from 8.5 percent to 3.5 percent, a decline of about 58.3 percent). This translates into a 5.0 percent decline in total costs for the U.S. health care system under Medicare for All (i.e. $0.085 \times 0.58 = 0.050$). Pharmaceutical Prices Comparative Prices As we reported in Table 1, working from the National Health Expenditure database and projections, expenditures on pharmaceuticals for 2017 were estimated to have been \$338 billion. This equals 10.2 percent of total health care spending for 2017, according to the NHE data. But the NHE figures do not include non-retail pharmaceutical spending in this category. Non-retail pharmaceutical spending consists primarily of purchases made through hospitals, clinics, nursing homes and physicians' offices. We estimate that the 2017 figure for non-retail ECONOMIC ANALYSIS OF MEDICARE FOR ALL / PERI 2018 46 pharmaceutical spending was an additional \$151 billion.⁴⁴ As such, non-retail pharmaceutical spending represented another 4.5 percent of total health care expenditures for 2017, through purchases accounted for by the NHE within the respective spending categories for hospitals, clinics, nursing homes and physician offices. Therefore, in total, retail plus non-retail pharmaceutical spending amounted to \$489 billion in 2017, equal to 14.9 percent of total U.S. health care spending. On average, pharmaceutical prices in the United States are substantially higher than those in other advanced economies. We can see this in Table 10, which shows comparative figures on pharmaceutical spending per capita for seven high-income OECD countries relative to the U.S. It also reports an average per capita spending figure for these seven countries, as well as an average for 15 European countries, including smaller countries in addition to the six European countries (plus Canada) that we have listed individually. As we see in the table, all seven individual countries spend substantially less per capita than the U.S. on pharmaceuticals. The differential ranges between 31 percent lower for Canada to 64 percent less in the Netherlands. The average differential for the seven comparison countries is 47 percent less than the U.S.⁴⁵ The average differential for 15 European countries, including smaller ones not listed individually, is 50 percent less than the U.S. Factors in High U.S. Prices As a matter of accounting, these large disparities in pharmaceutical spending per capita between the U.S. and other OECD countries could be due to some combination of two factors: higher drug prices or greater volume of drug treatments in the U.S. In fact, the most important factor is higher prices. This is illustrated through the data in Table 11, which are taken from a 2016 study by Aaron Kesselheim, Jerry Avorn and Armeet Sarpatiwari. Kesselheim et al. report the prices for seven top-selling prescription drugs, in the U.S., Canada, France, and Germany. We show in the table the price of each of the drugs in the U.S. market as well as the prices relative to the U.S. in Canada, France and Germany. In column 5, we then report the average price differentials for all three countries relative to the U.S. Taking the average differential by drug for all three comparison countries combined, we see in row 8 that drug prices for these 7 top-selling drugs are, on average, 53 percent lower than in the U.S. Overall then, the differential in prices for top-selling individual prescription drugs in Canada, France, and Germany relative to the U.S. closely corresponds to the difference in pharmaceutical spending per capita within the OECD economies relative to the U.S., with the OECD economies spending roughly 50 percent less per capita than the U.S. High pharmaceutical prices in the United States are a result of significant market power among key firms and the patent protections granted to specific drugs. Moreover, in the U.S., prescription drugs are priced differently for different pharmaceutical market segments and different payers. This generates price variations for the same pharmaceutical products within the U.S. market. It then also creates the opportunity to negotiate down drug prices under a single-payer system.^{46, 47} Federal agencies and programs, with the exception of Medicare, typically pay considerably less for prescription drugs than pharmaceuticals acquired through private means (i.e. private insurance or out-of-pocket payments). For example, analysis by the Congressional Budget Office shows that federal agencies pay between 16 and 35 percent less than the lowest private-sector prices.⁴⁸ The single largest factor here is the Medicaid program. In 2017, Medicaid

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spent \$61 billion on prescription drugs and collected about \$31 billion in rebates, with net drug spending therefore falling by about 50 percent, to roughly \$30 billion.⁴⁹ As another important example, the U.S. Department of Veterans Affairs (VA) oversees the country's largest integrated health care system. It includes a national drug plan for more than nine million veterans and provides 144 million prescriptions per year through this system.⁵⁰ The VA uses a managed formulary to set prices by weighing the additional therapeutic value of a drug to determine the amount of reimbursement. The VA retains the right to refuse reimbursement of a drug if the drug's low therapeutic value does not justify its price. It is precisely through restricting the number of prescription drugs that it is willing to purchase that the VA is able to increase its bargaining power and obtain lower prices. At the same time, the VA has achieved high levels of adherence to drug therapies. The VA system does also include a process to request coverage of prescription drugs not found within its formulary.⁵¹ According to one recent study, the VA pays, on average, 40 percent less than the price paid by the Medicare Part D prescription drug plan.⁵² Another recent study has estimated the VA discount to be 80 percent relative to Medicare Part D.⁵³ One potential concern in using the VA price-setting system as a comparison point for the U.S. health care system overall is that the VA system serves a limited sample of the U.S. population—i.e. veterans, who are all adults, and are mainly male adults. By contrast, the full U.S. population obviously includes young people and women distributed in their normal demographic proportions. It is therefore necessary to also consider pharmaceutical spending patterns in other countries as well—where the full demographic range of a national population is represented—in seeking to establish the savings potential in the U.S. within the overall pharmaceutical spending category. Given this consideration, it is especially notable that, as we have reviewed, the levels of pharmaceutical spending per capita and the prices for topselling drugs in comparable OECD countries are both roughly one-half the levels found in the United States. These patterns are therefore roughly in line with the lower-end average price reductions achieved by the VA through its formulary system. Moreover, as with the VA, most European countries exercise bargaining leverage in negotiating drug prices with private companies. The most common practice in Europe is “international reference pricing” (or “external reference pricing”). The European Commission defines external reference pricing as “The practice of using the price(s) of a medicine in one or several countries in order to derive a benchmark or reference price for the purposes of setting or negotiating the price of the product in a given country.”⁵⁴ Other countries, including Japan and Australia, also use this method for regulating drug prices within their national markets. At present, the U.S. stands virtually alone among advanced economies in having no regulatory policies in place to control the price of drugs for the majority of its residents.⁵⁵ The Medicare for All bill does propose a framework for negotiating prices. The bill endorses a prescription drug formulary system, “which shall encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.” At the same time, similar to the current U.S. VA system, this framework—as stated in the current draft of the bill—will also “promulgate rules regarding the use of off-formulary medications which allow for patient access but do not compromise the formulary,”(p. 54). We believe that through adopting this policy framework, the U.S. Medicare for All program will be able to reduce pharmaceutical prices in the United States by an average of 40 percent. As we have seen, this level of cost reduction is at the lower end of what is being achieved both through the U.S. VA system and within the seven comparison countries we have cited. It is also critical to recognize that achieving this level of pharmaceutical price ECONOMIC ANALYSIS OF MEDICARE FOR ALL / PERI 2018⁴⁹ reductions will improve adherence by patients to the drug treatments prescribed for them, and thereby, produce improved overall health care outcomes.⁵⁶ Lowering drug prices won't reduce development Impact of lower prices on new drug development. The U.S. pharmaceutical industry, along with some researchers supported by the industry, have long held that high drug prices in the U.S. are necessary to

incentivize and finance research and development in therapeutic new medications. One widely-cited series of industry-supported papers by DiMasi, Grabowski, Hansen, along with additional co-authors, consistently finds that the costs of innovation in the pharmaceutical industry are extremely high. The publication of these papers span from 1991 – 2016. In their most recent 2016 study, DiMasi et al. found that the R&D costs of 106 randomly selected new drugs amounted to an average of \$1.4 billion in out-of-pocket costs for the drug companies (in 2013 dollars). Total costs rise to \$2.6 billion when the out-of-pocket expenses are capitalized at a 10.5 percent discount rate. Adding the costs of post-approval R&D brings DiMasi et al.’s estimate of total average costs to \$2.9 billion per new drug.⁶⁵ Such results need to be considered seriously in developing a framework for substantially lowering U.S. drug prices under Medicare for All. At the same time, there is considerable evidence in the independent research literature that provides alternative perspectives as to both the total R&D costs involved in producing new therapeutic drugs as well as the extent to which private drug companies are themselves bearing these costs. To begin with, the research literature finds that most of the financing that undergirds the therapeutic improvements in new drugs is supported in the U.S. by public sources, including especially the National Institute of Health. Thus, a 2018 study by Cleary, Beierlein, Khanuja, McNamee, and Ledley finds that “NIH funding contributed to published research associated with every one of the 210 new drugs approved by the Food and Drug Administration from 2010–2016. Collectively, this research involved more than 200,000 years of grant funding totaling more than \$100 billion. The analysis shows that more than 90 percent of this funding represents basic research related to the biological targets for drug action rather than the drugs themselves.” Cleary et al. also conclude that private pharmaceutical companies have limited incentives “to make investments toward basic research that would negatively impact near-term earnings, offer uncertain competitive advantage, and may not generate profitable products for decades.”⁶⁶ These results are consistent with previous studies that Cleary et al. cite extensively in this 2018 paper. In addition, many researchers working independently of the pharmaceutical industry have questioned the methodology and findings of the industry-supported research.⁶⁷ For example, a carefully documented study by Light and Warburton (2011) found that the actual costs of new drug development borne by pharmaceutical companies amounted to approximately 5 – 10 percent of the figure derived by DiMasi et al. in the 2003 iteration of their research.⁶⁸ Light and Warburton note that their conclusion is supported by the fact that the average audited costs of all clinical trials submitted by pharmaceutical companies to the Internal Revenue Service in the late 1990s was, in fact, one-half the figure that Light and Warburton had themselves derived.⁶⁹ In addition to these findings on R&D costs, it is also relevant that, to a significant extent, the revenues received by pharmaceutical companies through charging high prices for new drugs are being channeled into financial engineering as opposed to supporting R&D. This includes share buybacks, whose purpose is to increase the stock prices of the firms. Thus, a 2017 study by Lazonick et al., “U.S. Pharma’s Financialized Business Model,” finds that: In the name of “maximizing shareholder value,” pharmaceutical companies allocate the profits generated from high drug prices to massive repurchases, or buybacks, of their own corporate stock for the sole purpose of giving manipulative boosts to their stock prices. Incentivizing these buybacks is stock-based compensation that rewards senior executives for stock-price “performance” (2017 p. 1).⁷⁰ Considering this range of evidence, the establishment of Medicare for All should encourage opportunities to develop alternative models for supporting new drug development. One starting point would be the framework developed by the Drugs for Neglected Diseases initiative (DNDi).⁷¹ DNDi is a non-profit organization which began operations in 2003, and has since successfully developed effective new drugs for six diseases. The average cost for developing these six new drugs was \$50 million per new drug. DNDi has been able to maintain lower costs through active collaboration with universities, governments

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as well as the private pharmaceutical companies. 72 Savings through reduce payments Physician/Clinics, Dental and Hospital Payments for Services The Medicare for All bill allows for the negotiation of provider payments for health services. Under the current system, reimbursement rates for service provision vary widely. The variation in rates depends on whether payments are financed through Medicare, Medicaid, private insurance, or out-of-pocket funds. A single-payer system would harmonize these rates, so that rates would not vary based on the type of insurance or source of financing. One well-established benchmark for determining the harmonized rates under Medicare for All would be the existing Medicare rates. Since 1992, Medicare has implemented a fee schedule that stipulates the payments for specific physician services. These fees are adjusted for geographical differences. Similarly, hospitals receive a set amount per episode of patient care, based on the diagnosis made at the hospital. Medicare rates can accommodate both fee-for-service and capitated payment models. Medicare rates are lower, on average, than the rates of private insurance plans.73 Medicaid rates are, in turn, lower on average than private insurance rates and Medicare rates.74 Creating a single rate system under Medicare for All based on existing Medicare reimbursement rates therefore has the potential to generate savings, as long as the lower rates relative ECONOMIC ANALYSIS OF MEDICARE FOR ALL / PERI 2018 53 to private insurance compensate for the higher rates that would be paid for individuals currently covered by Medicaid.75 Based on the analysis of the Medicare Payment Advisory Commission in its 2017 report to Congress, Medicare rates for physician and other health services were, on average, 22 percent lower than commercial rates.76 A study by the Government Accountability Office (GAO) found that Medicaid fee-for-service (FFS) payments were 27 to 65 percent lower than private insurance and managed care payments ranged between 31 to 65 percent lower.77 With regard to total expenditures, rather than simply reimbursement rates, a recent national study of spending under Medicaid found that, controlling for individual demographics and health status, spending under private insurance would be 34 percent higher than under Medicaid for physician services and between 33 and 40 percent higher for hospital services.78 Other studies yielded similar findings—spending under Medicaid was between 18 and 25 percent lower than Medicare rates.79 Table 9 shows estimated savings under Medicare for All in which existing Medicare rates are used to determine provider payments. The estimates assume that Medicare rates are 22 percent below private insurance rates and that Medicaid spending is 35 percent below private rates for physician and clinical services and 40 percent below for hospital services. Dental services, for the most part, are not covered through Medicare. We therefore do not have a Medicare-based rate schedule comparable to that for physicians as a reference point. For the purposes of our discussion, we assume that rates on dental services will adjust in conformity with the rate adjustments for physicians—i.e. that dental services under Medicare for All will be compensated at 78 percent of current private rates.80 Medicare does also cover services provided by other health care providers, including physician assistants, nurse practitioners, clinical nurse specialists, clinical social workers, physical therapists, occupational therapists, speech language pathologists, clinical psychologists and certified nurse-midwives, and in some cases, podiatrists, optometrists, and chiropractors.81 Our discussion here is focused on rates for hospitals, physicians and dentists. But we assume that Medicare rates will continue to also be applied to these other provider services under Medicare for All. Establishing uniform Medicare rates for these services will not have a significant impact on our overall Medicare for All budget estimate. Focusing then on fees for physicians and hospitals, if Medicare rates are 78 percent of private rates and Medicaid rates are 60 percent of private rates for hospitals and 65 percent for physicians, then setting all rates at the Medicare level will reduce payments relative to private insurance, but raise payments relative to Medicaid. Using the share of national health

expenditures financed through private insurance, Medicare, and Medicaid/CHIP, we estimate that the net reduction in expenditures on hospital services would be 3.1 percent. Since, as we show in Table 9, hospitals account for 34.1 percent of all health care spending in the U.S., the cost savings for the system overall would be 1.1 percent ($=3.1\text{ percent} \times 0.341$). Similarly, we estimate the net reduction in expenditures on physician, clinical, and dental services would be 7.1 percent. This would lower overall U.S. health care costs by 1.7 percent, since physicians/clinics as well as dentists account for 24.9 percent of total health care costs ($7.1\text{ percent} \times 0.249$). These results are presented in Table 9. We provide full documentation for our estimates in Appendix 2. In Appendix 2, we also review the results of a 2010 study commissioned by the Medicare Payment Advisory Committee (MedPAC) which estimates the impact on individual physician compensation levels of establishing uniform payment rates under the Medicare fee schedule.⁸² This study estimates ECONOMIC ANALYSIS OF MEDICARE FOR ALL / PERI 2018 54 the change in compensation levels according to five specialty areas—primary care; non-surgical, non-procedural; non-surgical, procedural; surgical; and radiology—and 26 subspecialties. We also discuss these findings further in Chapter 6.

Savings through payment system design

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Potential Savings through Service Delivery and Payment-System Design In addition to the structural sources of savings that can be directly derived through the establishment of Medicare for All—i.e. in the areas of administration; pharmaceutical prices; and payments for services—there are further opportunities to obtain significant savings through the major restructuring of the U.S. health care delivery system. The 2010 IOM study established what it termed a set of “lower bound” estimates of excess health care costs throughout the U.S. in four areas, in addition to the areas of administrative costs and overpricing by providers fees and of pharmaceutical suppliers that we have reviewed above as potential sources of “structural savings.”⁸⁴ In Table 13, we list these four additional areas of excessive costs along with a brief description of the excessive costs associated with each. As Table 13 shows, the four areas are: 1) unnecessary services; 2) inefficiently delivered services; 3) missed prevention opportunities; and 4) fraud. In combination, the IOM’s lower-bound estimate of excessive costs in these four areas amount to 18.8 percent of total health care spending in the U.S. This is in addition to the IOM’s estimate of about 11 percent excessive costs in the areas of administration and pricing, bringing the IOM’s “lower bound” estimate of excessive costs to about 30 percent. The IOM’s estimates are broadly consistent with several other well-regarded sources addressing this same set of questions. These include Wennberg (2002), Farrell (2007), Bentley et al. (2008), Berwick (2012), OECD (2017), and O’Neill and Scheinker (2018).⁸⁵ Beyond these studies providing global cost estimates, there is an extensive literature supporting these conclusions through detailed studies in each of these areas of potential cost savings. In Appendix 3, we provide further details and key references in support of each of these potential cost savings areas.

Net reduction in expenditures under Medicare for All

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As we have seen, our estimate is that, to fully fund Medicare for All within the framework of the 2017 U.S. economy, the federal government will need to raise \$1.05 trillion. This will be in addition to the \$1.88 trillion that is already being provided from existing public sources to fund the U.S. health care system. However, we will assume that the target for additional funding will be \$1.08 trillion, i.e. \$30 billion more than our estimate of the additional revenue required. By incorporating this additional \$30 billion into our estimated revenue requirement, we are targeting that Medicare for All will operate with a surplus equal to 1.0 percent above the total system budgetary requirement of \$2.93 trillion. We can think of this additional \$30 billion as providing a higher-end estimate of the additional overall spending requirements for Medicare for All. This higher-end estimate is consistent with our approach throughout the study—i.e. to work from higher-end estimates of spending needs and lower-end estimates of savings prospects. We can also consider this \$30 billion as a 1.0 percent funding surplus over the system's estimated budgetary requirements. This surplus could then be applied towards creating a rainy-day fund that can help cover possible budgetary shortfalls that might result, for example, during recessions. As needed, these funds could also be applied to help finance transitional programs as Medicare for All is implemented. As we discuss below, this should include Just Transition measures to support workers in both the health insurance industry and related sectors, since large numbers of jobs in these sectors will inevitably become redundant as Medicare for All is implemented. Even when we assume that our additional revenue target is \$1.08 trillion rather than \$1.05 trillion, it is still the case that financing Medicare for All will entail an overall level of funding that is about 10 percent lower than the funding requirements for the existing U.S. health care system. Specifically, again, current U.S. National Health Care Expenditures exclusive of the public health budget is \$3.24 trillion, while Medicare for All's total funding needs, including the 1.0 percent surplus, is \$2.96 trillion ($(\$2.96 \text{ trillion}/\$3.24 \text{ trillion}) - 1 = -0.09$). In working through the total revenue needs for Medicare for All, it is useful to keep in mind this overall framework as a basic reference. That is, because Medicare for All is able to operate at a funding level that is about 10 percent below the current overall funding level for U.S. health care, it implies that, on average, all households and private businesses will be able to pay into Medicare for All about 10 percent less than they are presently contributing to the U.S. health care system. As we work through some illustrative funding proposals, it will not be the case that all entities will uniformly see a 10 percent reduction in their health care budgets relative to their existing spending levels. Yet it will necessarily remain true that, in the aggregate, all funding sources will be paying into Medicare for All about 10 percent less than they provide under the existing system

***Medicare controls costs**

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

If an omnipotent observer were to choose one program as a model for reforming American health-care, it would be Medicare. It has improved health for the elderly and reduced financial stress while controlling costs more effectively than does private health insurance.⁴⁸ For most of its history since 1970, Medicare has controlled per capita costs more effectively than have private insurers, with spending per enrollee rising 1.5 percentage points per year less from 1970 to 2016. Over that same period, while Medicare benefits have increased, notably with the prescription drug program, private insurance benefits have been cut by increasing deductibles and overall cost-sharing.⁴⁹ Medicare's success has often been discounted, however, by policymakers and economists who have focused on its continued cost increases due to the rising and aging Medicare population, rather than on its success at containing price inflation. Paradoxically, Medicare has become more expensive because of population aging and longevity, which are marks of its success.⁵⁰ With some significant exceptions, economists distrust private health insurance.⁴⁸ For most of its history since 1970, Medicare has controlled per capita costs more effectively than have private insurers, with spending per enrollee rising 1.5 percentage points per year less from 1970 to 2016. Over that same period, while Medicare benefits have increased, notably with the prescription drug program, private insurance benefits have been cut by increasing deductibles and overall cost-sharing.⁴⁹ Medicare's success has often been discounted, however, by policymakers and economists who have focused on its continued cost increases due to the rising and aging Medicare population, rather than on its success at containing price inflation. Paradoxically, Medicare has become more expensive because of population aging and longevity, which are marks of its success.⁵⁰ With some significant exceptions, economists distrust

ACA Doesn't Solve the Cost Problem

ACA hasn't reduced costs

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Cost Saving Approaches within the Affordable Care Act The Affordable Care Act became law in 2010, but most of its key features were implemented beginning in 2014. The ACA includes measures designed precisely to deliver quality care while also achieving cost savings through developing innovative integrated care systems. This is most prominently the case through the development of Accountable Care Organizations (ACOs). The ACO framework encourages hospitals and physicians to collaborate effectively by offering financial incentives to these providers if they improve both the quality and efficiency of care.⁸⁶ During the program's first three years, 428 participating ACOs were established and served 9.7 million Medicare beneficiaries in what are called Medicare Shared Savings Program (MSSP) ACOs. To date, the evidence on the performance of these ACOs has been mixed. For example, Song and Fisher (2016) argue that the cost savings from ACOs have been modest to date, but that further savings are still achievable. They do also find that quality improvements have been significant. Hsu et al. (2017) are also cautiously optimistic in their assessment of cost savings to date through the ACO framework. They find, for example, that rates of emergency department visits and hospitalizations have fallen by an average of 6 and 8 percent, respectively through implementing ACO operating systems. The Inspector General for the U.S. Department of Health and Human Services (HHS) recently (2017) reviewed the performance of ACOs across the country. Their assessment was that, to ECONOMIC ANALYSIS OF MEDICARE FOR ALL / PERI 2018⁵⁷ date, cost savings and quality improvements have occurred, though only to a modest extent. They concluded that "ACOs show promise in reducing spending and improving quality."⁸⁷ A still more recent report by Saunders, Muhelstein, and McClellan (2017) supports the findings of the HHS report, concluding that "ACOs continue to achieve high quality, and specific MSSP ACOs—especially those with more experience—have reduced costs simultaneously... The challenge is how to extend these promising results more broadly." Against these perspectives, Schulman and Richman (2016) write that "based on 3 published evaluations of the ACO program, the experiment so far has failed to produce needed efficiencies," (2016, p. 707). Sullivan (2016) reports on meetings in October and November 2016 of the Medicare Payment Advisory Commission, the oversight board for the ACO program, in which staff reported that the ACO programs had, as of those meeting dates, failed to control costs. In addition, a recent large national study by Ryan et al. (2017) concluded that hospital based value payment, "was not associated with improvements in measures of clinical process or patient experience and was not associated with significant reductions in two of three mortality measures."⁸⁸ In another 2017 study that examined hospital data from 2008 to 2014, Papanicolas et al. noted, "We found no evidence to suggest that implementing Medicare's Hospital Value-Based Purchasing program

accelerated the improvement of patient experience beyond secular trends, even among the hospitals with the poorest performance at baseline. Instead, we found that the rate of improvements in patient experience has slowed since the program was implemented.⁸⁹ A major problem in implementing the ACO structure, and with the Affordable Care Act more generally, is that the incentives created to control costs are relatively weak, while the opportunities for hospitals and doctors to avoid cost controls and even expand their profit opportunities within the ACO system remain largely intact. Woolhandler and Himmelstein (2017) describe the results to date with ACOs and the ACA more generally as follows: Proponents claimed that this payment shift would give hospitals and doctors incentives to improve efficiency and save money, since they would share in the savings. They also asserted that the shift would give providers incentives to better coordinate care, upgrading the quality of care. Finally, they emphasized that quality measurement would protect patients against incentives for undercare, and that bonuses based on these metrics would goad providers to improve quality. Unfortunately, there is no evidence that any of these promises have been fulfilled. Medicare has realized no savings, after the cost of bonuses paid to providers has been factored in. And claims for quality improvement are based on providers' reports of their own performance that are heavily influenced by incentives to "teach to the test," improving scores on surrogate measures but not actually improving health outcomes.⁹⁰ Ashish Jha, a proponent of ACOs in principle, describes what he sees as its skewed incentive structure—what he terms a "one-sided model"—as currently organized. He writes: Right now, we have a classic "heads—ACO wins, tails, CMS loses" situation and it simply isn't financially sustainable. Senior policymakers need to continue to push ACOs into a two-sided model where they can share in savings but also have to pay back losses. Barring that, there is little reason to think that ACOs will bend the cost curve in a meaningful way.⁹¹

Equality

Distribution

The squo is heavily unequal because of economic disparities--single payer solves by removing the financial incentive for disparate treatment

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The US healthcare system provides unequal care. Just as life expectancy is determined by which neighborhood you live in, for many Americans what hospital or doctor you can see is influenced by neighborhood, insurance, race, and ethnicity. And if you live in a high-mortality neighborhood, a trip to the local hospital might just be a matter of life and death. There are three major reasons why health care delivery in the United States is not equitable. The first is that health care is treated as commodity, not a right. The poor (with or without insurance) living in neighborhoods of concentrated disadvantage often have more limited access to quality health care.² Those who are uninsured and underinsured experience great difficulty accessing needed care.³ Minorities and the poor are less likely to have private health insurance than white middleclass Americans.⁴ When minorities and the poor do have insurance, it is more likely to be one of the publicly funded insurance policies that not all hospitals and doctors accept. The second reason is that minorities sometimes get different treatment for the same illness from what whites get, regardless of insurance. Health care providers' implicit racial bias and patients' mistrust may be the causes of this differential treatment.⁵ The third reason why health care delivery is unequal is that the health care institutions that serve the poor in general suffer from cash and capital shortages. Neighborhoods of concentrated advantage where people with better insurance live have better-resourced hospitals and clinics than poor neighborhoods do. This is how structural violence works within the fabric of the health care system. It is not as if great care cannot be delivered in underserved settings. It is, every day. But it is inconsistent or constrained by a lack of resources. Thus minorities and poor people die disproportionately as a result of an unfairly structured

American health care system. The Deadly Divide Take breast cancer care. It is a gruesome fact that in the United States, black women are 40 percent more likely to die from breast cancer than white women. While black and white American women now develop breast cancer at the same rates (something that was not always the case), more black women will die of the disease.⁶ Why does this particular death gap exist? An oncologist will tell you that black women first seek treatment with larger, more deadly, laterstage breast cancers.⁷ But the truth is that the breast cancer death gap is not just a biological phenomenon but a consequence of structural violence. A woman's neighborhood can determine whether she will survive breast cancer or die from it. It would be grisly enough if breast cancer were the only disease that discriminated. It is not. From heart disease to hepatitis C, depression to diabetes, blacks throughout the United States suffer higher rates of illness and death than whites. It is tough to name many diseases that do not discriminate by race, place, and poverty. But breast cancer is a disease that demonstrates vividly how structural violence is woven into neighborhood fabric, especially in black communities. The Missed Breast Cancer The key to unlocking the inequity in breast cancer mortality came from a radiology reading room on the top floor of Mercy Hospital on Martin Luther King Jr. Drive on Chicago's South Side. The room was dark except for the projected image of a mammogram. Amid the cool gray background of fatty breast tissue was an unmistakable irregular-shaped mass, its speculated white tentacles invading the surrounding tissue—a telltale sign of advanced breast cancer. It was as obvious as a ticking bomb. Dr. Paula Grabler, a radiologist specializing in reading mammograms and diagnosing breast cancer, was then the director of breast imaging services. At most of the other small hospitals that served South Side African American communities, mammograms were read not by specialists but by general radiologists. Too often cancers were evident but missed. This case was no different. "She was a middle-aged African American woman," Dr. Grabler recalled.⁸ "The patient had been seen in the past at a small South Side hospital and had a screening mammogram that was reported to be normal. Months later she came to me with a lump in her breast. I asked to get a copy of the prior mammogram and there it was: a large, very obvious breast cancer." Grabler typically removes mammograms from the view box when she meets with patients. She does not want the image of the cancer to shock the patient. "But on this particular day, I forgot to," she said. The patient gasped when she saw the large white mass that exploded from the gray background of the x-ray. "How did they miss it?" she asked. It was a glaring mistake that could cost her her life. "I honestly don't know," Grabler replied. But she did know. The doctor who read her mammogram was not an expert. He was an itinerant radiologist who read all types of x-rays. Detecting breast

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cancer early requires meticulous attention to detail. Trained experts who read mammograms find six times more breast cancers than general radiologists do.⁹ In Chicago, most of the breast centers that are near or in the black wards do not have such specialists. Cancers are missed. Women die. An obvious breast cancer on a mammogram. The patient presented with a lump in her breast; the prior mammogram had been read as normal. Sometimes the cause of racial disparities in health care can be as banal as an inexperienced or busy doctor missing cancer. Source: authors personal collection. That missed breast cancer held the key to understanding an aspect of premature mortality: access to screening is important for finding breast cancer early—but the quality of that screening is even more critical. We found a screening facility serving Chicago's black community that found two breast cancers for every thousand women screened, when the correct number should have been at least six.¹⁰ More than half were missed. Add to this injury the insult a black woman feels later when she goes to see a doctor with a bad cancer and is told that her genetics are at fault. Institutional racism as a structural cause of increased mortality can sometimes be as banal as a poorly qualified doctor

missing a cancer in a poorly run mammography center. In a Chicago study of missed breast cancers, poor women, minority women, and publicly insured women were significantly more likely than well-insured white women to have their cancers missed (they were there on the mammogram on a lookback.)¹¹ Socially disadvantaged women (poor, minority, and uninsured) are significantly more likely to have a cancer missed on mammography because they are more likely to receive care at substandard facilities, in segregated neighborhoods, than advantaged women are.¹² Even if women of color do everything

right—get screened, schedule follow-up appointments—they can still fare worse than white women simply by virtue of where they live. This is not just a product of poverty, though poverty itself is a big predictor of inequity. There are plenty of poor white women in Chicago, but there is not one poor white Chicago neighborhood.¹³ Poor white women can get their breast care in the same neighborhood hospitals as the more wealthy women in their neighborhoods. This is structural violence and institutionalized racism at work.

Women living in Chicago's neighborhoods of concentrated advantage are 37 times more likely have ready access to a "breast center of excellence" than women living in high-poverty neighborhoods.¹⁴ This maldistribution of resources did not occur by chance. The Spread of Racial Disparity None of this mattered when there were no effective treatments for breast cancer. From the mid-i930S, when breast cancer mortality was first measured in the United States, until the early 1980s, when screening mammography and new chemotherapy agents were shown to be effective at reducing mortality, there were no black-to-white or rich-to-poor gaps in breast cancer mortality.¹⁵ But in the early 1990s, as breast cancer became more amenable to new treatments, the breast cancer death rate for white women across the United States began to plummet.¹⁶ The death rate for black women in Chicago did not budge.¹⁷ The improvement for white women was easy to comprehend. Years of effort to raise awareness about the importance of regular mammography screenings coupled with improvements in technology and the emergence of specialists like Grabler meant that more cancers were detected early. Meanwhile, advances in treatment further increased survival rates. But it was here that a new racial death divide emerged. It grew from a sliver to a chasm over the next twenty years. Poor women, and specifically poor black women, were not getting the same quality of breast cancer care as wealthier and white women. Researchers have described this growing racial gap in cancer mortality as the "amenability factor."¹⁸ As cancers such as breast cancer become more amenable to treatment interventions, racial cancer survival disparities widen because poor minority women do not have easy access to the lifesaving cures.¹⁹ Inequality in Quality In 2007,160-plus doctors, researchers, and community activists in Chicago convened the Metropolitan Chicago Breast Cancer Task Force to investigate the gap and decide how to close it. We analyzed the data. We drilled into the deaths. We held focus groups of black and Latina women on the South and West Sides. We heard their stories of fragmented and disrespectful health care in their communities. We released a report.²⁰ It confirmed that access to quality of care was responsible for the wide racial gaps in breast cancer mortality.

The report also made thirty-seven recommendations for closing the gap. Yet breast cancer researchers scoffed. They clung to the usual genetic and biological explanations. We fought back, pointing out the structural components of the death gap, both in Chicago and nationwide. Chicago's gap was twice as large as the national gap and seven times larger than the gap in New York City, suggesting that geography is a significant variable.²¹ Cities like Memphis and every major Texas city had even larger breast cancer death gaps than Chicago's.²² In Detroit, black and white women had the same terrible mortality rates. The cities with the greatest breast cancer death gaps were also the ones with the largest dissimilarity index scores, denoting advanced degrees of racial segregation.²³ Moreover, biology cannot explain the variability in the racial death rates in cities within the same state. For example, in Los Angeles black women are 71 percent more likely to die from breast cancer than whites. In Sacramento and San Francisco this gap does not exist.²⁴ A Map and a Story The task force published a map of Chicago showing the communities with the highest breast cancer mortality. Twenty-three were black communities and one was white. All were located on the West and South Sides. All the black communities were neighborhoods of concentrated US Health Care: Separate and Unequal * 119 Years Disparity ratios in breast cancer mortality between white and black women across New York City, the United States, and Chicago from 1990 to 2010 show that geography, more than biological and genetic factors, influences women's mortality. Source: Metropolitan Chicago Breast Cancer Task Force. poverty and disadvantage.²⁵ In mostly black neighborhoods, not one hospital has earned the American College of Radiology's seal of approval for breast imaging centers. Only one hospital in a high-mortality black neighborhood has been certified by the American College of Surgeons' Commission on Cancer as a cancer treatment center. In contrast, in the white wards there are fourteen cancer accredited hospitals. This was a bleak picture of the structural nature of racial inequality. It's one thing to look at disparity on a map. It's another to hear from the women who try to navigate the fractured system of care. Chicago and other cities have a hodgepodge of public and private hospitals and clinics, with little communication between them and poor coordination of care. Barbara Akpan is a retired nurse in Chicago. After her breast cancer diagnosis and treatment at an academic medical center, she began serving as a volunteer community advocate for other African American women on the South Side. Her observations reinforce the notion that inequality in the quality of breast cancer care was failing women. "Many of the women I work with are afraid," she said. "They do not trust the health care system. Many of the clinics and hospitals they go to do not provide the best care, or they simply give them the wrong Hospitals with American College of Surgeons Approved Cancer Programs African American Community Areas with Elevated Breast Cancer Mortality In Chicago's African American neighborhoods with high mortality for female breast cancer, there are few hospitals with American College of Surgeons-approved cancer programs. Consequently, black women with breast cancer concerns have to either travel for care or receive care at nonapproved cancer treatment sites. This map depicts how health inequality is structured into the geography of a region. Source: <http://link.springer.com/article/10.1007/s10552-009-9419-7>. information. It's hard to overcome the mistrust. For women in the southland—Ford Heights, Chicago Heights, Harvey, poor areas on the South Side—access to mammography screening sites is really poor," says Akpan. "Women are falling through the gap—they don't know where to go."²⁶ When we traveled around Chicago and other cities, showed audiences of black women the mortality curves illustrating the black breast cancer death gap, and gave our explanations, they cried. We had validated something they knew to be true: the systems that served them were often inadequate. They cried because our data told them that the breast cancer death gap was a system problem and not a problem within black women. Their reactions galvanized us to focus on fixing the system. Because the mortality gap was structural, we needed hospitals to work together to improve care for black women. We identified hospitals with undertrained mammography technicians and radiologists and arranged free continuing-education courses. We met with CEOs to share their hospital's quality data and make recommendations for improvement. But this was not going to improve care fast enough. If a small inner-city hospital lacked the expertise to provide comprehensive breast cancer care, no amount of quality improvement would remedy it. But what if we could move women from poor institutions to good ones? Navigating to Quality We hired health "navigators." These were community health workers and nurses who could direct women to high-quality hospitals for screening and treatment. We solicited breast cancer services from all the region's top hospitals. Most obliged. The navigators guide their clients into care at the city's highest-quality medical centers even when they are two hours and two bus transfers away. Sometimes the navigators battle with the local doctors to wrest the patient into better care. Gerri Murrah is typical of the patients

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navigated. She was 60 and developed a sore lump in her breast in 2015. Not having a primary-care physician, she had gone to her local emergency room. The doctor didn't even consider cancer; Gerri was given antibiotics and sent home. Luckily, Murrah knew something was wrong and went to a different clinic and requested a mammogram. The results were suspicious. Murrah was assigned to a surgeon at a neighborhood hospital. This surgeon, not a breast specialist, made two bungles: Instead of doing a needle biopsy, he surgically removed the lump—a painful and unnecessary procedure. Then, without informing Murrah of the stage of her breast cancer (stage III), he recommended an unneeded mastectomy. When DeShauna Dickens, one of the task force navigators, finally connected with Murrah, she referred Murrah to the University of Chicago Hospital for a second opinion. There, Murrah learned she had other options that would preserve her breast. "DeShauna came in just in time to stop me from having my breast cut off," she says, in an O, the Oprah Magazine interview.²⁷ There are setbacks. Not all women respond. Not all institutions have the will to better their conditions. Some facilities were deplorable, such as the mammography facility in the Washington Park neighborhood's Provident Hospital, which the task force staff visited in 2014. The room that was used to develop mammography films had a sewer manhole cover in the middle of the floor and was suffused with noxious sewer fumes. The path to improve quality and reduce mortality can be slow and painful. The Breast Cancer Quality Consortium Yet progress has been made. The grassroots team persuaded 160 health care providers across the state, including every Chicago hospital, to share their data, such as tumor detection rates and follow-up rates. Slow improvements in quality were made even in the poorly performing hospitals. In 2013, after seven years of work, the black-white breast cancer death gap in Chicago had narrowed by 35 percent.²⁸ While the exact reasons for the improvement in the mortality gap are not easy to tease out, in no other metropolitan area of the United States has that death gap been reduced. The reduction in black breast-cancer deaths in Chicago shows that mortality inequities caused by structural violence are fixable. Focused and deliberate work directed at equalizing the health care system can save lives. Racial disparity can be reduced—and possibly eliminated. "We don't need a magic bullet to fix this," says Dr. Patricia Ganz, a member of the Breast Cancer Research Foundation Scientific Advisory Board and professor of medicine and public health at UCLA. "We just need to give black women the same standard of care."²⁹ Implicit Bias Contributes to Unequal Care While the story of the Chicago breast cancer death gap has had early success, in too many areas and on too many levels we are still dealing with the most basic inequities and prejudices. Bias, even if unconscious, affects individual physicians and their treatment decisions. This is unsettling but true. While most doctors do not exhibit explicit racial bias, such as refusing to treat certain patients because of their race, on tests of implicit bias they, too, show unconscious preferences for whites over dark-skinned faces. The Implicit Association Test is a widely used test of social cognition. More than 70 percent of the millions of Americans who have taken it exhibit a subconscious preference for whites over blacks.³⁰ Physicians score similarly. An ingenious 1999 experiment showed how Unconscious bias affects clinical decision making. Thousands of doctors were asked to test their clinical acumen by reviewing the medical history given by a performer who acted out the symptoms of a potential cardiac syndrome on film.³¹ There were eight elderly patients. Four were men: two white and two black. Four were women: two white and two black. Physicians were asked to recommend a cardiac workup based on the clinical information the patients relayed. In addition, physicians were told whether the patient was insured or uninsured. The results were not surprising. Based on the gender, race, and insurance status of the patient, doctors recommended entirely different medical workups. Men of both races were more likely to be referred for angiograms to evaluate symptoms of chest pain. But blacks of both genders were less likely than the whites to be referred for the full cardiac workup. Those who were noted to be insured were more likely to be referred for a full workup as well. While this was an experiment and not real clinical care, unconscious bias in health care delivery seems to be a real phenomenon. In an eye-opening 2002 report on health care disparities, the Institute of Medicine found "strong but circumstantial evidence for the role of bias, stereotyping, and prejudice" in perpetuating racial health disparities.³² Some research suggests that there is a direct relationship among physicians' implicit bias, mistrust on the part of black patients, and clinical outcomes.³³ In a prospective study of older adults, patients who experienced discrimination in health care more than once yearly were twice as likely to have a disability four years later than cohort members who suffered no discrimination.³⁴ What needs to be done to address implicit bias in medicine? Awareness is a start. Mandatory bias testing and cultural intelligence training have been proposed. But it requires day-to-day interactions between people of different backgrounds to break the implicit boundaries that prevent deeper understanding.³⁵ And that's necessary, but fair. But bias is only a piece of the story. Having No Insurance Is Bad for Your Health Another major factor driving inequitable care is lack of health insurance. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether. Twenty-five percent of adults without coverage say that they went without care in the past year because of its cost, compared to 4 percent of adults with private insurance coverage. Moreover, 55 percent of uninsured adults do not have a regular place to go when they are sick or need medical advice.³⁶ When uninsured patients get injured or develop a chronic disease that requires follow up, they are less likely than those with coverage to actually obtain all the services that are recommended.³⁷ Blacks and Latinos are more likely to be uninsured than whites, which only increases the burdens of health care inequity borne in neighborhoods of concentrated poverty. Prior to the Affordable Care Act, an estimated 45,000 residents died each year due to a lack of insurance, or one person every twelve minutes. If being uninsured was a cause of death, it would be the tenth most common one in the United States.³⁸ The next chapter will deal further with the issue of health insurance. Apartheid Hospitals Once people do get insurance, there is no guarantee they will get good treatment. As Nobel Prize winner Angus Deaton has noted, "Hospitals in the United States are run on something close to an apartheid basis with few white patients in the hospitals that treat mostly African Americans and vice versa."³⁹ Hospitals in which the majority of patients served are minorities have higher mortality rates across the board, whether from trauma, cardiac surgery, or general surgery procedures. In fact, as the percentage of minority patients served increases at an institution, so do the mortality rates across many conditions. There seems to be a direct correlation between the proportion of minority patients served by a hospital and death rates.⁴⁰ Take trauma care as an example. Trauma centers that serve mostly minority patients have higher mortality rates than those that serve mostly white patients. There is a gradation of trauma mortality based on the percentage of

minority patients served by the trauma center. Those trauma hospitals with fewer than 25 percent minority patients have 60 percent better trauma survival rates than trauma hospitals with more than 50 percent minority patients. Hospitals with 25-50 percent minority patients have trauma mortalities in between the two.⁴¹ Why would this be? Trauma centers require specific levels of physician and other staff coverage, and they require periodic rigorous certification. Shouldn't this attention and regulation lead to better care, regardless of race and ethnicity? There are only two possibilities. One is that trauma severity or high-risk conditions are more prevalent among patients in institutions that serve mostly minorities. However, even when severity of illness is controlled for, minority trauma centers have 37 percent higher mortality rates than those serving mostly whites. The other possibility is that the care is actually unequal. I have shown how this is true for breast cancer care. It seems to be true for many conditions. What hospital you attend is literally a matter of life and death. In general, hospitals and clinics where many minority patients receive care are lower quality than those that serve white populations, whether for medical or surgical conditions.⁴² Further, hospitals treating a higher proportion of black patients have higher mortality rates for many surgical procedures. In addition, these hospitals have higher mortality rates independent of race: both black patients and white patients have higher mortality in hospitals with mostly black patients than their racial counterparts in other centers.⁴³ The federal Center for Medicare and Medicaid Services recently created a national star ranking system for hospitals, to allow consumers a means to assess hospital quality. A hospital can be ranked from five stars to one star, with five stars denoting a very high quality hospital with lower mortality and one star being a low-quality hospital with high mortality.⁴⁴ In practice, star rankings vary by the whiteness of the hospital's clientele. Five- and four-star hospitals in America serve patient populations that are predominantly white. One- and two-star hospitals in America serve predominantly minority patients and very few whites. This is true for care at clinics as well as hospitals. The doctors who work at clinics that care for predominantly black and other minority populations are less likely to be board certified, have less access to specialty consultation, and work in more chaotic conditions. It is not a matter of the patients' race or ethnicity. Hospitals and clinics in poor neighborhoods, those that serve uninsured populations or those on Medicaid, often do not have enough resources to provide the very best care.⁴⁵ What seems at first blush to be a racial disparity is actually a consequence of structural violence and institutionalized racism. Just follow the money. Let's compare the cash situations at two Chicago hospitals, both trauma centers. During my decade at Mount Sinai Hospital, located in a low-income black neighborhood, 20 percent of the patients had no insurance. Another 60 percent had Medicaid. The patient population served is virtually 100 percent black and Latino. If a white person happens to be hit by a car down the street from Sinai, then they might be brought there. Otherwise a white patient, or anyone who is well insured, would rarely set foot inside Sinai. Then there's Northwestern Memorial Hospital. One of the top hospitals in the United States, on the US News and World Report Honor Roll, it towers over Lake Michigan about five miles from Sinai, in Chicago's predominantly white Streeterville neighborhood. It has an A bond rating, and about 500 days of cash brimming in its accounts. This translates to \$2 billion in bank reserves. Most of Northwestern's largely white patient population has private insurance. A small number are uninsured. During my time at Sinai, there were often only a few days of cash on hand. Sinai had no bond rating—meaning no bank would lend it money for capital investments. Just as Lawndale had been redlined seventy years prior, Sinai and other hospitals that serve poor communities are redlined by the banking industry today, limited in their ability to borrow. Sinai has been an anchor in the Lawndale neighborhood since 1919, and it takes care of everyone who comes to its doors, regardless of ability to pay. The price of this noble mission is a hospital's equivalent to a vow of poverty. From a banker's perspective Sinai is a bad investment. Compare Northwestern and Mount Sinai's spending on capital in 2012. Capital dollars reflect the amount of money that a hospital has to spend on patients, doctors, equipment, and upgrades. Northwestern spent \$273 million on buildings and equipment. Sinai spent just \$6 million.⁴⁶ The failure of capital markets to support Sinai contributed to its chronic struggles to maintain service quality. If we really want to achieve equity in health care outcomes, then we have to invest more into the institutions serving those who need care the most, like Sinai. This means redistributing capital dollars based on need from Northwestern and its neighborhoods to invest in Sinai and its Lawndale neighborhood. This is just the opposite of how the American health care system works. In America we have arranged it so those who need it the most (often black people and other minorities) get less, while those with the most (white and affluent people) get the best care and facilities available in the world. It is no surprise that life expectancy in Northwestern's neighborhood is 85 years. In Sinai's neighborhood it is 72 years.⁴⁷ Failure to Rescue When it comes to providing the highest quality of care, volume matters. The doctors and the nursing staff who are exposed to high volumes of particular kinds of cases have more time to hone their skills, and this leads to better outcomes. A surgeon who does liver transplants every week is better at them than one who does one per year. As for complex surgical conditions where high volumes of cases are crucial to achieve the best outcomes, nonwhite patients are more likely than whites to receive them at low-volume institutions. These patients are also less likely to be rescued if they deteriorate postoperatively. Procedural complication rates are exactly the same at high-mortality and low-mortality hospitals. So what is the reason for the death gap? The answer is culling failure to rescue. When a sick patient gets a complication, the doctors and nurses have to recognize and treat it—that is, rescue the patient from dying. Hospitals with well-developed systems to recognize complications and rescue patients have lower mortality.⁴⁸ While all the components of rescue have not been identified, adequate nurse staffing and training is critical. The hospitals with the least capability to rescue—due to nursing shortages, lack of training opportunities for staff, or other factors—serve significantly more minority patients and suffer higher mortality rates.⁴⁹ Truth or Consequences Cardiac surgery at Mount Sinai Hospital is an example of a low-volume and high-mortality program. Its struggles are instructive for understanding the day-to-day decisions in a poor hospital and how they lead to health inequities. When I worked there, the heart surgery program was small—about fifty cases each year. Programs this small have trouble maintaining quality because there is not enough repetition for all the staff who need to be in top form. In addition, because the capital investments required to maintain the service were so high, Sinai managers thought the limited capital we had should be invested elsewhere. So we closed the program and partnered with a nearby, higher-volume academic medical center (University of Illinois) to take our patients. It made sense. The neighborhood did not need a small, poorly functioning heart-surgery program. Then one day we had a patient in the cardiac-care unit with three blocked coronary arteries. He needed emergency bypass surgery. Our cardiologists inserted a special pump into his aorta to boost to his failing heart until lifesaving cardiac surgery could be performed. Time was critical. But the patient was uninsured, and the University of Illinois refused the patient. In desperation I phoned the chief of cardiology there. He recommended that the patient be discharged from Sinai and instructed to walk to the University of Illinois emergency room. Then, he said they would be required to treat him. I was shocked. Not only was this immoral, but it was medical malpractice. The patient was hooked to life support, teetering on the edge of death with an artificial heart pump attached to a blood vessel in his groin. Without surgery soon he would surely die. It took a call from our CEO to U of I's CEO to get this patient transferred. After this event, against their better judgment, our cardiologists urged our CEO to restart cardiac surgery at Mount Sinai. Despite the low volumes, inability to guarantee quality, and high capital costs, it became a necessary investment. These are the choices faced by safety-net hospitals in communities of concentrated disadvantage. Provide nothing and let patients die from neglect; or provide the best care you can, at risk of higher than desired mortality, and hope to pull most patients through. More broadly, a 2014 study evaluated cardiac-surgery mortality in patients insured by Medicare. Nonwhite patients succumbed at a 33 percent higher rate than whites (after risk factors were controlled for). Thirty-five percent of the death gap was due to deficiencies in hospital quality. The highest-mortality hospitals were those that served predominantly minority populations. Both white and black patients who received their heart surgery at predominantly minority hospitals had higher mortality rates, suggesting structural factors were responsible. When we speak of institutionalized racism as a structural cause of premature death, it is not the virulent type of racism that we associate with opposition to the civil rights movement of the 1960s. It's a more banal but deadly form of brutality woven into the tapestries of our institutions and thus harder to eradicate. I was not shocked by the study's findings.⁵⁰ I knew that race itself—as a social marker—was not the reason for the cardiac mortality gap at predominantly minority hospitals; it was our tolerance for inequality in quality across our health care system. This becomes even more obvious when we contrast these findings with the outcomes in the Veterans Administration system, where care is structured the same way nationwide. In the VA system there is no equivalent racial heart-disease death gap.⁵¹ Inequality in Quality and Unequal Treatment It is not only in majority minority hospitals that black health-care inequities exist. When black and brown patients receive medical care in any setting, they are more likely than white patients to receive unequal care. This was documented in the Institute of Medicine's shocking Unequal Treatment report, which synthesized hundreds of studies of age, sex, and racial differences in medical diagnoses, treatments, and health care outcomes. The report concluded that for almost every disease studied, black Americans received less effective care than white Americans. These disparities prevailed even among groups with identical socioeconomic or insurance status. Minority patients received fewer

recommended treatments for diseases ranging from AIDS to cancer to heart disease.⁵² How much of the treatment gap is related to implicit bias, patient mistrust, physician practice style, or systematic organizational dysfunction is not known, but these gaps have persisted over the decade and more since the Institute of Medicine report.⁵³ Each year since 2003, the Agency for Health Care Quality and Research has tracked progress on health care inequity across America, analyzing more than 250 quality measures across a broad array of settings and services. In the 2014 report, the agency reported no overall improvement in racial health disparities from prior years. Not one iota. The American Hospital Association Pledge In 2015, in response to years of intractable health care inequities, the American Hospital Association called upon CEOs of hospitals across America to sign a pledge to measure health inequities within their own institutions and to fix them. The Equity of Care Campaign to End Healthcare Disparities focus is on four areas. First, hospitals are to choose a quality measure that is important to their community. Next, they are to develop a plan to address a disparity, whether by race, ethnicity, or language preference. Third, hospitals are asked to provide cultural competency training for all staff or finalize a plan to do so. Finally, hospital operations teams are asked to initiate a dialogue with the board and leadership team about this disparity work.⁵⁴ After over a century of documented health-care disparities, this step is important. But it is hardly enough. The nation's hospitals have been organized for the most part to make money by attracting the best clientele with the best insurance policies. For most hospitals this means avoiding poor and minority neighborhoods. Those frayed and capital-poor hospitals that have made it their mission to care for poor and uninsured often struggle in poverty like their clients. Just as the neighborhoods of concentrated disadvantage were created by white and industrial flight and the expansion of neighborhoods of concentrated advantage, a similar phenomenon has occurred in health care. The nation's wealthiest health care systems for the most part have avoided serving the residents of concentrated disadvantage by placing offices and hospitals only in white communities of advantage. So pledges are well and good, but without larger structural changes that level the insurance and capital decisions that underpin the health care system, health care equity will continue to be elusive. Only with national health insurance reform that begins with the idea of health as a human right could these structural issues be resolved. The Affordable Care Act, the most recent response to the need for health care reform, has tried to address these issues. However, as we will see, it has been an inadequate solution so far. HEALTH INSURANCE IN AMERICA You guys are evil. Canada's the best country in the world. We go to the doctor and we don't have to worry about paying him, but here your whole life you're broke because of medical bills.¹ J U S T I N B I E B E R It will not do to note that under the Affordable Care Act almost 90 percent of Americans currently have some form of health insurance, any more than it would do for a hotel to note that 90 percent of the time the roof over your bed does not leak when it rains.² Of all possible ways to remedy structural violence in America, the creation of an equitable universal health-care system based on the idea that health care is a right, not a commodity, ranks high. While the health care law was a reform of the old system that saw fifty million Americans uninsured, the Affordable Care Act perpetuates health care inequity and fragmentation by its very design. Yet if Republican calls to repeal the law are heeded, we will be back to square one. And bad will revert to worse. I was not surprised that the solution for universal health care in the United States would be to prop up the existing costly, inequitable, and inefficient insurance system. In 2003 my wife and I cosponsored a fundraiser in Chicago for the then little-known Illinois state senator Barack Obama, who was running for the US Senate. In the living room of a modest single-family home in the neatly manicured South Shore neighborhood of Chicago, I asked the future president his position on national health-care reform. His words presaged what came to be known as "Obamacare." "I'm a proponent of a single-payer system," he responded. But he explained that the political power held by the health insurance companies was so formidable that opposing them would be political suicide. He noted that the insurance industry had over 250,000 employees across the country and a lobbying apparatus that had to be reckoned with in any drive for universal health care. "Single payer will never get passed in the United States," he concluded. He was correct. Single payer did not even get a hearing. The Affordable Care Act was a modest reform of the existing tiered healthinsurance system, which treats health care as a commodity, not a human right. The coverage provisions in the Affordable Care Act built on and attempted to fill in the gaps in a piecemeal system that had left many without affordable coverage. There have not been impressive gains since the passage of health reform.³ A net of twenty million more people gained health insurance coverage between 2013 and 2015. Medicaid has expanded in thirty-two states and the District of Columbia, providing new access to coverage to millions of previously uninsurable Americans.⁴ The Affordable Care Act has been successful in reducing the number of uninsured, but about 30 million Americans remain uninsured.⁵ Most important, the Affordable Care Act fails two critical parameters of health justice: it is neither universal nor equitable. Elegant, Equitable, and Not to Be The most elegant, comprehensive, fairest, and lowest-cost solution to the health care crisis would have been to expand and improve the Medicare insurance plan to cover all Americans.⁶ Medicare, enacted in 1965 as a single governmental payer system to provide health insurance for Americans 65 and older, has been well liked since its inception. Before Medicare, 48 percent of such Americans had no insurance; now only 2 percent are uninsured. In addition, before Medicare 56 percent of senior Americans paid out-of-pocket health care expenses, compared to 13 percent now.⁷ Satisfaction with coverage is substantially higher among Medicare recipients than for those who

have private insurance. Only 8 percent of Medicare enrollees report their experience as fair or poor, compared to 20 percent of those with typical employer-based health insurance coverage and 33 percent of those who purchased private insurance directly.⁸ Moreover, the costs of administering the program are substantially lower than those of private insurance companies—only about 2 percent of the total cost for Medicare, compared to 12 percent for the least expensive insurance company's overhead charges.⁹ Most important, experts estimate that since its inception Medicare has added five years to the life expectancy of older Americans.¹⁰ Polls have shown that universal government-sponsored health coverage is preferred by half of Americans.¹¹ And an improved Medicare would be an entitlement available to all Americans, with the exact same benefits for the wealthy and the poor.

Medicare for all would achieve the goal of universal access to health care. As an entitlement for all US citizens (and extended to noncitizen residents), access to health care would be a right. This would contribute to the improvement of the life expectancy gap between rich and poor. Plus it would save an estimated \$400 billion yearly by eliminating administrative waste.¹² So if one wanted to solve the problem of the uninsured and reduce the death gaps between rich and poor, expansion of Medicare with other enhancements would have been the most logical approach. This is not a radical idea. Thirty advanced industrialized nations have forms of universal health care.¹³ Canada has a “Medicare for All” health insurance with easier access to care, lower costs, and better health outcomes (including life expectancy) than those of the United States. The evidence is compelling. While health inequity has not been eliminated in Canada, the differences between poor and rich are not as striking as they are in the United States.¹⁴ In Canada, men in the poorest urban neighborhoods experienced the biggest declines in mortality from heart disease from 1971 to 1996.¹⁵ Life expectancy gaps between income groups declined during that period as well. Poor Canadians with cancer had better survival than poor people from Detroit, an outcome The Poison Pill: Health Insurance in America * 135 136 * CHAPTER TEN attributed to the Canadian system.¹⁶ Of all the major Western economic powers, the United States is the only one without a universal health care system in which health care is considered a human right.¹⁷ Rather than treating access to health insurance as a universal right, the language of the Affordable Care Act endorsed the idea that health care is a mandate.¹⁸ The difference between health care as a right and health care as a mandate is critical, as these conceptions lead to very divergent solutions. If health care is a right, universal health care is an entitlement that should be the same for all citizens. If health care is a mandate, however, then there is no such entitlement, and health care is a commodity to be bought and sold. The Affordable Care Act established the mandate as a core component of health care coverage, perpetuating the complex system of multiple payers, limited access, variability in quality of care, high costs, and large rich-poor life expectancy gaps. Obamacare and Beyond The 2010 Affordable Care Act remains the most significant overhaul of the American health care system since the passage of Medicare in 1965, expanding insurance coverage to millions. The law survived multiple attempts by Congress and two Supreme Court challenges that aimed to gut its major provisions.¹⁹ As a reform of the current for-profit insurance marketplace, the Affordable Care Act addressed two major gaps in the existing system. First, it allowed young adults to stay on their parents’ health insurance until the age of twenty-six—a popular provision that benefits almost eight million Americans.²⁰ The second major reform prevented insurers from denying coverage to people with preexisting medical conditions. Medicaid was expanded to include millions of previously uninsurable individuals who had been excluded from the health care system. Uninsured rates among whites, blacks, and Hispanics dropped, narrowing though not eliminating racial and ethnic insurance coverage gaps.²¹ At the same time, the Affordable Care Act incorporated the worst aspects of our fragmented for-profit health insurance system. The tiered system of insurance—where the coverage options for the poor are markedly different from those for the rich—has further hardwired inequity into the law. In 2004 there were fifty million people without health insurance in the United States. That year the Institute of Medicine published a report, “Insuring America’s Health,” that outlined the principles against which any health reform legislation would have to be measured.²² The institute identified the ideal system as having “universal, continuous insurance coverage that is affordable and sustainable for individuals, families, and society, and should enhance well-being through care that is effective, efficient, safe, timely, patient-centered, and equitable.” Eleven years later, none of these standards was being met. Even after the passage of the Affordable Care Act, there are around thirty million Americans without insurance and an equal number of underinsured who have health insurance policies but with deductibles and copayments that are high enough to deter care.²³ How did the United States end up with a more fragmented, more costly, and more confusing health care system? Simply stated, collusion between members of Congress and entrenched corporate health insurance and Big Pharma interests precluded a more equitable and lower-cost solution. What Americans got with the Affordable Care Act was complicated insurance marketplaces in every state with a complex array of confusing private insurance products. The health reform process exposed, in the words of the British medical journal The Lancet, “how corporate influence renders the US Government incapable of making policy on the basis of evidence and the public interest.”²⁴ When the moment arrived to consider having a Medicare-like “public option” on the state exchanges to compete with private insurance companies, Senator Joseph Lieberman of Connecticut, the deciding Senate vote, deep-sixed the idea by threatening a filibuster.²⁵ The capital of Connecticut is Hartford, the home of Aetna, one of the big five health insurance companies. Skin in the Game There are three major structural flaws in the Affordable Care Act, all of which could be solved by a single-payer system. The first flaw is The Poison Pill: Health Insurance in America * 137 138 * CHAPTER TEN that the insurance expansion is neither universal nor equitable. For example, because mandatory Medicaid expansion was blocked by the Supreme Court, nineteen states have left millions of poor people uninsured.²⁶ These states account for over half of poor uninsured blacks, single mothers, and the country’s uninsured working poor. For poor people in these states, it is as if Obamacare was never enacted. Note that for the most part these states that have refused to expand Medicaid are the former Confederate slaveholding states, accentuating the legacy of structural racism. Access to specialty care for those who receive Medicaid coverage is limited compared to access for patients with private insurance.²⁷ More than one-third of US doctors refuse to take Medicaid—another structural barrier.²⁸ The second flaw is that premiums, copays, and deductibles for private health insurance and products on the marketplaces are prohibitively high for many people, especially the working poor. In 2015 average annual premiums for employer-sponsored health insurance were \$6,251 for single coverage and \$17,545 for family coverage. Between 2014 and 2015, premiums increased by 4 percent, while during the same period workers’ wages increased 1.9 percent. Premiums for family coverage increased 27 percent during the last five years, while cost sharing has skyrocketed.²⁹ The average individual deductible across the marketplace plans in 2016 was \$5,765 for bronze plans. After the deductible is paid, an individual with such a plan will face 40 percent copays for services.³⁰ Insurance companies have reacted to their rising costs by creating narrow networks of providers and hospitals.³¹ This limits choice of patients by restricting the doctors and hospitals whose services they can use. At the heart of the Affordable Care Act are subsidies for the working poor to pay for health insurance premiums.³² The goal was to keep these premiums within reach of most Americans. It was a sweet deal for the insurance companies. The insurance companies are guaranteed to get their premiums; the federal government poured billions of dollars into their coffers. In exchange, an individual gets an insurance card. But with that card came unprecedented out-of-pocket expenses that kicked in before the insurance company paid one cent.³³ The belief is that without “skin in the game,” the newly insured will overuse the system. As a result, coinsurance and deductibles that many Americans now are forced to pay have skyrocketed across the insurance markets. Yet every study ever done on the impact of copays and deductibles (even for middle-class people) is that they cause individuals to delay medical care.³⁴ Under a single-payer health care system there would be no copays or deductibles. Obamacare

Bullshit The third flaw of the Affordable Care Act was that long-term doctorpatient relationships have been disrupted by insurance restrictions. President Obama said, "No matter how we reform health care, I intend to keep this promise: If you like your doctor, you'll be able to keep your doctor; if you like your health care plan, you'll be able to keep your health care plan."³⁵ This turned out to be untrue. Windora Bradley, a year before her stroke, struggled to pay her health insurance premiums. Faced with the dilemma to buy food or go without medications, she chose to go without medications. At one of her office visits, she let loose. "I'm tired about this Obamacare bullshit," she shook her head, frowning as her jowls quivered. "I worked for thirty-five years. Those people on welfare who never worked are getting free health care. I am paying \$700 each month and there is not enough left for medicines and food. That's not right. That's why I call it Obamacare bullshit." Windora lived on a pension of about \$1,000 per month. Most went for the premiums on her health insurance, which she still received through the Chicago Board of Education. She scrimped and saved to pay for her medications for her diabetes, hypertension, asthma, and vascular disease. Her situation is common among the working poor. Windora was ultimately able to get insurance on the marketplace that reduced her premium costs but not her out-of-pocket expenses. At first she purchased a Blue Cross insurance plan that she was told my hospital accepted, but this proved incorrect. She then had to purchase a more expensive plan to stay with me. Meanwhile her two sisters, who The Poison Pill: Health Insurance in America * 139 140 * CHAPTER TEN had also been my patients for over thirty years, had to switch doctors because my group did not accept the insurance they enrolled in. A number of my long-term patients found themselves in this dilemma. In 2015, after her stroke, Blue Cross dropped my hospital and many others from the plan Windora had just purchased. There was only one plan, from United Health Care, in all of Cook County that included my hospital and me in the network. The week after Windora signed up for it, United Health Care let it be known that it was considering withdrawing from all the exchanges in 2017.³⁶ In three years of the Affordable Care Act, Windora had purchased three different insurance policies just to retain me as her physician. In the fall of 2016, United Health Care announced it would drop my hospital from its network, and Windora, now wheelchair bound and speechless, is forced to find another doctor (to say nothing of her many specialists) after thirty-six years. For someone like Windora with complex medical and social obstacles, keeping a team of providers who are familiar with her medical travails is essential to getting good care. For me, her longtime doctor, it is a gut-wrenching experience. The fact is that Obamacare, despite its modest benefits, does not remedy American health inequity. It will never achieve universal coverage. Eleven million noncitizen residents will never be eligible for its benefits. Thirty million people will remain uninsured. While insurance coverage has increased for all races, there is still a large racial and ethnic gap in insurance coverage, which will perpetuate health disparities. For those with health insurance, spiraling copays and deductibles have made access to care more difficult. Finally, by allowing a dizzying array of for-profit insurance carriers with high administrative overhead expenses, the Affordable Care Act as currently configured will not control costs. In 2016, the third year of Obamacare, insurance companies asked for double-digit increases in premium prices, as they claimed costs of delivery had outstripped the revenues. Meanwhile, health insurance stocks are trading at all-time highs, while patients like Windora Bradley face rocketing expenses and uncertainty about the future.³⁷ The Poison Pill: Health Insurance in America * 141 A Call for Single Payer I speak for many of my health care colleagues across the nation when I say that the Affordable Care Act is a **disappointment**. In contrast, an improved and expanded Medicare for All would achieve truly universal care, affordability, equity, and effective cost control. It would put the interests of our patients—and our nation's health—first. By replacing multiple private insurers with a single nonprofit agency like Medicare that pays all medical bills, the United States would save approximately **\$400 billion annually**. Administrative bloat in our current private-insurance-based system would be slashed. That waste would be redirected to clinical care. Copays, coinsurance, and deductibles would be eliminated. A single streamlined system would be able to rein in costs for medications and other supplies through the system's strong bargaining clout—clout directed to benefit health, not profits. Finally, it would create an equitable system of care that would provide equal access to rich, poor, black, and white. As a result, life expectancy gaps between rich and poor would narrow. Hospitals that serve poor communities would have access to capital investment based on need. It has been done in other countries, and it can be done in the United States. Single-payer health care stands in stark contrast to the ACA's incremental reform. Yet it is important to remember that enactment of a single-payer system requires the defeat of deeply vested, deep-pocketed ideological opponents, health insurance conglomerates, and a thick alliance of health care constituencies along with other interest groups. The Affordable Care Act, passed by a Democratic majority and signed by a Democratic president, was a weak compromise that left the foundations of our flawed \$2.9 trillion health care system intact. It will be some time before political conditions are again right to tackle an improved Medicare for All. So why, given these hurdles, do I (and many other health care providers) persist? I persist because I have watched too many patients suffer and die because they lacked health insurance or had the wrong insurance card. I persist because I have witnessed the racial and ethnic death gaps enabled by our current health insurance arrangements. I persist because simple fairness dictates that health care is a fundamental human right. I persist because of patients like Win142 * CHAPTER TEN dora and Sarai, who deserve better. For those who counter that single payer is too expensive or politically unfeasible, we persist because the American ideal of "life and liberty" cannot be achieved without an equitable and universal health care system. Winston Churchill reportedly said, "You can always count on the Americans to do the right thing... after they have tried everything else."³⁸ We have tried everything else. I look forward to being part of a single-payer health care system that values the health of individuals, families, and communities as a common good—where health care is valued as a human right. Someday.

The impact is unique: 84,000 deaths annually

Mantou Chong 17, citing David Atkins, of the Agency for Healthcare Research and Quality, "Health inequalities in US kill 84,000 - expert", <http://www.mantouchong.com/2017/02/health-inequalities-in-us-kill-84000-expert/>

Health inequalities in the United States cause about 84,000 additional deaths a year, more than the equivalent of a hurricane Katrina every week, a health care expert said on Friday. David Atkins, of the Agency for

Healthcare Research and Quality (AHRQ) in the United States, said the images of people clinging to rooftops made it clear that being poor and black in a poor southern state is hazardous to health.

Stats prove our internal link

Adam **Gaffney** 16, fellow in pulmonary and critical care medicine at Massachusetts General Hospital. He is also an adviser to the board of the Physicians for a National Health Program, Is the Path to Racial Health Equity Paved with “Reparations”? The Politics of Health, Part II, <https://lareviewofbooks.org/article/is-the-path-to-racial-health-equity-paved-with-reparations-the-politics-of-health-part-ii/>

But would “true” universal health care do much to combat racial health inequalities, if it were, say, a single-payer system that eliminated out-of-pocket expenses and was equally accessible by all, without tiers or walls?[25] **Or would it replicate current biases and inequalities?** To some extent, the answer is yes to both questions. But even so, a body of research has suggested that, even if these biases persist, a fully universal system might nonetheless be a powerful tool in reducing racial health care inequalities. That evidence comes from what is arguably a quasi-single-payer system located in the US: the Veterans’ Administration (VA). Notwithstanding recent scandals that are indeed of great concern, the modern-era VA has justifiably earned praise for delivering a high – indeed, comparatively superior – quality of health care.[26] There is also evidence that it may indeed effectively reduce, even potentially eliminate, some racial health inequalities. Last fall, a study published in Circulation, the premier journal of the American Heart Association, received wide coverage in the media for some provocative findings. “The US Veterans Health Administration (VHA),” as the study notes in its introductory section, “is a healthcare system that does not impose the typical access barriers of the US healthcare system that may disproportionately impede enrollment of blacks.” The investigators therefore hypothesized that racial inequalities in cardiovascular outcomes and mortality found in the general population might be reduced in the VA, a “healthcare system that allows enrollment independent of race or socioeconomic status.”[27] Consistent with previous studies, in their analysis of data from the general (non-VA) population, they found racial inequalities much as they expected to find them: blacks had a much higher mortality (after adjusting for various other factors) as compared to whites (indeed, approximately 40 percent to 50 percent higher).[28] In striking contrast, in the VA population, even though the risk of stroke was either higher or similar among blacks as compared to whites depending on which statistical adjustments were used, the risk of coronary heart disease as well as overall death was actually lower among blacks. This is, of course, only a single study, albeit a rather large one with more than three million subjects. An accompanying editorial concedes that a number of factors may be at play. Nonetheless, the fact is that, as described by the investigators, these findings build on an existing literature consisting of multiple studies that together point to a reduction of racial health inequalities within the VA for critically important outcomes like mortality.[29] No doubt, there are still discriminatory practices in some or all of these facilities, and we can assume that there are conscious or unconscious biases at work in the minds of some of its clinicians, as there are elsewhere. Indeed, other studies clearly show that, even after the significant reorganization and reform of the VA in the late 1990s, there are still racial disparities in the VA.[30] If we moved to a single-payer system on a national level, such biases would still need to be addressed along the lines Matthew argues. But the point is that a more egalitarian structure of the health care system itself might go even further in reducing them. Indeed, in light of this research, it seems fair to say that health care universalism could be a very powerful tool in combatting ubiquitous racial health inequities. Attaining health care equality, in other words, requires true equality of access. And yet this simple notion is all too often ignored entirely in any discussion of health “disparities.” 5.

Imposing audience costs on the government through grassroots activism is an effective strategy---but it has to grapple with complexity

Ashley **Farmer** 17, historian of African-American women's history, 3-5-2017, "The Black Freedom Struggle, Healthcare Activism, and the Affordable Care Act," AAIHS, <http://www.aaihs.org/the-black-freedom-struggle-healthcare-activism-and-the-affordable-care-act/>

Medicare For All Master File

At a recent press conference President Donald Trump remarked, “nobody knew that healthcare could be so complicated.” This statement was in response to questions about his administration’s efforts to repeal the Affordable Care Act (ACA), also known as “Obamacare,” and replace it with something “better.”

Trump’s statements were met with bewilderment by many, especially black activists who have been grappling with the complex nexus of healthcare and racism for years. In fact, black activists and intellectuals have made healthcare education and activism an integral part of the black freedom movement, developing many creative ways to help engage this complex system and make it more accessible for all people today. Throughout the twentieth century, activists have simultaneously created community-focused grassroots healthcare infrastructures and compelled the federal government to support their health-related work. In the early 1900s, black club women fundraised and staffed black hospitals, such as the Provident Hospital and Nurses’ Training School in Chicago, to help train black healthcare professionals and provide care to neglected black communities. These club women also developed groups, like the Tuskegee Woman’s Club of Alabama, to engage in grassroots health education initiatives. Through these and other endeavors black women filled the gaps in healthcare access and education in their local communities. Pamphlet from Negro Health Week. Photo: National Archives. Black club women’s private endeavors became public with the help of HBCUs like the Tuskegee Institute. Following Booker T. Washington’s lead, Tuskegee’s staff built on black women’s infrastructure to develop “Negro Health Week,” aimed at amplifying public health education and challenging segregated healthcare facilities. This programming eventually spread. Black nurses, doctors, and uplift clubs developed community programming to support these initiatives. Leaders of this movement—including Washington and sociologist Monroe Work—eventually lobbied the government for support. In 1921, the Surgeon General agreed to offer government facilities and funding. Although limited in scope, federal support for “Negro Health Week” reflected a direct instance in which the government-backed black healthcare education and access. By the 1940s, black activists and intellectuals had pushed the government to establish the “Office of Negro Health Work” as part of President Franklin D. Roosevelt’s New Deal programs. Black healthcare activists had argued for decades that the government should be accountable to the black communities that they decimated in the past. In establishing this office, the government acknowledged that it had a role to play in supporting black health education and that it could finance black healthcare workers’ existing grassroots efforts. The office employed black doctors to expand the programs started by “Negro Health Week” activists. With the help of healthcare leaders like Dr. Roscoe Brown, the office broadened community campaigns aimed at improving communal living conditions, educating black communities about diseases and care, and “practical work” like check-ups and vaccines. Black Panther member attends to a young girl. Photo: Stephen Shames/Polaris. By the 1960s, grassroots activist groups had effectively pressured the government to fund community health centers in rural and underserved areas.

During the 1964 Freedom Summer, the Medical Committee for Human Rights (MCHR) partnered with civil rights organizations in order to bring medical care to workers. A collection of black and white doctors, nurses, dentists, psychologists and social workers volunteered their services. The MCHR acted as a sort of medical wing of the Civil Rights Movement. By 1965, members had expanded programming, assisting local community health associations in establishing a series of rural health centers in Mississippi. The MCHR’s physician-activists lobbied the government, eventually securing Office of Economic Opportunity (OEO) funding to establish a set of health clinics in disadvantaged communities. A direct outgrowth of the Civil Rights Movement, these free clinics used government aid to provide healthcare to disadvantaged communities in cities like Boston, Denver, and Chicago. Perhaps the most notable example of black activists’ contributions to national conversations about healthcare access and activism was the work of the Black Panther Party. The Panthers created free clinics across the country to supply black communities with basic healthcare needs. At the George Jackson Free Health Clinic, for example, black community members could get basic check-ups and medications as well as learn about the interrelationship between racism and the lack of access to medical care. Poster for free health clinic held by the Black Panther Party. Photo: Black Panther Party Survival Programs. The Panthers also influenced national healthcare policy. In the early 1970s, the group launched a Sickle Cell Anemia initiative, which led to increasing national awareness and ultimately millions of dollars to study and treat [Sickle Cell Anemia] the disease. Their initiative had “two interdependent emphases”: health education and genetic testing. Members engaged in an ambitious campaign to educate the black community on sickle cell anemia and increase testing for the disease, connecting it to larger discourses of black suffering and state-sponsored racism. The Party was integral to raising awareness about sickle cell in black communities. As Alondra Nelson notes, it also “likely influenced the Nixon administration’s decision to allocate significant federal resources for research on the disease.” Despite the

president's sudden epiphany, many have understood that healthcare is complex, particularly black activists and intellectuals who have continued to advocate healthcare as a basic human right. The administration is correct in stating that there are legitimate issues with the ACA and its implementation. However, the ACA has also reduced the uninsured rate and improved access, particularly among African-Americans. It seems, then, that part of the administration's concerns are based on the fact that the law was passed by a black president and disproportionately helps black and brown communities, not "government overreach" or "one-size-fits-all spending." As we continue to mobilize against authoritarian and anti-democratic practices, we must also view healthcare activism as part and parcel of our emancipatory visions. We must also make it clear that a significant part of its complexity lies in overcoming the discriminatory frameworks that undergird our current healthcare system, not in the idea of healthcare as a right itself.

Translating details into policy meets the demand for incisive scholarship about single payer proposals in political spaces

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Most of the people I know who work on health policy on a practical level don't think the idea of a big political push to enact a Medicare-for-all plan makes a lot of sense. But the push is already underway, whether the wonks like it or not. Medicare-for-all bills have come close to passing in both New York and California, Bernie Sanders's national political organization is firmly behind the idea, and giving some form of verbal endorsement to the notion is becoming a litmus test of character for huge swaths of grassroots activists. But the plans that are out there tend to suffer from grave design flaws that make it extraordinarily unlikely they'll ever be enacted. The authors and sponsors of the existing single-payer bills ought to try harder to address their flaws, but it's also legitimately difficult for them to do the work without the support of the kinds of institutions that would normally craft proposals. Yet at the same time, technocrats fundamentally can't steer the course of a political movement. Some group of well-informed progressive health care wonks who work at one of Washington's several well-known Democratic Party-aligned think tanks ought to sit down and write out the details of a single-payer health care plan that they think make sense. Their reluctance to do this work as of two or three years ago — when single-payer health care was considered laughably implausible — was entirely understandable, but in the wake of the 2016 election outcome and the apparent failure of the Republican Party's drive to repeal the Affordable Care Act, it's [has] become counterproductive and dysfunctional. If progressive activists want to make a push for single-payer health care, then a push is going to be made. If competent technocrats don't help, then the push will end up being for something unworkable and will likely end in tears. It's time for Democratic health wonks to stop refighting old wars and start working on the health care system of the future.

The dance of political feasibility The basic paradox of the intra-Democrat war on health care policy is that very few people are willing to say clearly that the single-payer proponents are wrong. Instead, Barack Obama's 2009 observation that "if I were starting a system from scratch, then I think that the idea of moving toward a single-payer system could very well make sense" is a much more common thought. In a 2014 press conference, Nancy Pelosi — who really did spend all of 2009 and much of 2010 fighting for the inclusion of a public option in the Affordable Care Act — said that on some level she "wanted single-payer," but that she's very proud of the ACA as passed, imperfect though it may be. Kathleen Sebelius, former governor of Kansas and secretary of health and human services in Obama's first term, probably put the mainstream Democratic thesis most clearly in a July podcast produced by the Center for American Progress. She said that if you were to "wipe the slate clean and come up with a different American system for health care, you would never put together health care based on people's employment." The current system, "where if you turn 65 you have insurance, if you're below a certain poverty level or in a certain category you have insurance, if you work for the right company you have insurance, but otherwise you're out on your own," she said, fundamentally does not make sense. But she thinks it would be unnecessarily disruptive to try to overhaul tens of millions of people's existing health insurance, and the priority, instead, should be to focus on the fact that "we need to get everyone in" and keep expanding coverage until we achieve true universality. These are completely reasonable kinds of concerns to have. But on other issues, considerations of political feasibility aren't considered a halting point for policy discussion. The CAP plan for universal access to affordable, high-quality pre-K was not feasible for the foreseeable future when it was published in 2015. Nor was the Economic Policy Institute's 11-point plan to build a high-wage economy when they published it last December. Len Burman of the Urban Institute recently sketched out a plan to create a massive new system of wage subsidies financed by a 15 percent consumption tax. That's obviously not politically feasible either. But wonks try to develop these ideas anyway, in part because publishing and discussing them can itself shape the landscape of feasibility and in part simply because it's good to have ideas on the shelf if conditions change. Right now there's a risk that if future events do dump a cartload of

political power in progressives' lap, it'll largely go wasted due to a paucity of workable plans. Just look at the single-payer debate in California. California's single-payer push is a cautionary tale. The Golden State has long been a Democratic Party stronghold, but the Trump-induced shake-up of the electoral landscape has left it bluer than ever before. California is also big — with a population significantly larger than that of all five Nordic countries combined — and it's richer than the average American state. Consequently, it's a very reasonable place to try to field test ambitious progressive ideas that might later go national, and it naturally became the target for a single-payer organizing effort led by the National Nurses Union — one of the few interest groups that backed Bernie Sanders in the 2016 primary. But while the idea of a single-payer health care system for California makes sense, the specific legislation that the California Medicare-for-all movement got behind was strange in a number of ways. For starters, the basic challenge for any plan to move people off private health insurance and onto a Medicare-like system is you're going to need a big tax increase to pay for it. The California legislative framework would have substantially exacerbated that difficulty by proposing a program that's actually much more expensive than Medicare, because unlike Medicare there would be "no co-pays or deductibles," but the expansive coverage package would offer everything from vision services to nursing home care — all with no premiums. Also unlike Medicare (but like Canadian health care), California's Medicare-for-all bill would essentially ban private health insurance. Then, having set up the need for a very large tax increase to pay for a very generous program, the California bill didn't specify what kind of taxes should be raised. There's no doubt that the state could, economically speaking, afford higher taxes and a more expansive welfare state (households and companies would, after all, save money by not needing to pay for health care), but the design of the taxes is a big, important question that the bill just punted on. Last but by no means least, as the Intercept's David Dayen has explained in some detail, the whole thing was unworkable. The California Constitution requires that half of the state's budget go to fund K-12 schools and community college. Shifting a huge amount of health care spending from the private sector onto the state budget would thus require a gigantic boost in education spending, which would require its own tax hikes. This, like the design of the taxes needed to finance the health care system, is a solvable problem (you'd need a ballot initiative to amend the constitution), but to achieve the goal, someone would have to actually solve it. The upshot of this was that organizing work, rather than leading to progress toward a single-payer system, led to a game of political hot potato. Most California Democrats didn't want to tell activists "no" even though the shell bill was unworkable, so it was eventually killed by the speaker of the state assembly, who now has to play the role of bad guy. Meanwhile, a broadly similar process is playing out on Capitol Hill, where a John Conyers single-payer bill is gaining momentum even though many of its co-sponsors don't actually think it's a good idea. Democrats are signing on to a bill they don't support Among House Democrats, the big way to signal true progressive commitment in the year 2017 has been to sign on as a co-sponsor of John Conyers's HR 646 — the Expanded & Improved Medicare for All Act. This is a bill that Conyers has had kicking around for years, always intended as more of an aspirational statement than a real piece of legislation. But it's gained new momentum in the wake of Bernie Sanders's primary campaign, and now fully 60 percent of the House Democratic caucus has signed on as co-sponsors. Sanders himself is expected to introduce a broadly similar bill next month, and the odds are that House challengers seeking the support of the grassroots left will face pressure to endorse it too. Yet like the California bill, the Conyers plan is very expensive and dramatic — it would eliminate Medicare's existing cost-sharing provisions, extend the program to everyone immediately, and cancel basically all private insurance — without really specifying how it's to be paid for. Members of Congress who've signed on as co-sponsors for this bill, it turns out, don't actually expect that to happen or think it would be a good idea. "The goal is to move forward with ways to strengthen it and get more people covered and look at a public option and extend Medicare to more people" says Rep. Jared Polis of Colorado, by way of explaining that he doesn't actually envision the Conyers bill he's co-sponsored becoming law. "That's where this bill goes and it's part of a discussion." Arizona Rep. Ruben Gallego thinks the legislation he's co-sponsored is an excessively disruptive way to achieve its goal. Single-payer, he says, "is something you phase in. I have different ideas for how to do it, though it's not in the Conyers bill — you could start with Medicare phase-in, dropping the enrollment age to 55 and then covering everyone up to 18 just for the first couple years." Over time, "you keep moving inward and inward until you get to a happy medium." Vermont Rep. Pete Welch says the Conyers bill "is more of an aspiration," and says that since Medicare "works and it's more popular" than private insurance, it makes sense to move everybody onto it as a goal. But "the challenge is the transition." Indeed, that's a big problem. And it's one that health and tax policy wonks ought to be working on in partnership with politicians who support the goal. Instead, politicians who support the goal are plowing ahead with legislation that even they don't really support —

setting up unnecessary intraparty fights and not really laying the groundwork for policy success. The transition problems aren't just politics

The difficulties of transitioning a couple hundred million people off their current health insurance and onto a new federally run system, it's worth saying, aren't just problems of political feasibility.

The tax issue, for example, is a critical substantive lacuna in the major health care bills. There's no serious doubt that America could afford a heavier tax burden to finance a publicly provided health care system. But the design of that tax burden still makes a big difference. If you finance the system mostly with a value-added tax like many European countries do, for example, then senior citizens who already get Medicare will end up paying higher taxes in exchange for a program that doesn't help them. But if you finance the system mostly with higher payroll taxes (how Social Security and Medicare work), you are creating a pretty strong new disincentive to work, since everyone would get the benefit whether or not they pay for it. These aren't insuperable obstacles any more than the California

Constitution is. But the policy work would have to be done, followed by the difficult job of selling the plan to politicians and stakeholders. There are also some real questions about the transition. Right now I, like most Americans, get my health insurance mainly through my job. If that insurance were to be replaced by a new tax-financed system, the result would be a financial windfall for my employer. In a standard economic model, the long-term consequence of that windfall is higher cash wages for employees, which offset the new taxes. But there's no economic model at all that suggests the higher wage bill will be paid out evenly to each current employee. If Vox Media's health care costs fall drastically, I might be able to bargain for a raise for myself. But someone else with more bargaining power might get it instead. Or the money could be spent on increasing the pace of hiring. There are particular questions here about the fate of union workers whose pay and benefits are set by multi-year collective bargaining agreements and public sector workers whose pay is set by law. The jobs and livelihoods of people who currently work for insurance companies or in medical billing are also not an entirely trivial concern. And the interaction of the new health care system with existing programs like the Veterans Administration also needs to be thought through. All of this is potentially doable, but very little of it has actually been done. Send in the wonks

Sanders's 2016 campaign started as, essentially, a protest movement that didn't particularly seek expert policy advice in crafting its proposals and certainly didn't receive it, given fear of retaliation by presumed victor Hillary Clinton against anyone who worked for

her opponent. The result was, among other things, a health care plan that was fairly sketchy and technically unsound and was criticized as such by people like me. That, in turn, prompted counterattacks on the entire concept of sweating the details of policy and the ensuing standoff has largely defined left-of-center politics ever since.

Paul Krugman writes that the political logic that counseled against a single-payer approach in 2009 still applies, while Jacobin articles explain that even failed state-level campaigns help build organizing capacity for socialism. To the extent that people want to endlessly refight the 2016 primary, this is all fair enough, and there's plenty of grist for the mill. But there is something perverse about politicians signing on as co-sponsors of legislation whose provisions they don't actually support. And there's something doubly

perverse about policy experts refusing to engage with an idea that actual elected officials want to embrace on the grounds of political inexpediency The politics, at the end of the day, is the politicians' job. What they need are some concrete policy options that would let them begin to seriously weigh the pros and cons of different possible approaches.

How much revenue would be needed, and what taxes could raise it? Can disruption be usefully minimized by phasing in the new program over time? Can both disruption and tax increases be minimized by structuring payments as "premiums" or something that employers "buy in" to? What happens to private insurers' participation in selling of Medicare Advantage and Medigap insurance plans? How can we help ensure that the money employers save actually does pass through to workers as

wages? These are the kinds of details that voters don't really care about right up until something is about to become law. But if you want to pass a law, you need to address them And as the ultimate collapse of Republicans' ACA repeal efforts shows, it's not good enough to simply assume that good solutions will emerge in the future Nothing at all is politically feasible from a progressive point of view right now. But

in truth, nobody knows what 2019 or 2021 will hold or **what avenues for action may open up** in state government. Right now, though, the left wing of the Democratic Party has a **big idea on health care but no plan. It's time for the wonks to step up.**

AND provides the tools for grassroots to pressure policymakers into credible commitments---promises absent detail are posturing

Jim Newell 17, Slate Staff Writer, 9-13-2017, "Advice for Democrats on Single-Payer: Don't Lie About It," Slate Magazine,

http://www.slate.com/articles/news_and_politics/politics/2017/09/advice_for_democrats_on_single_payer_don_t_lie_about_it.html

On Wednesday, Vermont Sen. Bernie Sanders introduced the **Medicare For All Act** of 2017, his long-awaited single-payer health care proposal that (as of this writing) has earned 16 Democratic co-sponsors. That's a 16-senator improvement on the last single-payer bill he introduced in the Senate. It's not just fellow lefties, like Oregon Sen. Jeff Merkley and Massachusetts Sen. Elizabeth Warren, supporting the Sanders plan. The bill has also earned the co-sponsorship of more typically cautious Democrats like New York Sen. Kirsten Gillibrand and New Jersey Sen. Cory Booker, as well as one senator, Wisconsin's

Tammy Baldwin, who's up for re-election in a state Donald Trump won. **It has become difficult for any Democratic senator considering a 2020 presidential bid not to co-sponsor Sanders' bill, a sign that support for single-payer will be the default position. But how committed will that support be?** Single-payer supporters shouldn't just take these supposed believers in government-sponsored health care at their word. **Until they answer the difficult questions** the Medicare for All Act of 2017 evades—**omissions that were made specifically to earn** their **buy-ins**—**their support should be treated as posturing and not a true commitment** to push for single-payer if and when they have the chance. The politicians latching onto single-payer to **score points** with the Democrats' progressive base **don't owe those answers to Washington's** scolding **policy wonk class**. They owe a **full litigation** of the **process to single-payer's supporters**, who deserve to know that their representatives aren't making them promises they're **not willing to keep**. The Medicare for All Act is built on a compromise that works well in the short-term for both Sanders and his co-sponsors: **the decision not to include financing details** within the bill itself and instead offer a separate white paper with some financing options to "begin that discussion." **By separating out the spending, Sanders makes co-sponsorship an all-gain, no-pain decision.** As Vox's Jeff Stein explains, structuring the bill this way "will make it easier for Senate Democrats to co-sponsor the legislation and win over Sanders's supporters, but also not co-sign their names to legislation calling for billions in new personal income taxes." The push for single-payer is a long project, and Sanders and his co-sponsors don't need to commit to a financing model now.

"We'd rather give the American people options," Sanders said in an interview with the Washington Post. "The truth is, embarrassingly, that **on this enormously important issue, there has not been the kind of research and study that we need**." Further study is a reasonable enough excuse for the moment, since it's not like this bill is going anywhere in Paul Ryan and Mitch McConnell's Congress. And there's value, in terms of expanding the Overton window, in showing that an idea once relegated to America's leftist fringe now has mainstream party buy-in. But **the process gets much harder from here, and it takes more than a chummy press conference** for these members to **show they're serious**. Introducing single-payer—which would eliminate most existing insurance arrangements in a country where two-thirds of people are satisfied with their coverage—is always going to be the steepest of steep political tasks. The only way I'm certain it will never, ever happen, though, is if the politicians who promise they'll support it don't reckon with the difficult challenges that single-payer presents until the moment they're forced to. I spent the first half of this year writing about what happens when a party rides the wave of a promise it's made to its base without bothering to address the trade-offs required to keep that promise. By ignoring those questions during the many years when they didn't control every lever of government, Republicans ensured that the country would learn at the last possible moment that repealing Obamacare might make some stuff Americans care about a whole lot worse. Politicians got scared, the bill died, and Republicans lost whatever credibility they ever had on health care. There is a lesson here. That lesson is: Don't do that. I have never not supported single-payer. Though it is striking, and welcome, to hear more than one-third of the Senate Democratic caucus lay out a case for why for-profit insurance needs to go, that alone is not commitment. **Commitment means educating the public** on the whole product, including the specific levels of tax increase that will be necessary, **and explaining why they're worth it**. It means telling voters directly that their taxes will go up, and not by a small amount—but by less than they had been paying in annual premiums. **This means having the courage to risk collapsing single-payer's polling support** and only then determining whether it's a product worth pushing for legislatively. **Anything else is opportunism** and a **guarantee that whoever wins the Democratic nomination in 2020 will stop talking about single-payer** the

moment he or she emerges from the primaries. Cory Booker, Kamala Harris, Elizabeth Warren, Bernie Sanders, and Kirsten Gillibrand don't need to commit to a funding model now, or even next year. But they do need to make a commitment well before they have unified Democratic control of government and have to make good on a promise to the base. They need to tell people who are satisfied with their employer coverage that they will no longer have that coverage, and convince them that what they'll get from a government-sponsored system will be better. They need to show, in short, that they're not duping single-payer supporters to get their votes—that they care about single-payer health care as a government program they're serious about implementing, and not just as a talking point.

AND spills over to future political gains by building organizing capacity

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In Bernie Sanders's wake, the socialist left has experienced a historic resurgence. The Democratic Socialists of America (DSA), which now counts over 25,000 members, is the largest socialist group in the United States since Students for a Democratic Society in the late 1960s. The challenge now is to hone its political vision and build a durable and democratic organizations that can affect real change. A focus on winning single-payer health care can help us do that. The growing demand for single payer rankles establishment Democrats, who insist that the Affordable Care Act — with its labyrinthine subsidies program meant to provide coverage without undermining the private insurance industry — is the best deal on offer, and to demand anything more is pie-in-the-sky and politically counterproductive. But with Obamacare given reprieve for the moment (albeit unsafe from future attacks), and our still-broken health care system on everyone's mind, socialists have an opportunity to organize ordinary people toward a better common goal: genuine universal coverage, managed and dispersed by democratic, transparent, and efficient institutions that are accountable to us, not corporate shareholders. California has the unique potential to become the first state to pass single payer. A grassroots movement for the cause, spearheaded by the California Nurses Association, goes back decades. This movement twice passed single-payer bills through both houses of the state legislature in the 2000s, but both were vetoed by then-Governor Arnold Schwarzenegger. Out of this legacy of popular action, 70 percent of California voters now support single payer in polls. To appeal to that active grassroots and public support, California Democrats have made single payer an official plank of their party platform. Democrats hold the Governor's seat and an exact two-thirds supermajority in both houses of the legislature, so the time has come to deliver on promises. We are two organizers with the East Bay chapter of DSA, which has made a strategic decision to focus on a single campaign: organizing around single-payer health care legislation, SB562, in California. The lessons from our campaign aren't universal (no one's are), but in explaining the strategic thinking behind our mass canvassing program and sharing the lessons we've learned from implementing it, we want to show how a focus on Medicare for All can increase socialist organizations' organizing capacity and build working-class power for long-term struggle. Zeroing in on Single Payer In recent months, socialists — many of them newcomers to the movement — have flocked to DSA, seeking opportunities to continue pushing for left political-economic reforms after the Sanders campaign. Both the national DSA organization and local chapters have begun a program of political education to introduce these members to socialist history, theory, and strategy — some for the first time in their lives. The East Bay chapter has been no exception: over five hundred people joined after Trump's election. At East Bay DSA's chapter elections in January — our first following the membership explosion — many candidates running for a leadership role pledged to focus our organizing on the California single-payer effort. The members who won election were nearly unanimous in their interest in pursuing this campaign. Based on that mandate, the leadership voted to officially join the campaign for Healthy California in February and started canvassing almost immediately. Two generations of our elected leadership have now committed to single payer as the core focus for our organizing work. Importantly, this hasn't prevented ongoing chapter actions on other issues: our direct action committee helped blockade an ICE office and held the line to protect an elderly renter from eviction; we were at the airport protests, the Women's Strike, and May Day; we have a housing caucus, a prison abolition caucus, and a socialist feminist caucus. But we've found that focusing the bulk of our organizing effort on single payer comes with major benefits: we concentrate and replicate our capacity for training members, we stress-test our organizing against the clear benchmarks of a single campaign, and we build internal unity and transparency by working together on a common cause. The singular focus helps convey to our coalition partners and members alike that we're in this for the long haul, and we're in it to win. As a result of our recent growth in both size and legitimacy, coalition partners have asked to table with us at events for increased visibility, and local candidates have sought our endorsement. East Bay DSA's commitment to campaigning for SB562 is a tactic in service of a larger strategy to build good internal structures in our burgeoning group and effective

organizing skills among a new generation of grassroots leftist activists. We also seek to strengthen ties between socialists and the labor movement — in this case the women-led and substantially non-white nurses' union — and win reforms that will strengthen the power of the working class. The Ground Game Our focus on winning single payer has driven the evolution of our organizing process. Our canvassing strategy began with a focus on large canvasses that gathered members from across our entire chapter as well as non-members interested in joining in. Before these canvasses, a select team of canvass captains received training from the union and community organizers in the chapter. On the day of the large canvasses, these captains trained and facilitated practice sessions for teams of about a dozen people each. To date, five hundred people have received training from team captains, then pounded the pavement together to knock on doors. In a frightening national political moment, door-to-door organizing has been heartening for many members, showing us we're not as alone as we think. One of our members, who originally described herself as shy, remarked that her canvassing experiences with our chapter had convinced her there are only two kinds of people in the Bay Area: socialists, and people who aren't home. Across all of our canvassing, we've focused on empowering neighbors to see their experiences with medical fees and debt in terms of class conflict, explained the mechanics and upsides of single payer, and gathered thousands of pledges to support DSA and our coalition partners in the fight for public universal coverage. In the process, our organizers have also developed as leaders. In a testament to the skill- and commitment-building potential of this tactic, about half of the chapter's newly elected Local Council started out as single-payer canvassers. The large, chapter-wide canvasses provided a good way to kick start training across our membership but weren't well suited to build steady teams of organizers consistently working the same neighborhoods. To address this issue, our organizing tactic has shifted since May to focus on district canvasses, where our members develop dedicated teams for their own neighborhoods. The point is for socialist organizers to talk to their own neighbors and build lasting political relationships. We live in an atomized, alienating society where most of us don't know our neighbors' names, and don't see any reason to learn them. These district canvasses break our own members out of their isolation, while simultaneously building stronger community ties between our organization and existing neighborhood networks. In early July, one of our canvassers, after a particularly successful round of door-knocking, was invited to speak at a block party. The person then found themselves literally organizing their neighborhood. Another district canvasser was invited to give a talk for a second block party just last week. A third stage in the evolution of our organizing is just beginning. Our canvassing program has done well at training our members for the initial conversations with neighbors, but we've found we need more structure and shared skills for follow-up to keep our neighbors consistently involved. As our chapter grows, the most involved members have largely had their workload expand just as fast; this has made it clear that helping members develop into leaders needs to become a central part of our organizing system. To clarify who should take on our member development efforts, we passed new bylaws in April which created distinct positions (both elected and appointed) for internal organizers and external organizers. The internal organizers, who were elected in June, are now focused on developing a member steward system based on the model used in many unions and the New York City and Philadelphia DSA chapters. This will build a trained network of stewards among our membership, with each responsible for supporting and catalyzing a set of less-active members and interested neighbors to become regular participants. Strong local relationships like these are invaluable to socialist organizers and can be tapped in future campaigns for fights around housing justice or workers' rights. Democratic elites have all but abandoned field organizing, especially in down-ballot races, in favor of exorbitant, consultant-led media strategies. In many places, by training even a few dozen regular canvassers through the single-payer cause, socialists can quickly develop one of the strongest ground games in town. By building ongoing relationships with our neighbors, this emphasis on field organizing will put us in a position to be helpful, in-demand allies for local unions and other Left campaigns, and lay the foundation for real impacts on electoral politics. And while we should only organize for what we are committed to winning, we should also organize so that, whether we win or lose one round in a fight, we are building the skills and relationships for power in the long term. The focused campaign gives us an opportunity to troubleshoot our organizational structure and its challenges, which makes our chapter increasingly resilient, responsive, and effective, and will serve us well beyond the fight for single payer. Already, our work has rippled outward; we've shared our training guides, canvassing scripts, and leave-behind literature to be put to use in chapters across California and as far afield as Ohio. Advancing the Program The advantages for our organization are only part of the equation.

Any unifying campaign will be beneficial to an organization finding its footing, but single payer is a strategic central focus. In fighting for it, we can build solidarity across lines of difference and continue to build power for the working class. Everybody needs health care. Nearly everybody in the working class has been hurt by private insurance greed, or has seen a friend or family member denied care so that a rich few can profit.

When we organize in the East Bay, we share our own personal stories and ask our neighbors about what they could personally gain from single payer. We work to show how our direct self-interest intersects with that of all working people: we can only win single payer for ourselves if we win it for each other. Political education that fosters this sense of shared self-interest — rather than charity for a distant other — is the foundation of a sense of solidarity built to last. The fight for single payer is an urgent anti-racist struggle. Currently in the United States, the uninsured rate is 60 percent higher for black people than for white people. The Movement for Black Lives platform demands a universal, guaranteed health care system, with particular focus on equitable access for currently excluded communities of color. In committing to the fight for single payer, socialists can take up that call to action. Meanwhile, across the US, Latinos have an uninsured rate 300 percent higher than white people. Undocumented immigrants — and many documented ones — are not covered by Medicare, nearly all Medicaid programs, and many subsidized private plans. This cruel exclusion is despite the fact that immigrants pay into the public system through taxes, and worse, is in spite of the fact that they are members of our communities who need care like everybody else. By providing coverage to all state residents regardless of documentation status, California and New York's single-

payer bills not only directly help millions, but could point a socialist path out of the current dead end around immigration politics in the US and Europe. Over the past decade, most parties of the center and many on the left have shifted towards far-right positions on refugees and migrants as a supposedly necessary concession to white-working-class xenophobia. This is morally and strategically wrong. When socialists win truly universal social programs that cover migrants, we can demonstrate that social care is not a zero-sum game. Instead, building social systems for everyone who lives here makes for stronger public institutions and a healthier society for all. If we are to push further towards building a powerful multiracial working-class movement, then a proud politics of inclusion for immigrants is not only right — it's essential.

Single payer is also a critical feminist fight. Public health coverage for all would be transformational to a society in which most unpaid and underpaid care work falls to women. When people can't get the care they need, someone is usually compelled to pick up the slack — and, especially in the realm of home care for family members, those people are disproportionately women. ("The best long-term care insurance in our country," concluded a recent study about home care for older adults, "is a conscientious daughter.") Women are more likely to receive health insurance as dependents, which means that losing a spouse through death or divorce puts them at greater risk for being uninsured. Single mothers are nearly twice as likely to be uninsured as mothers in two-parent households. Meanwhile, women who are insured also suffer disproportionately from confusing and predatory private insurance industry practices. Care costs more for women, is harder to obtain, and employers can refuse to cover contraception on religious grounds, meaning a woman's reproductive health is in many cases dependent on the conditions of her employment. California's Medicaid program covers abortion, contraception, and prenatal care. To universalize that comprehensive and inclusive care is an urgent and crucial feminist reform. The California Nurses Association, which is leading the charge on the state single-payer effort, has eighty thousand members across both unionized and non-unionized workplaces in the state. These workers are overwhelmingly women, and about half are people of color. Women fill nearly all of the top leadership roles at CNA. Who better to lead the fight to bring care into the public sphere than women care workers, who disproportionately shoulder the burden of undervalued care? Organizing in close alliance with care workers is an essential way we can put our principles into practice and expand socialist-feminist understanding within our ranks. Working with organized nurses is also strategic for building solidarity between socialists, the labor movement, and the broad working class. CNA has led the drafting of legislation and steered the inside game while coordinating and supporting grassroots allies across the state. Nurses at the helm makes this not just a "consumer movement," made up of health-care users, but a workers' movement. The nurse-led campaign sets up a clear dynamic of workers, both inside and outside the industry, against our common adversaries at the very top: health insurance executives, shareholders, and the 1 percent. Over the last half-century, the relationship between socialists and the labor movement has grown tenuous, as both groups have been diminished and devitalized by state repression and capitalist advancement. As socialists, we know that acting in concert with organized labor is fundamental, and that it's necessary to rebuild our role, both as socialist organizers and workers ourselves, in the labor movement. **By uniting with nurses against CEOs, we're committing to working-class solidarity in practice, not just in theory.** Socialists must continue to build our own independent organizations steered by the democratic power of our members, but the nurses are a strategic ally to learn from and fight alongside in this moment. Finally, single payer would win power for the working class like no other reform popularly on the table in the US today. When socialists consider fighting for a reform, we should ask if it builds working-class power towards future struggles. **Some left organizers and scholars call this "building the crisis": by winning reforms that strengthen the material conditions and class consciousness of working people, we advance the fight for more radical victories.**

Many union workers, who have seen spiraling private health insurance costs undermine their position for wage and benefit increases, have rallied behind single payer as a bulwark for future battles with management. For non-union workers, too, single payer would strengthen both their actual health and their bargaining position for raises and other benefits. A push for single payer, in this political moment, is uniquely able to draw clear lines of class conflict: it's capitalists versus all of us who work. Single payer is already a concession on the part of socialists. We want fully socialized medicine, which would function on the same principles but extend to hospitals and doctors themselves, and which already exists in many nations. We envision single payer as a first step in a long struggle to implement full universal social programs. **We see it as a non-reformist reform: that is, a structural modification of power relations that elevates the ability of working-class people to fight against capital while radically shifting the window of political possibility.** We're interested in using SB562 as a political education opportunity for our membership and neighbors, and publicly advancing the idea that universal social programs are better than means-tested ones. **According to the neoliberal logic of means-testing, some people need public assistance to attain things like health insurance, but only those in the direst of straits. Socialists, on the other hand, believe in the decommodification of essential goods and services for all, for both moral and politically strategic reasons.** Universal programs are essential to eliminating wealth inequality. **They decrease disparities in the here and now, creating a stronger working class that is less fearful and insecure, and therefore less easily exploited by capital. They also build powerful new**

constituencies dedicated to defending public goods against privatization. In this way, universal programs can function as “**engines of solidarity.**” To make health insurance universally guaranteed and public is to both assert that

coverage is a right, and to build a stronger body politic that can mobilize to protect that right. In our discussions at peoples’ doors, we hear our neighbors’ indignation that the wealthy are able to receive medical care when necessary without fear of ruinous financial consequences, while everybody else is faced with hard choices about whether to go into massive amounts of debt to seek necessary treatment. In those conversations, we hear the raw material for a mass oppositional class politics. That’s why we ask for commitments from those people to join the campaign, instead of just signing a petition or donating once. For example, behind one door was a twenty-six year old with a bandage wrapped around his hand. He had just lost his job, where he was paid poorly to work with dogs, one of which had bitten him badly. He was a few months too old to be listed as a dependent, and suddenly found himself uninsured. He talked to our neighborhood canvassers for twenty minutes. At the next neighborhood canvass there he was, DSA clipboard in his healing hand, knocking on doors with the rest of us. California’s Single-Payer Melee Pressured by a growing movement and a single-payer bill that has passed the State Senate, elite Democrats have been forced to show their true loyalties. In late June, Assembly Speaker Anthony Rendon froze the bill in committee, halting any formal legislative progress in his chamber until next year. We knew this opposition was coming. Contrary to recent allegations of unpreparedness and deception, from the start of the campaign, CNA leaders have been clear on statewide conference calls with coalition

activists that we are building strength for a multiple-year effort — which could require a ballot campaign as a costly last resort. That’s only necessary if the legislature can’t be pushed to deliver single payer past the state’s tax and spending constraints. The coalition’s current effort to turn up pressure on Rendon and other resistant Democrats is essential to build that necessary legislative will. At doorsteps, DSA organizers have been talking with our neighbors about what it will take to win this protracted and difficult fight. After fifty years of conservatives and centrists passing severe restrictions on taxes and spending, California’s political playing field is badly rigged. That’s why our victory requires building a powerful movement off that field. Democratic elites — steered by donors from real estate, insurance, dirty energy, and tech, and backed up by the management of huge non-profits and major unions — treat the handcuffs on state power as “sacred doctrine that should never be questioned.” Even if they wanted to overturn suffocating restrictions on the state, Democratic leaders can’t imagine building the popular power needed to do it. If Democrats bury the legislation now, they will be opposing the idea that politics ought to involve imagination, mass effort, and the will to fight uphill battles so that people’s lives might be freer and better. In this context, socialists have a critical role to play in the movement for single payer: unlike the Democrats, we can build broad working-class power while expanding the public imagination of what politics could be. East Bay DSA regards SB562 as an opportunity to build, mobilize, and grow our organizations and movement. While the bill is frozen in committee, we’re going to continue educating, coordinating, and taking full advantage of the swelling interest in both single payer and socialism. In those respects we’re already winning, and no legislative defeat can undo our victories.

But this isn’t a trap, or a trick question meant to expose neoliberal hypocrisy. Single payer is a real policy demand, and we want it to pass. If it does, there will be several subsequent obstacles to actually implementing a functional single-payer health care system in our state. If we proceed to a ballot measure, the health insurance lobby will wage a media war to scare Californians out of it. (Of course, the best way to combat a propaganda campaign that well-funded is to organize and educate people on the ground, grassroots-style — which we’re currently doing.) In the meantime, socialists around the country must start thinking critically about building and wielding organizational power.

Not every socialist group has the opportunity to rally behind state single-payer legislation like we have. But given our national moment of historic upheaval for health care and the broadening popularity of Medicare for All, we think socialists throughout the nation can build alliances and open political imagination by being a loud voice — and given the refusal of the Democratic Party to champion it, perhaps the loudest voice — for single payer in their specific political climate. A nationwide single-payer campaign that embraces a diversity of location-specific tactics can help socialists replicate a skill-building, infrastructure-honing strategy across cities and states. This shouldn’t preclude simultaneous local and regional campaigns on other issues, but we believe a primary nationwide focus on single payer, more than any other issue, will build power for socialists and the working class. East Bay DSA’s campaign for single-payer legislation shows how we can get started.

BUT, pushing back against healthcare inequalities is valuable even absent spillover because it expands the tactical options available to those suffering from structural violence

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Equity in health care cannot be achieved simply by the actions of legislatures, doctors, nurses, and health care organizations. As we saw in chapter 11, one measure of collective efficacy and social cohesion is an activated community ready to organize and act on its own behalf. Such a community can be a powerful tool for health improvement. Communities that are interested in the health of their members and demonstrate this through community participation may be healthier communities in the long run.² A sense of purpose, so critical to personal health, can also be important to improve community health. In the absence of national or statewide policies to address health injustice, health inequity conflicts become local. The battlegrounds in these conflicts are often hospitals, clinics, insurance companies, and government agencies. Not surprisingly, Chicago has been ground zero for a number of churning health controversies. The transplant activism discussed in chapter 8 is one example.³

Environmental activists, stirred by high pediatric asthma mortality in the area, forced the mothballing of coal-fired toxin-spewing power plants in Chicago.⁴ The shuttering of public mental health clinics was accompanied by public outrage, demonstrations, and arrests.⁵ While health care institutions naturally try to avoid public confrontations about policies and practices, at times these skirmishes are unavoidable. Public actions directed against health institutions can be disruptive, but at the same time they foster opportunities for substantive structural improvements. Partnerships between communities and institutions are critical to overcome the structural and social conditions that precipitate premature mortality. While contentious conflicts between disadvantaged communities and powerful institutions can be painful, common cause, when achieved, can improve health.

In this chapter, against a backdrop of neglected and violence-torn neighborhoods, I spotlight a battle between a local black youth group demanding a Level 1 trauma center and the University of Chicago, a bastion of academic prowess.⁶ The fight for a trauma center was linked to citywide activism over the decline of health and the implosion of poor neighborhoods in the wake of the Great Recession. An epidemic of gun violence in Chicago and a rash of highly publicized police brutality cases fueled feelings of disenfranchisement among the youth. Two separate realities fanned the conflict: the business priorities of a successful, internationally renowned university medical center and the moral demands of members of a violence-stricken, poverty-afflicted neighboring black community. The battle zone was Chicago's South Side, but the conflict eventually breached the portals of the White House.⁷ Community Activists Target Health Care The underlying neighborhood conditions on the South and West Sides of Chicago that contributed to disease burden and premature mortality have also spawned a new generation of community activists. The years from 2010 through 2015 saw a flurry of this community activism around the issues of health care delivery, mental health, school closings, and public safety.⁸ Spawned by an epidemic of gun violence and fueled by long-standing mistrust between the communities and institutions like the police, city hall, and health care infrastructure, the activism caught the city by surprise. But these outbursts were more than a series of disconnected events. 162 * CHAPTER TWELVE Rather, they reflected the growing frustration of people living in longneglected neighborhoods. Simmering grievances and injustices needed airing. The residents of these inner-city areas had watched their neighborhoods deteriorate since the middle part of the twentieth century. Despite fair housing laws, blacks are still preferentially steered by realtors to black neighborhoods with overpriced housing and are forced to pay what has been called a "race tax": the increased cost of goods and services from food to insurance to gasoline.⁹ Underserved by banks, these neighborhoods had been targeted by the harsh terms and high interest rates of predatory subprime lenders in the latter part of the twentieth century. Like unscrupulous ghetto contract lenders of the 1950s, subprime lenders strong-armed people into taking on risky debt. These neighborhoods were then pummeled by the mortgage loan crisis that caused the Great Recession in 2008. Foreclosures ravaged poor African American and Latino neighborhoods in particular.¹⁰ In sixteen poor black Chicago neighborhoods, 10 percent of the homes were in foreclosure.¹¹ Boarded-up houses blighted residential neighborhoods, inviting drug dealing and vandalism. The devastation crippled even middle-class neighborhoods. The Bronzeville neighborhood recovered more slowly than other middleclass black neighborhoods in the nation, such as Harlem.¹² Black families, stripped of jobs, homes, cars, retirement accounts, and savings, saw wealth gains of a lifetime wiped out.¹³ By 2011 black median household net worth had nosedived to \$7,134. (By comparison, the average white household's wealth was \$111,146.)¹⁵ Half the collective wealth of African American families was obliterated during the Great Recession.¹⁶ It was an economic calamity of stupendous proportions and perhaps the largest drain on black American wealth ever recorded.¹⁷ But this wealth death spiral failed to gain the attention of a nation as did police shootings of black men in many of the same affected neighborhoods in 2014 and 2015.¹⁸ #BlackLivesMatter and Community Health Activism On Black Friday 2015, thousands of #BlackLivesMatter demonstrators disrupted Christmas shopping on Michigan Avenue in response to a Chicago city hall cover-up of the police murder of teenager Laquan McDonald.¹⁹ McDonald's death was one of many well-publicized police shootings of young black men across the United States that spawned the #BlackLivesMatter movement in 2014.²⁰ McDonald, a troubled seventeen-year-old, was shot sixteen times by a police officer. A police conspiracy to cover up the murder ensued and eventually reached Mayor Rahm Emanuel at city hall. Fourteen months after the murder, an investigative reporter forced the city to release the video of it. It shocked the city and nation.²¹ Police homicide and brutality were not new phenomena. Police have enforced structural violence and the criminalization of black life across America for generations. What was new was video evidence of police brutality and the way it could now travel via viral social media. The invisible was now visible. The crowd of demonstrators included members of a South Side community organization named STOP, Southside Together Organizing for Power, and its youth organization, Fearless Leading by the Youth.²² STOP and FLY led fights for housing equity and access to health care. The connection between the national movement and the local issues 164 * CHAPTER TWELVE could not be any clearer to them. After all, the #BlackLives movement was not just about racist police violence. It was about long-standing structural violence and inequity. Race, Place, and Policing The tension between Chicago's black communities and the police had long simmered. For years Commander John Burge and his squad of detectives had tortured black prisoners into confessions in a South Side police station, yet the city defended him and other abusers in the face of lawsuits.²³ Between 2007 and 2012, Chicago police shot over four hundred people.²⁴ There were seventy police fatalities during that period, the most in the nation. Between 2004 and 2014, the cash-strapped city dished out \$662 million in police brutality settlements.²⁵ Imagine how those funds might have helped failing schools or the health-care safety net. In April 2016, an independent investigative report declared the Chicago Police Department to be systematically racist, an assertion that was no surprise to residents.²⁶ Three-quarters of the police shootings and 72 percent of the use of tasers have been directed at black people.²⁷ "The video that depicted the death of Laquan McDonald motivated a movement, and it was a tipping point, but really again the conversation about the narrative of the intersection of race and policing goes back decades," said Lori Lightfoot, chair of the Police Accountability Taskforce, which released the report.²⁸ Meanwhile, an epidemic of gun violence targeting teenagers and young adults plagued the same Chicago neighborhoods affected by racist policing practices. What the neighborhoods needed was safety. The violence epidemic in these high-poverty neighborhoods was a fivealarm public health emergency. While some teen violence prevention programs, such as Cure Violence, have reduced repeat gun violence by 40 to 71 percent in some neighborhoods, the scope of the crisis is far greater than these programs can handle.²⁹ The root of the violence epidemic is structural violence: the lack of jobs, limited educational opportunities, the loss of wealth, and the loss of hope and purpose in these neighborhoods. Community Activism against Structural Violence * 165 We can best understand the fight for a South Side trauma center in the context of this precipitous neighborhood decline, on top of generations of neighborhood neglect. In 2012 the city's decision to shutter six of twelve long-standing mental health clinics—four of them on the South Side—spawned wide protests and many arrests. County sheriff Tom Dart, who has described his jail as the state's "largest mental health provider," opposed the closings. "This is not higher math," Dart said. "If you reduce programs and remove funding, it isn't as if fairy dust will be spread throughout the clouds and these people's mental health issues will go away. They will still have them, and it's a question of where they will go from there. The majority are coming to the criminal justice system."³⁰ STOP and other groups protested the closings, which the city claimed would save \$3 million yearly.³¹ The need for mental health services in the community was enormous—and growing even as the funding evaporated. This tension between money and need would fuel the trauma debate. From the perspective of neighborhood leaders, the five-year battle for a Level 1 trauma center was not a one-issue battle. They had witnessed the besieging of their neighborhoods by losses of wealth and life, clinic and school closures, and the dimming of their children's prospects. The best efforts of the University of Chicago Hospitals to provide community health to the South Side was no match for the expectations of young black people who had to contend with the ravages of day-to-day violence in their communities. Damian Turner Is Shot A random shooting in 2010 triggered the demand for a South Side trauma center. Fifty-eight Chicagoans were shot that

August, two fewer than the number of Americans killed in Iraq that entire year.³² Damian Turner was one of them. A stray bullet pierced his 18-year-old chest in a drive-by shooting just four blocks from the University of Chicago Hospital. Wounded and bleeding, he staggered to his sister's nearby apartment and collapsed on her doorstep. She raced to the phone and called 911. The paramedics arrived and transported Damian to North 66 * CHAPTER TWELVE western Memorial Hospital, the closest trauma center, ten miles away. He was pronounced dead an hour after arrival. His family and friends were left wondering whether his life could have been saved had he been taken just a few blocks, to the University of Chicago.³³ "Nobody on this earth deserves to die if they have a chance to live," Turner's mother, Sheila Rush, said to a reporter from *The Nation*. "My son did not even have a chance, because he was fighting for his life on the way in that ambulance on that long ride to the hospital."³⁴ The University of Chicago had closed down its adult trauma unit twenty-five years prior, when it was hemorrhaging \$2 million a year.³⁵ The university maintained a pediatric trauma center but admitted teenage trauma victims only up to the age of 15. Located in the middle-class Hyde Park neighborhood, the hospital is flanked by black neighborhoods where gun violence is rampant. Mistrust between the university and the black South Side had festered for seventy-five years because the community interpreted the university's urban development practices as a tool to blunt black intrusion into Hyde Park. In the 1930s, a Metropolitan Chicago Housing and Planning Council (MHPCC) composed of white real estate and banking interests was formed to address "urban blight" just as blacks were flowing into the city's neighborhoods. The council steered into law the Illinois Blighted Areas Redevelopment Act, which pioneered the concept of "urban renewal." The law created and empowered a Land Clearance Commission to use eminent domain to acquire land in "blighted" areas, demolish the existing buildings, then sell the land at steep discounts to private investors. Urban blight became a code phrase to justify the dismantling of black neighborhoods that encroached on white neighborhoods and business districts. Black neighborhoods were thus disproportionately targeted for redevelopment. The city council doubled down on this scheme by passing legislation to keep public housing that was open to black people from being located in white neighborhoods. These laws inspired federal urban-renewal legislation that replicated the Chicago plan across the United States, but also provided funding for black neighborhood destruction. Black people displaced by urban renewal and blocked from white wards were forced to take refuge in dense, overcrowded black neighborhoods. One neighborhood that attracted Community Activism against Structural Violence * 167 new black apartment dwellers and homeowners in the 1940s was Hyde Park.³⁶ In the late 1940s, University of Chicago officials feared that they might lose their student base if the neighborhood became black. Working with the MHPCC, they engineered a piece of state (and eventually federal) housing legislation that allowed neighborhoods that were not yet "blighted" to be razed by targeting what were euphemistically called "pockets of decay"—in other words, black neighborhoods. By 1958 the "conservation" of the Hyde Park neighborhood had destroyed perfectly fine housing in the black southwest side of the neighborhood. The urban renewal plan called for the destruction of 20 percent of Hyde Park's housing and the removal of 20,000 black residents without any relocation plans. Over the next fifty years university efforts to clear "blight" in the neighborhoods surrounding Hyde Park fanned the tension between neighborhood residents and the university.³⁷ While the University of Chicago Hospital officials thought they were making a simple business decision about whether to offer trauma services, some black neighbors interpreted the decision through the historical prism of mistrust and perceived racial discrimination by the university. In 2009 some claimed that the university was trying to deflect routine care of the local community to other institutions by limiting emergency room care, a move that was widely condemned.³⁸ The university hospital is the only major hospital on the South Side. It boasts a deep bench of medical and surgical specialists. The other hospitals are essentially small safety-net institutions with limited services and shaky finances. If you are sick on the South Side, the University of Chicago Hospital is the best place to go. When Damian Turner died, his murder awakened long-dormant grievances held by some black South Siders against the university. Turner was a popular community youth leader and a cofounder of FLY, an organization composed of high school and college-age students. At the time of his murder, the group had been working to improve the living conditions of kids detained in the city's Youth Detention Facility. When FLY leaders assembled to mourn Damian's death, they shared memories of other friends who had perished from gunshots. In these discussions they identified the lack of South Side trauma care as a 168 * CHAPTER TWELVE public health issue. They believed that if the University of Chicago had a trauma center, Damian would not have died. So FLY publicly asked the university to open a trauma center.³⁹ On what would have been Damian's nineteenth birthday, FLY activists held a demonstration in front of the university hospital to reiterate their demand and request a meeting with the university leadership. Five years passed before the medical center leader agreed to meet. Yet FLY leaders, undaunted by the challenge ahead and determined to honor the memory of their fallen leader, chanted at every rally and meeting, "I believe that we will win!" For its part, the university maintained that Chicago had no need for another trauma center and to build one would be cost-prohibitive. Both positions were accurate. There was plenty of trauma capacity at the regional trauma centers. As *The Nation* later described the situation: Chicago's four trauma centers are located on the city's west and north sides. The Southside of Chicago where most of the gunshot victims were being injured had no adult trauma center. Dr. Gary Merlotti, the chief of trauma at Sinai Health System on the Westside, noted that the city suffered from neither an insufficient quantity nor quality of trauma centers. "I don't think we have an inadequate number," Merlotti says. "We have a geographic maldistribution."⁴⁰ The finances of trauma care are dismal. Most trauma centers lose money, as many patients are uninsured. For FLY's new leader Darius Lightfoot, the issue was not revenue but the value of black lives. "Show us that you really care. Show us that you really value a black life," he said.⁴¹ FLY understood the issue as a crisis of morality and health justice, as well as a test of the university's commitment to the black South Side. The medical center leaders saw it as a question of resource utilization. But it was difficult to frame the debate as simply a resource question in light of the national #BlackLives movement and the depth of racial inequities in Chicago. FLY's demands extended beyond trauma care. FLY sought a broader program to address the health issue of greatest concern to the community: violence. Alex Goldenberg, executive director of STOP (FLY's parent organization), explained the connection: We definitely see gun violence cutting across a number of other issues. The fight for trauma care allows you to talk about these issues. We're not asking just for the care but we are really fighting to change the whole continuum of issues that violence is resulting in. At one end of the spectrum you have the trauma center, which is leading for the care for the injury. But you also have the violence interrupter that's there with the friends, family, relatives and the person who is injured. Then there are the services to follow up with the family and friends. Then you have all the other needed things like jobs and after school programs that support prevention. The coalition we are building is fighting for all of those things.⁴² The activists organized students, religious leaders, not-for-profits, physicians, and other health professionals under an umbrella Trauma Care Coalition. Change Starts to Come Over five years, three independent events contributed to the medical center's reversal of its position. The first was the 2013 grand opening of its \$700 million high-tech, gleaming hospital bed tower, the Center for Care and Discovery, in 2013. The tower's state-of-the-art magnificence contrasts with the poverty of surrounding neighborhoods. For community members who feel locked out, it symbolizes the wealth gaps and structural inequities that they experience every day. After the new hospital opened, the medical center found it difficult to use cost as an argument against building a trauma center. "The optics were kind of absurd," said Alex Goldenberg.⁴³ FLY disrupted the building's opening by signing up for a public tour and then holding a sit-in in the lobby. Batons swinging, University of Chicago police cleared the demonstrators and arrested four people. Shortly afterward the medical center dean announced that the hospital would study a regional strategy for a trauma center—the first glimpse Community Activism against Structural Violence * 169 170 * CHAPTER TWELVE that a victory might be possible. Many demonstrations and prayer sessions followed, with police dragging protesters from a construction site in 2014 and clearing praying protesters from the hospital's lobby at other times. In June 2015, nine protesters were arrested after barricading themselves in a university building.⁴⁴ An influential study by Northwestern trauma surgeon Marie Crandall, in the June 2013 journal of the American Public Health Association, helped FLY's cause, calling Chicago's South Side a trauma care desert.⁴⁵ Crandall's study illuminated the extent to which the maldistribution of trauma care posed a deadly threat to a subset of patients. Studying gunshot wounds in Chicago, she found higher mortality among people who traveled more than five miles for trauma care than among those who traveled fewer than five miles—particularly patients with wounds like those of Damian Turner.⁴⁶ The Nation estimated that almost a fifth of Chicago residents live five or more miles away from a trauma center, most of them on the black South Side. More than a third of the city's homicides and shootings between 2001 to 2013 have unfolded more than five miles away from a trauma center.⁴⁷ Crandall's study provided evidence that sanctioned FLY's and Turner's family's suspicions that delay and distance might contribute to death. Studies beyond Chicago have not proved that distance factors in trauma mortality. But given that Crandall's study was specifically based on Chicago's data, it was hard to argue with her conclusions. The third factor that may have tipped the scales was the US president himself. In 2014 the University of Chicago and the City of Chicago lobbied for the Obama Presidential Library to be located near campus. Trauma-center protesters seized the opportunity, organizing events and chanting "No trauma, no Bama." Soon influential community leaders conditioned their support for the Obama Library on the building of a trauma center.⁴⁸ The university's pursuit of the Obama Library may have forced it to concede on the trauma center. The University of Chicago Medical Center faced internal pressure about trauma care as well. Many medical students, medical faculty, nurses, and staff supported the Trauma Coalition's demand and urged the administration to concede. The moral suasion of the university community was at the very least a factor in the eventual decision. Victory for the South Side in December 2014, the medical center leaders began stutter-stepping their way to a decision. They announced that the age for pediatric trauma treatment would be raised from 15 to 17. Then in September 2015, the university announced that it would partner with the Sinai Health System to build a trauma center five miles west of the university hospital on a Sinai hospital property. In December 2015, however, they scrapped the deal with Sinai and announced that they had decided to open an adult trauma center on their own campus as part of a larger commitment to expand health care services on the South Side.⁴⁹ Some viewed the expansion announcement as a cynical attempt by the university to improve its finances by providing lucrative cancer and other medical care in addition to trauma care.⁵⁰ But others saw it as a welcome and genuine about-face that will lead the medical center to focus more fully on the complex needs of communities beset by structural violence. The voice of the community had been heard. Members of FLY and STOP were cautiously optimistic that a trauma center would be built but will remain wary until it opens.⁵¹ On December 15, 2015, the Trauma Care Coalition released a statement: In this moment, the whole world is watching Chicago and its history and practice of institutional racism. The decision by President Robert Zimmer and Dean Kenneth Polonsky of the University of Chicago to listen to the community and concede to the demand to open a Level I Adult Trauma Center and save black lives shows that young black people can absolutely impact policy and influence political change for the betterment of the black community. We applaud the University of Chicago for taking responsibility as a member of the broader south side community. A Level I Adult Trauma Center at the University of Chicago will provide the best possible outcome for addressing the current lack of south side trauma care. It also signals a significant shift in the University's approach to responding to the needs of its predominantly Black South Side neighbors. This is a movement moment. We are winning and need to dream bigger and demand more to create a society where healthcare is a human right and all human rights are respected. We are calling on everyone who has struggled with us and all oppressed people to dream bigger. Let's do more, it's working, we can get the things that we want. The "I believe that we will win" chant is not just a chant, it is real.⁵² Community Activism against Structural Violence * 173 O BSERVUUDGUCT 13 Ultimately a great nation is a compassionate nation. America has not met its obligations and its responsibilities to the poor. One day we will have to stand before the God of history and we will talk in terms of things we've done. Yes, we will be able to say we built gargantuan bridges to span the seas, we built gigantic buildings to kiss the skies_____It seems that I can hear the God of history saying, "That was not enough! But I was hungry, and ye fed me not. I was naked, and ye clothed me not. I was devoid of a decent sanitary house to live in, and ye provided no shelter for me_____". This is America's opportunity to

help bridge the gulf between the haves and the have-nots. The question is whether America will do it.¹ MARTIN LUTHER KING JR. Observe, Judge, Act It would not suffice for me to diagnose inequality as a cause of America's premature mortality and death gaps without offering a prescription for cure, any more than it would suffice for a firefighter to witness a three-alarm blaze without grabbing a hose. For my prescription I turn to the insights of Dr. Paul Farmer, the humanitarian physician whose work in Haiti, Rwanda, Peru, and Russia with his human rights group, Partners in Health, has been at the forefront of treating the maladies of the poor caused by structural violence. In his book *Pathologies of Power*, Farmer wrote about three precepts that have guided his health justice work around the world: observe, judge, and act.² These precepts Observe, Judge, Act * 175 are critical to grasp to solve the problem of inequality as a cause of premature American death. Observe what is happening. Analyze it. Judge the reasons why people are dying prematurely. Then act. These three precepts were first introduced in 1930 by the

Belgian cardinal Joseph Cardijn, then promoted by Pope John XXIII in his encyclical letter *Mater et Magistra* in 1961.³ They were widely adopted in Latin America as a thread of liberation theology and in Chicago by antiracist priests fighting redlining, blockbusting, and other acts of structural violence.⁴ They are meant as a guide to follow to translate social justice principles into action.

Observe Medicine has a clear obligation to work on behalf of the poor but often falls short in the United States—indeed, across the world. With its focus on profit margins, the American health care system has directed the tools of biomedical technology to preferentially benefit the rich and middle class at the expense of the health needs of the poor. Because health care is a commodity and not considered a human right in the United States, the poor inevitably suffer. We have developed a polite vernacular that allows us to avoid the scandalous conditions of health inequality in our midst. Using euphemisms like “poor payer-mix” allows health system administrators to avoid delivering direct service to poor and minority neighborhoods. We tend to build clinics and high-technology centers in wealthier (and often white) neighborhoods. We avoid some of the Medicaid insurance plans that cover the poor, because they don’t pay us well. We limit the uninsured access to our clinics and technology. Our doctors and administrators are from largely white and privileged neighborhoods and often have little insight into the day-to-day lives of their poorest patients. While some of our institutions and many physicians do their best to serve the sick and poor, their service falls short of the need. We have too long tolerated rich-poor, white-minority inequities in treatments and health care outcomes. We have pretended that separate health care for the poor is equal to the care for the middle class and the rich. It is not. 176 * CHAPTER THIRTEEN Physicians are the “natural attorneys” for the poor, uniquely positioned to advocate on their behalf. Yet too often we have remained silent as our hospitals and insurance companies have pursued material gain over solving the health needs of patients in our most troubled communities. Most of us are uncomfortable acknowledging the brutal truth of life and death in America—that much suffering and early death stem from social and economic conditions and are preventable. Most of us, even if we acknowledge the unnecessary deaths, do not feel comfortable speaking up. It is uniquely the province of medicine to observe and ameliorate the conditions affecting populations suffering in ill health and poverty. One could argue that the disproportionate burden of disease and premature mortality inflicted on the poor obliges medicine to preferentially serve, care, and treat our most marginalized populations. To observe the state of health and low life expectancy in the poor requires that medicine not just heal the individual. It must address the social and economic conditions that elicit and aggravate illness. Take for instance, the visit of Mr. M to my office. A Suicide Attempt Mr. M is a 62-year-old black man. He looks ten years older, with cropped gray hair and a heavily wrinkled face with deep-set walnutcolored eyes and silver stubble on his cheeks and chin. He’s been my patient for a few years and suffers from diabetes, cirrhosis of the liver, emphysema, hypertension, and arthritis. An ex-offender, he is living a precarious hand-to-mouth existence in the inner city. Usually we discuss his diabetes or his chronic pain. But today he told me that he had tried to kill himself. I stopped typing into the electronic chart, slid back on my rolling stool, and turned to face him. As he told his story, the pained look on his face contrasted with the bright gleam of my examination room with its wall rack of trendy magazines and an examination table centered on an antiseptic white tile floor. My current office sits within one city block of the cubicle where I saw my first outpatient in the summer of 1978. In these almost four decades of practicing primary care in this one Chicago neighborhood, I have observed over and over again the trauma that a lifetime of structural violence inflicts on the human body and soul. Today was no exception. Mr. M had been acting erratically during the last month, and Megan, the nurse practitioner, thought that he might be using drugs. “What happened to you?” I ask. “We were worried that something was wrong.” I run through a standardized checklist of questions to assess whether Mr. M was depressed. When I ask him if he has thoughts of suicide, he nods. “I thought I needed to kill myself,” he says. “Forget this. I am outta here.” He described his physical pain and his shortness of breath. “Stuff is coming to me from everywhere. I can’t move like I used to. I am short of breath and in pain all the time. I need to leave here.” Mr. M is also homeless. He moves from shelter to shelter, from street to street, day in and day out. He was evicted from his last apartment and owes \$1,400 in back rent. There is not a stable housing option on his horizon anytime soon, so he wanders with his possessions from place to place. “So I went to a guy I knew who sold heroin, and I snorted some because I wanted to end it. Everything was too much for me. The way I was living. I’m sick, myself. Then I watched my mom have a heart attack. My brother is an alcoholic and all he wants to do is fight all the time. I did not want to live no more. Someone found me and called the ambulance. I was taken to Swedish [a Chicago hospital]. I came back to my senses after that.” “Why did you want to kill yourself?” I ask. “I have my own stress,” he says. “Then I have the stress in my family, trying to hold them together. Then there is the stress in the streets, trying to maneuver around to avoid this person or that street. The stress is so much sometimes that it makes me feel like my head is going to bust. It is the fear that I feel all the time. Sometimes I feel like giving up. I just want to lay down and die.” Doctors can be overwhelmed by the sheer magnitude of the distress and disease burdens that target the poor. Those of us who provide health care for the poor often encounter patients like Mr. M, living in the midst of despair. All of us have witnessed the crippling impact of grinding poverty on our patients. It’s not just the premature mortality. Observe, Judge, Act * 177 178 * CHAPTER THIRTEEN It’s the burden of living with disease and distress on a day-to-day basis. There is not a pill for Mr. M’s misery. However, safe and affordable housing might have prevented his suicide attempt. All I had to offer was a willing ear to listen, a social work referral, and an offer to see him again in a couple of weeks. I have been at this for a long time. It does not get easier. When one takes the time to peel back the doctor-patient

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relationship, a world is revealed that would be quite shocking to the average middle-class American. Yet we are all a bankruptcy, a job loss, a catastrophic illness away from a life of misery ourselves. I wish I could report that the lives of the poor have materially improved in my decades as a doctor in Chicago. By many measures they are worse. We recently analyzed the causes for hospitalizations in the West Side neighborhoods just beyond my hospital's portals. In most neighborhoods of concentrated advantage people go to the hospital to deliver babies or to get cardiac treatments and the like. But in the neighborhoods of high hardship, the top reason for hospitalization is mental illness. An epidemic of mental illness caused by the social and economic conditions in Chicago's inner-city neighborhoods. Mr. M is just the latest victim. Judge To judge requires we accurately assess the root cause of America's death gaps. I have named structural violence as a critical driver of health inequality. Not behaviors. Not biology. Not culture. Not bad luck. But deliberate public and economic policies that have allowed inequality to flourish at the cost of life itself. That is not to reject individual responsibility and accountability for health outcomes. Or to deny that diseases have biological manifestations. But individual behaviors, biology, and culture are insufficient explanations for the Observe, Judge, Act * 179 neighborhood-to-neighborhood gaps in illness and life expectancy. And they deflect attention from the social, political, and economic fault lines that create survival gaps. The Chicago Transit Authority Blue Line train has a stop just in front of my hospital. The life expectancy around the Blue Line stop in Chicago's Loop, just east of Rush University Hospital, is 85 years. Three stops down the Blue Line from Rush is Mr. M's neighborhood, where life expectancy plummets to less than 69. No measured assessment of the health conditions in America's neighborhoods could fail to connect the marginalized existence of so many and the economic structures and racial discrimination that have enriched many at the expense of the poor. Even if you don't agree that structural violence is the root cause of our neighborhood ills, there can be no doubt that something is dreadfully wrong. Neighborhood and life conditions have deteriorated to the point where they drive patients like Mr. M to madness and, worse, suicide. And yet we are anesthetized by these neighborhood conditions. We have tolerated the wickedness of inequity as if it were a natural condition of a modern capitalist society. We avert our gaze so we do not have to endure the jarring emotional dissonance created by the juxtaposition of great wealth and mammoth poverty. Despite the evidence that structural violence inflicts terrible psychological stress on the poor, the City of Chicago's Health Department closed its mental health clinics a few years ago.⁵ At the same time, Chicago's jails and emergency rooms overflow with the mentally ill. Under what measure of fairness and justice can this be justified? Concentrated poverty and distress are mushrooming in the United States. For those on the short end of the wealth stick, the system is rigged. The negative impact of structural violence has skyrocketed as jobs, opportunities, and wealth have deserted more and more American neighborhoods in the twenty-first century. The United States now boasts more high-poverty neighborhoods in any time since the 1960s.⁶ Since 2000, the number of people living in high-poverty ghettos and slums nearly doubled, from 7.2 million to 13.8 million, while poverty became more densely concentrated. More than one in four African Americans and more than one in three Latinos now live in neighborhoods of extreme poverty. Contrast this to white America. One in thirteen white Americans lives in this concentrated poverty—nothing to celebrate, but disproportionate to the US black and Latino experience.⁷ Because white poverty is more dispersed than black and Latino poverty, the death gaps within the white community can be difficult to discern. While white America experiences better health overall than black America, some neighborhoods in white America are not inoculated against the impact of structural violence. An analysis by the Washington Post found that since 2000, American white women have been dying at higher rates expiring in their 30s, 40s, and 50s, an invisible crisis driven by the impact of postglobalization job loss on small-town America. In one of the hardest-hit groups—rural white women in their late 40s—the death rate has risen by 30 percent. As life has evolved in rural America, as jobs have been dispatched overseas, as poverty has swelled, more white men and women are dying prematurely. A greater proportion of Americans lived in poverty in 2015—a staggering 45 million—than in the late 1960s. Children are the hardest hit, with almost half of them below five years old living in poverty.⁸ Chicago is an epicenter for child distress, with the highest child poverty rate in the nation. While black and Latino men have been imprisoned at unprecedented rates, black women and their children have faced an epidemic of evictions because of poverty and racism.⁹ The wealth gap between whites and minorities is the largest it has been since 1989.¹⁰ The wealth gap for single women in America is even starker. Single black and Hispanic women have a median wealth of \$100 and \$120 respectively; the median for single white women is \$41,500. Nearly half of all single black and Hispanic women have zero or negative wealth, meaning that their debts exceed their total assets. These statistics demonstrate graphic inequity, but we should not forget that the preponderance of poverty in the United States is among whites.¹¹

We have performed enough analyses. There are **no more observations or judgments to make.** If we were studying the **impact of structural violence on health and longevity** in a randomized clinical trial, the experiment would have been **halted long ago on ethical grounds.** It is time to act. It is time for healing. Observe, Judge, Act * 181 Act We can act on behalf of the poor. We can choose to neither objectify nor dismiss their experiences. We can insist on and pursue their right for health and longevity. We can speak up against structural violence. We can demand political and policy solutions to mitigate or eliminate the structures that impart violence. We can advocate for a fair and equitable health-care system organized around the precept of health as a human right. We can expect our institutions to do more to serve the interests of America's high-poverty communities and their residents. We can expect our leaders and policy makers to hold all our institutions to greater accountability for the lives of the poor. Finally, we can act personally to preferentially serve the poor. To speak against the forces of structural violence—racism; economic exploitation; mass incarceration; the lack of safety, good education, and decent-paying jobs—requires us to make the invisible visible. That means we have to acknowledge and address the distress in our high-hardship communities. We can seek to understand all the ways in which racial and anti-poor bias is explicitly and implicitly built into our institutions and then work to overcome these biases. To act against structural violence first requires us to expose the conditions that curtail life and

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hasten death in our midst. During the 1960 presidential campaign, when John F. Kennedy visited coal-mining country in eastern Kentucky, he was so jarred by what he witnessed—"the hungry children,... the old people who cannot pay their doctor's bills, the families forced to give up their farms"—that he pledged to take action.¹² At age eight, because of that visit, I confronted the faces of suffering and misery in the papers and on my living-room TV screen. The whole nation was moved to action, shocked by the abject poverty in the midst of American postwar prosperity. This revelation ultimately resulted in the War on Poverty, Medicare, Medicaid, Head Start, and other social programs that lifted the lives of millions of poor Americans and redistributed wealth back to the poor.¹³ Similarly, when #BlackLivesMatter activists descended on Ferguson, Missouri, and stood down law-enforcement officials in the summer of 2014, after the police murder of teenager Michael Brown, they made the invisible suffering within that community visible to the country and world.¹⁴ To break the silence about the structural causes of poverty and discrimination is a necessary first step toward cure. It requires that we talk openly about structural violence as a root cause of health inequity and premature mortality in our nation. Political and policy action are required as well. A restructuring of American society is necessary to reverse the corrosive impact of structural violence on mortality. These structural reforms could take many forms, from tax and job policy to the ending of mass incarceration. From the perspective of health care reform, the adoption of a single-payer health care system is the only way to create equity in health care.¹⁵ Single-payer health care will be vigorously opposed by the profit-driven private health insurers and by those who will insist it is too costly or not feasible. But those of us advocating for health and longevity for the poor must insist on an insurance system that is universal, free, and accessible to all. Such a system will also be a step toward a fairer distribution of wealth. But to achieve lasting equity will require more [but] than single-payer health care. It will require a massive reinvestment of new jobs and educational opportunities into the United States' most distressed neighborhoods. To challenge the structures that impart violence and perpetuate hardship is no easy task. After all, the forces of structural violence are mighty. They have deep historical roots. One cannot comprehend the misery experienced in inner-city black neighborhoods today without honoring the fact that that today's neighborhood conditions are historical products of a quarter of a millennium of brutal slavery, ninety years of Jim Crow peonage, decades of neighborhood segregation, discriminatory lending policies, poverty, and mass imprisonment.¹⁶ One cannot note the suicides, the alcoholism, and the sub-Saharan life expectancy on Native American reservations like Pine Ridge without acknowledging the historical connection to the genocide of millions of Native Americans, followed by the exile of their remnants to desolate regions. One cannot note the soaring mortality rates from drug overdoses, suicide, and cirrhosis among poor white Americans without acknowledging the historical growth of vast income inequality and job loss in rural America caused by globalization and tax policies.¹⁷ The contours of health and life expectancy in the United States are shaped by these destructive historical forces and events. As a nation, we have never reconciled or collectively grieved the sins of our history, national origins, and economic success. There are restorations and reparations to be made. There are more immediate ways medicine can act on behalf of the poor. We need to take these actions for a number of reasons.

First, a prescription for social and economic injustice is not readily to hand. The reshaping of the balance of equity in American society is necessary but not likely to happen soon. Reversing the structural conditions that have caused poverty rates to skyrocket will require long-term political and policy changes. Finally, the structural and political conditions that culminate in premature death have never been motivated by a desire to oppress people for the sake of doing so. These have always been the ways that powerful interests have maintained their rule and accumulated wealth. This will not change overnight, and not without a fight. But medicine can act, even in the face of such massive social and structural obstacles, to ameliorate suffering and even cure.

And as doctors and health professionals (and others) facing the maladies of the poor, we have an obligation and ability to heal now. Most doctors across the world take the Hippocratic Oath as a public rite of passage into medicine. In the aftermath of World War II and the revelations of genocide and sadistic medical experimentation by Nazi physicians, the oath was revised (and thus is now sometimes called the Declaration of Geneva, Physicians Oath): At the time of being admitted as a member of the medical profession: I solemnly pledge to consecrate my life to the service of humanity; I will give my teachers the respect and gratitude that is their due; I will practice my profession with conscience and dignity; The health of my patient will be my first consideration; I will respect the secrets that are confided in me, even after the patient has died; Observe, Judge, Act * 183 184 * CHAPTER THIRTEEN I will maintain by all the means in my power, the honor and noble traditions of the medical profession; My colleagues will be my brothers and sisters; I will not permit the considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing to intervene between my duty and my patient; I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat. I make these promises solemnly, freely and upon my honor.¹⁸ It is a doctor's oath but one we can all aspire to live by. If we choose to live and practice by this oath, then we have a special responsibility to preferentially prevent and treat the diseases that afflict the poor. To offer our personal services as caregivers in service to the poor is a critical action even in the absence of major structural changes in society. For doctors and nurses who treat those experiencing great social hardship and illness, the

simple act of healing is a way to create common cause and dispense hope. It is not a world-changing act but a powerful

statement of alignment between the profession and the most oppressed in our midst. While I focus on the responsibility of doctors under the Hippocratic Oath, this is not limited to doctors. We all, whether doctor, nurse, administrator, or layperson, have something we can do to mitigate suffering through personal advocacy. Unfortunately, there are many in the healing professions who are numbed to the suffering of the poor or grimace in uncomfortable silence when confronted with the harsh and seemingly unsolvable realities of life and death in America just beyond the four walls of their clinics. I am hopeful that one day the discussion of preventable premature deaths and their links to the social and economic conditions in American neighborhoods will be central to professional discourse and practice. There is something else that preferential care on behalf of the poor allows. It has the possibility to create hope and a sense of common purpose between ourselves, our institutions, our patients, and their communities. We know that individuals who feel that their life has purpose live 15 percent longer than those without purpose.¹⁹¹ do not want to overstate the impact of acting preferentially on behalf of the poor in creating purpose and hope, but honoring the views of the community is critical to building trust and effect cure. Paul Farmer calls this acting in pragmatic solidarity with our patients and communities. Farmer gives an example of pragmatic solidarity in describing the work of his organization, Partners in Health, in Haiti as he and his colleagues tried to understand why Haitian dirt farmers who had tuberculosis were resisting treatment. Some anthropologists thought these Haitians believed that tuberculosis was caused by spells cast by others and that their beliefs explained their refusal to take the medications. But Farmer found that the peasants themselves had a more logical explanation. When they took the tuberculosis medication, their condition improved, but they became very hungry. Since they had no food, they stopped taking the medications because the tuberculosis curbed their hunger. They explained their predicament regarding taking TB meds without food to Farmer in Creole, roughly translated this way: "It's like washing your hands and drying them in the dirt."²⁰ Once Partners in Health provided food with the medications, the patients were fully adherent. Farmer's point was that you did not have to change the Haitians' cultural beliefs to improve their health. But you did have to listen to them and solve the problem in a manner consistent with their needs. There were many times when Windora Bradley's diabetes and blood pressure were out of control because she cut back on her medications. I discovered that she could not afford her medication copays and also pay to feed her children. At times, in pragmatic solidarity, I arranged to get her bill paid so she could get back on track. If medicine can act in solidarity with the poor by understanding and treating their social as well as medical needs, suffering can be mitigated; diseases cured, Observe, Judge, Act * 185 | 86 * CHAPTER THIRTEEN lives extended. Sometimes, though, there is no treatment to offer, and listening itself is the only act of solidarity available. In the summer of 2012, three pre-med students and I visited a church in the Mexican American La Villita neighborhood, about a mile and a half from Rush. The congregants were all uninsured, undocumented immigrants in need of organ transplants. One after another they and their families pleaded their cases to me. Each story was more poignant than the one before. Marco was 19 and had developed renal failure at 17. He was tethered to dialysis three times a week. His life, his education, was on hold. His mother was with him and described through tears their family's anguish over Marco's illness. Blanca was 21 with a similar history. Gustavo was 38 on dialysis, and Maria was 54 with liver cirrhosis. I spent two hours with the students at the church, witnessing the testimonies and taking notes. I had no transplants to offer. I came emptyhanded even though there were three transplant centers within a few miles of the church. But as a doctor, I could listen. In the car driving back to the hospital, I asked the students to debrief their observations of the church visit with me. One of them broke into sobs. "It's so unfair!" she cried. And yes, it was so unfair. To witness the brutality of inequality can reduce one to tears. It is why medicine often opts to ignore the harsh reality of premature illness and death in high-poverty neighborhoods. It is difficult to witness misery without suffering oneself, especially when the solutions to health inequity are available but denied simply because of money. But sometimes the act of listening provides a little dose of hope to those in need. Two weeks after our visit to La Villita, the congregants, demanding transplant access, held a rally at the University of Illinois Hospital.²¹ My three students showed up to join the action. When the congregants recognized the students, they enveloped them with hugs and tears. The students' presence was an act of solidarity that validated the demonstrators' struggle. The students' witness was an affirmation that these undocumented patients and their hope for cure were not invisible. Hope and purpose can be transmitted like a vaccination, a booster against despair. Hope does not cure disease, but it is palliative. Three years later, many of these patients we encountered that afternoon at the church have received transplants. Family members or strangers donated organs for a number of them. Some have become my patients at my institution. Marco received a kidney donated by his brother and is now in college. His mother and brother are now my patients. Gustavo and another undocumented patient, Maria, each received a kidney transplant the same day at my hospital. The family of a dying patient in Houston saw a story about these undocumented transplant patients and directly donated both kidneys when the patient passed. The three students, now all in medical school, will carry the lesson of that visit in the church forward in their medical careers. But there is even more that we must do to act on behalf of the poor. It is our job to set the moral standards high for ourselves and our institutions. Too often our avoidance and passivity fails the poor. We do not speak up on their behalf. We do not allow the stories of our patients' privation and injustice to be amplified through our voices. If one solution to health inequality is a system of true universal health care as a fundamental human right, it starts when we make demands on our own practices and institutions to do more to serve the poor and uninsured. To do this is not that difficult. But it does require that we ask ourselves and institutional leaders at every critical medical center decision, How is this decision relevant to the suffering of the poor and to the relief of that suffering? If we can align our institutional practices to answer this question, we will make progress in eliminating neighborhood life-expectancy gaps. It is critical that doctors see their responsibility to be advocates for the human rights of their patients wherever they work. These conversations are necessary and uplifting for health care organizations, most of which were founded on moral grounds to serve those in need. But these organizations can lose their moorings in the murky world of health care finances and insurance politics. There is a business imperative to health care delivery, but hospitals that act as holding companies and profit centers while denying the poor the human right to health Observe, Judge, Act * 187 | 88 * CHAPTER THIRTEEN care have lost their way. Demands by doctors, health care workers, and the public on behalf of the poor can help redirect such organizations back to their healing missions to the benefit of all. Medicine is human rights work. It is what we took an oath to uphold. But only if we all act. As physicians, health care workers, or just everyday people interested in justice and fairness, we have an obligation to speak up politically to improve access to health care for all. At the time of this writing, there are nineteen

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states into which the Affordable Care Act has not expanded. Because of this, the black uninsured rate is twice what would be otherwise.²² Because half of black America lives in nonexpansion states, 1.4 million blacks—23 percent of the nation's black uninsured population—have been prevented from getting insurance.²³ Meanwhile, the health care marketplaces are failing to reduce out-of-pocket costs for the middle class across the country. The system is a flawed, crazy mess. But we need to fight on our patients' behalf for full implementation of the Affordable Care Act while we campaign for a universal single-payer solution to replace it.

Judge the aff comparatively--perfect justice is both impossible and unknowable, evaluating actions empirically and experimentally develops an eclectic pluralism that's key to effective ethics

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Whatever readers are inclined to think about the "neutrality" issue, we argue that the pragmatist silence about justice can be accounted for, at least partially, in terms of three related and mutually reinforcing ideas to which virtually all pragmatists are committed. In no particular order, these are (1) A prioritization of concrete problems and real-world injustices ahead of abstract precepts (2) A distrust of a priori theorizing along with a corresponding fallibilism and methodological experimentalism (3) A deep and persistent pluralism, both in respect to what justice is and requires, and in respect to how real-world injustices are best recognized and remedied To see how these three large clusters of ideas inform a broadly pragmatist approach to justice and injustice, consider a distinction drawn recently by Amartya Sen (ironically, someone who has never self-identified with the pragmatist tradition). In his magisterial work *The Idea of Justice*, Sen distinguishes between two kinds of theoretical approaches to justice, both of which, he claims, have many eminent proponents in the history of moral and political philosophy. The first is a group of theories that Sen consolidates under the banner "transcendental institutionalism." Such theories are "transcendental" in that they aim "to offer resolutions of questions about the nature of perfect justice" (Sen 2009, ix); they tend to focus on the pure concept of justice—the unchanging and essential nature of "the just"—rather than on relative comparisons of justice and injustice. And they are "institutionalist" in that they concentrate on getting the institutions right, as it were, while neglecting (or ignoring altogether) questions that arise about the actual societies that would ultimately emerge from any given set of institutional arrangements. Sen cites Hobbes, Locke, Rousseau, Kant, and Rawls as paradigmatic examples of this kind of approach. "Transcendental" accounts of justice stand in contrast to what Sen calls "comparative" accounts. Comparative accounts abjure the search for perfect justice focusing instead on locating criteria for some alternative state of affairs being "less unjust" than another". Adam Smith, Condorcet, Wollstonecraft, Bentham, Marx, and John Stuart Mill are cited as exemplars. While Sen does not mention the names of any pragmatist philosophers in his discussion, we believe that pragmatists are far more likely to be "comparativists" than "transcendentalists." Like comparativists, pragmatists will be skeptical about the usefulness of trying to specify—absent some particular project, context, or specific complaint—what ideally just institutions would be like. They are likely to regard such attempts as emblematic of what Dewey criticized as "philosophy's search for the immutable" (LW 4:21), as yet further examples of philosophy's ambition for "finality and foreverness" (LW 2:357). Comparativists and pragmatists will agree that perfect and consummate justice—like perfect and consummate truth—is chimerical. Just as many of the beliefs we take to be true may turn out to be false, many of the laws, institutions, and behaviors we take to be just may turn out to contain hidden, previously undetected, injustices. In both

cases, a healthy commitment to **fallibilism** ensures that such possibilities can never be finally ruled out. From a pragmatist view, there are obvious advantages to conceiving of justice in "comparative" rather than "transcendental" terms. First, a comparative approach helps us make sense of real-world struggles for justice in a way that transcendental approaches simply cannot. "What moves us," Sen writes in his book's preface, "is not the realization that the world falls short of being completely just ... but that there are clearly remediable injustices around us which we want to eliminate" (2009, vii). This focus on "clearly remediable injustices" chimes with pragmatism's basic appreciation for **concrete problems**. Unlike the famous rationalists, for whom philosophy begins with disinterested contemplation, and unlike the famous empiricists, for whom it begins with passively receiving sensory stimuli, pragmatists believe that thinking and inquiry are fundamentally occasioned by problems. **Problems spur us into action.** They unsettle previously settled experience, disrupting the normal flow of things. When genuine problems arise, it is no longer possible for us to carry on as usual. While the language of "problems" is characteristically Deweyan — he preferred the clunky phrase "problematic situation" — the same basic idea underlies virtually all pragmatist thought. The pragmatist prioritization of "problems" goes hand in hand with an approach for which real-world struggles carried out in the name of justice, as opposed to abstract and idealized principles, will be given priority. **Pragmatists need not insist that abstract (idealized) philosophizing about justice is useless or always beside the point.** Minimally, perhaps, it can do no harm. Maximally, it can be useful to the extent that it moves people to see the present setup as one alternative among many, thus inspiring them to dream up new options (Rorty 2006, 58).⁴ Nevertheless, the kind of approach favored by pragmatists affords a certain **priority to questions about how injustice is actually experienced in the real world**, and to questions about the **specific problems** (political, moral, cultural, economic) to which this gives rise. Comparativists and pragmatists will agree that questions about the concepts and content of justice cannot be satisfactorily answered from the philosopher's armchair, in **isolation from some context, complaint, or problem**. They agree that **in the real world, demands for justice always reveal themselves as demands [are] made by specific people at specific times and places, and always for something specific**. There has never been a political movement that mobilized without an agenda or a set of demands — in the name of nothing but transcendental "justice" itself." As Dewey well summed up the point, "Men have constructed a strange dream-world when they have supposed that without a fixed ideal of remote good to inspire them, they have no enticement to get relief from present troubles, no desires for liberation from what oppresses and for clearing-up what confuses present action" (MW 14:195). Because pragmatists tend not to be involved in the search for "perfect justice" — because justice is not, they think, the sort of thing one "gets right" once and for all — they tend also **not to be perturbed by the fact that judgments of justice and injustice suffer from a certain degree of vagueness and indeterminacy**. Unlike conventional theories of justice, which aim to establish a set of principles from which all claims about justice can be understood to follow, pragmatists adopt the different (more modest) goal of trying to **find better ways of meeting this or that complaint, solving this or that problem, overcoming this or that injustice**. This is not a plea for simplifying or dumbing-down theoretical reflection about justice. Nor is it a plea to focus on the "practical" in place of the "theoretical." On the contrary, as C. I. Lewis writes, **Pragmatism could be characterized as the doctrine that ... there can be ultimately no valid distinction of theoretical and practical**, so there can be no final separation of questions of truth ... from questions of the justifiable ends of action" (Lewis 1970, 108). The aspiration rather is that theoretical reflection on justice and real-world struggles against injustice become correlated, integrated, aligned. The aspiration is born of the conviction that a philosophical theory of justice, no matter how intellectually alluring or elegant, must be modified or discarded if it cannot intelligently speak to the problems that men and women find themselves having to contend with. The pragmatist emphasis on concrete "problems" thus also goes hand in hand with a **methodological experimentalism**. Different problems can be dealt with in a variety of ways, some better and more intelligent than others. Solutions, in turn, are potentially **as diverse and numerous as the problems** they seek to address. No one can say in advance how a particular problem will best be resolved. Discovering that requires **conducting experiments**, and even then such knowledge is always **tentative and revisable**. Put differently, if we construe our fallibility in terms of the idea that **improved habits and beliefs are always possible and desirable**, then it becomes reasonable to view our theorizing about justice not as the search for absolute truth or unmovable certainty, but as a generic name for **problem solving**: as shorthand for

the activity, as Dewey put it, of generating hypotheses “to be used and tested in projects of reform” (MW 12:189). As Richard Rorty captures the thought, “Pragmatists are entirely at home with the idea that political theory should view itself as suggestions for future action emerging out of recent historical experience, rather than attempting to legitimate the outcome of that experience by reference to something ahistorical” (1999, 272). One of Sen’s central arguments is that there is no such thing as the one best approach to justice, one ideal form of reasoning, one privileged perspective, one procedure or rubric with which to make all decisions about justice. He emphasizes throughout his book “the need to accept the plurality of reasons that may be sensibly accommodated in an exercise of evaluation,” sensibly noting that “The fact that a person can reason his or her way into rejecting slavery ... does not indicate that the same person must be able to decide with certainty whether a 40 per cent top rate of income tax would be better than—or more just than—a top rate of 39 per cent” (2009, 394–396). Again, this pluralist outlook is one with which pragmatists are likely to be sympathetic. Pragmatists will agree that wisdom is to be potentially found in all corners. No one has a monopoly on insight, there are a variety of different ways of fruitfully proceeding. Here it is helpful to remember William James’s characterization of the pragmatist methodological temperament from the Pragmatism lectures: She [pragmatism] is willing ... to follow either logic or the senses and to count the humblest and most personal experiences ... Her only test of probable truth is what works best in the way of leading us, what fits every part of life best and combines with the collectivity of experience’s demands, nothing being omitted ... [Y]ou see already how democratic she is. Her manners are as various and flexible, her resources as rich and endless, and her conclusions as friendly as those of mother nature. (WWJ 1:44) As we will see more clearly in the chapters ahead, pragmatism’s approach to questions of justice and injustice will be likewise open-minded, eclectic, and “completely genial.”

Our critical quantitative research method is key.

Lindsay McLaren 17. University of Calgary. 08/08/2017. “A Space for Critical Quantitative Public Health Research?” Critical Public Health, vol. 27, no. 4, pp. 391–393.

I jumped at the opportunity to join the Critical Public Health editorial board as Co-Editor, a position I started in January 2017. I am primarily a quantitative researcher, which is a departure from the journal’s typical content. For example, of the 40 research articles published in the journal in 2016 (Volume 26), only one could be described as quantitative (Ballantyne, Casey, O’Hagan, & Vienneau, 2016). In my application for the Co-Editor position, I somewhat hesitantly stated that I might be positioned to help increase critical quantitative research submissions to the journal. But that got me thinking, what is critical quantitative research? Does it [quantitative research] have a place in Critical Public Health, and what value does, or could, it bring? What are some of the challenges? Drawing from the journal’s website, ‘critical’ is about ‘exploring new ways of thinking about public health’. It is about ‘interdisciplinary’ and ‘innovative’ approaches to ‘exploring and debating issues of equity, power, social justice and oppression in health’. Although nothing in that description excludes quantitative methods, it would be remiss not to acknowledge that some features associated with a quantitative approach (e.g. beliefs about truth, bias and the role of values) seem epistemologically at odds with critical inquiry. Critical scholars working in social epidemiology (e.g. O’Campo & Dunn, 2012) have highlighted this tension between perceived objectivity of epidemiological research on the one hand and its ‘solution-oriented’ use in policy or advocacy on the other, as an important challenge to that field. Some have argued that there is no inherent incompatibility between quantitative methods and critical inquiry. In scholarship on higher education, Stage and Wells (2014), used the term ‘quantitative criticalist’ to describe quantitative scholars who ‘resisted the term positivist with its implications of fixed theoretical frameworks and prescriptive variable definitions’. Quantitative criticalists use quantitative data and methods to pursue research questions that, for example, reveal inequities and the social or institutional factors that create and perpetuate them. Critical quantitative scholarship may also question measures and analytic practices used in quantitative research, to ensure that they adequately represent circumstances and contexts, and do not themselves inadvertently perpetuate exclusion and hierarchy. A critique of social epidemiology (related to, but not the same as, critical quantitative inquiry) is that, despite being purportedly ‘social’, in practice it tends to be descriptive and downstream (O’Campo & Dunn, 2012). For example, it may focus on

associations between some social indicator and some health outcome without consideration of the **drivers of the association** and corresponding **implications for social change**. This is not an inherent feature of quantitative methods, but rather reflects – in part – **insufficient or non-explicit attention to theory**.

My quantitative mind leads me to think about ‘types’ of theories, ranging from intra- or individual level theories used in the behavioural sciences, such as the Health Belief Model, through community or organizational level theories, to large-scale social or critical theories such as Feminism or Marxism, which represent the outermost of the concentric circles. I recall my own ‘aha’ moment when I realized that the social and critical theories are where the action is, and where one can question and challenge the status quo. Over a decade ago, Frohlich, Mykhalovskiy, Miller, and Daniel (2004) helpfully outlined different ways in which those ‘outer’ theories can be integrated into population/public health research: to frame and orient an entire research endeavour; to interpret emerging findings as demanded by the data; and to critique the arguments and interpretations of others.

It seems reasonable that these different ways of using theory could be applied across methods. Critical quantitative scholarship offers a valuable complement to its qualitative counterpart.

Numbers can be powerful, as some of my favourite examples illustrate. A 2009 meta-analysis by Kondo, Sembajwe, Kawachi, van Dam, Subramanian and Yamagata estimated avoidable mortality attributable to income inequality.

To prompt attention to large-scale social and economic drivers of population health, we need ‘burden’ studies resembling those in other areas of public health, such as tobacco and alcohol.

In their 2013 book, The Body Economic, Stuckler and Basu illustrate, using descriptive quantitative methods, how the impact of global economic recession on population health outcomes depends on the degree to which a country implements austerity measures in response. This is a great example of work that goes beyond descriptive social epidemiology to identify the ‘causes of the causes’ (Marmot, 2005). A 2015 study by Sutin, Stephan and Terracciano observed an association between reported experiences of discrimination based on body weight, and mortality risk, even taking weight into account. Such work contributes a powerful counter-narrative to the dominant obesity discourse where weight itself is seen to be the problem. A 2016 study by Huisken, Orr, and Tarasuk (2017) demonstrated that household food insecurity in Canada is not associated with food skills (i.e. food preparation, cooking and shopping), thus exposing the limitations of individual or household-focused solutions to that problem. Finally, an upcoming paper in this journal (Mulinari, Wemrell, Rönneström, Subramanian, & Merlo, 2017) uses sophisticated statistical methods to examine and illustrate problems with (dominant) categorical approaches to identifying race/ethnic groupings in the United States. Their work has very important implications for targeted approaches in public health policy, which seem to be growing in popularity.

One can look to other disciplines to find excellent examples of critical quantitative scholarship.

Quantitative sociology, which I tend to think of as inherently critical because of the ‘outer’ level of theory used, comes to mind. An example is Bourdieusian-inspired **work** (Bourdieu himself used quantitative methods) **on social class and health outcomes** (e.g. McLaren, Godley, & MacNairn, 2009; Veenstra, 2007).

Scholarship in policy studies is also illustrative; **for example, the literature on termination of public policies**. To complement case studies that provide rich analysis of factors

contributing to policy termination in a particular circumstance, **recent** quantitative (**‘large n’**) studies have tested and

demonstrated a more general role of these factors across settings and/or time.

For example, across municipalities in the United States, Krause, Yi, and Feiock (2016) identified that political ideological factors (measured using indicators of Tea Party activity and Republican voters) played a significant role in predicting which settings terminated local policy on climate change, and which did not.

There are challenges with critical quantitative scholarship in public health. One has to do with available data.

Though primary data collection is always a good way to ensure that one’s critical theoretical questions are accommodated, existing data (e.g. national survey data) constitute an important and efficient source for quantitative researchers, including those with a critical perspective. One could argue that the onus is on critical quantitative scholars to use those data (which are used to inform policy, e.g.

<https://crdcn.org/about-crdcn>) and participate in its development. For example,

critical use of national survey data can help to identify gaps or implicit assumptions around the inclusion or exclusion of particular **indicators**, and

critical quantitative scholars are positioned to help ensure that survey methods and data collected are theoretically rigorous. A second challenge, which is relevant across methods, is the continued influence of the ‘evidence hierarchy’.

It is ironic that when one searches ‘critical quantitative public health’ online, many of the top hits are about critical appraisal in a conventional epidemiological sense. This is highly problematic and remains an important challenge, as we found during a recent experience with a Cochrane Systematic Review (McLaren et al., 2016).

Our aim to quantify effects of large-scale government interventions (in this case, for dietary sodium reduction), **to demonstrate that healthy public policy at a national level has demonstrable benefits for population health and health equity**, was largely deflated by the

critical appraisal criteria, which left us no choice but to characterize the evidence as the very lowest level of quality.

We build movements by countering narratives of political ineffectiveness

Jennifer Cullen Loomis 15. Portland State University. 2015. Activist Doctors: Explaining Physician Activism in the Oregon Movement for Single-Payer Healthcare. Portland State University. Google Scholar, <http://search.proquest.com/openview/1698ec86b0abf84005237826b581c407/1?pq-origsite=gscholar&cbl=18750&diss=y>

Feasibility Makes Single-payer Activism Unattractive Perhaps the most powerful deterrent to single-payer activism for the non-activists is the limited perceived feasibility of passing legislation to enact it. This acts as a formidable barrier. The physicians must confront. This section will discuss how the non-activists view these barriers as immutable resulting in the conclusion that single-payer "impossible" in America. Two of the most frequently cited reasons are that Americans would never support a plan that appears to give more control to the government and that even if Americans wanted single-payer, Congress would never be able to pass such reform. Given that these physicians do not see single-payer as an attainable solution, they see no point investing personal resources trying to attain it. For these reasons, if the physician does engage in activism, it is for other causes deemed more feasible. Americans' Distrust of Government. The first main barrier the non-activists perceive is that of the American people and their focus on individualism and small government. Single-payer systems are sometimes portrayed as a "government takeover" of medicine or increasing the size of "big government." This common perception runs counter to the ethos of individualism that is pervasive in American culture. Non-activist physicians believe Americans in general are distrustful of the government and would not support an entitlement system where everyone is provided equal care because it runs counter to values of individualism and the Protestant Work Ethic (Weber 2002[1920]; Skocpol 1996). Every non-activist physician cited this as a formidable obstacle to the passage of single-payer legislation. The following quote from a retired male whose specialty was critical care demonstrates the link he sees between American culture and single-payer. He said, "Considering the antagonism towards government that so many people have in this country. It runs deep and it runs strong and I just can't see us going in that direction politically in the near future." Doctors also mentioned that publicly-financed healthcare that is equally available to all is not attractive to the American people because of the belief that people must work for what they have and some people do not deserve access to high quality healthcare. In other words, they subscribe to the Protestant Work Ethic that says one must work hard to enjoy valuable goods like healthcare services. A retired, male, family practice doctor questioned, "Why don't we have systems like other countries do that actually take care of their citizens? It's because it's in the American culture. Really going back to the founding of the country, which is this kind of individualism and every person for themselves." He feels that American individualism is very strong and the public will not support a system where everyone is equal. Along these lines, a practicing female cardiologist expressed her doubt of the public supporting a single-payer system: "I think there's just no way because we're a society that's much more into 'I want everything for me right now' especially if I can pay for it. And you know, really, it'd be hard to follow a more socialized society that's thinking of the common good, so I just think it's never going to happen in my lifetime and kind of give up." We see how this sentiment influences activism. She surmises that it's never going to happen, which for her is the defining factor. Without being able to achieve the goal, she abstains from the process of activism. More evidence of American's hostility for them was seen as how some Americans want to repeal the few healthcare policies we currently have that seek to improve healthcare access for disadvantaged populations, like the Affordable Care Act (ACA) and Medicare. Non-activist doctors believed that if the American public doesn't like the small incremental changes in the ACA, they would never support the radical changes required by the establishment of a single-payer system. A retired, male, family-practice doctor explained it this way: "There's a fairly large number of tea-party Republicans, whatever, who actually think we should get rid of social security and Medicare, you know? So why would they support Medicare for all when they don't even support Medicare as it currently exists? There's still fighting the battles of the 1930s. So you know, that's just true. It's stupid, but it's true." The doctors do view these groups of Americans who want to roll back important social programs, as implacable foes of single-payer reform. They see this feature of American culture as unchanging; something that cannot be swayed with education and outreach. A male endocrinologist echoes this hostile public sentiment and the confusion among Americans about single-payer: "When you look at the right-wing reaction to the Affordable Care Act which is far from single-payer, which they're calling 'socialized medicine' or 'government medicine' and all that. There's so much hostility and anger and dishonesty and political power that whatever incremental improvement the Affordable Care Act brings is barely hanging on by its fingernails. To get from there to a true single-payer system, in our lifetime, I just don't see it." These sentiments reflect Skocpol's (1996) assessment that Americans fear any programs that appear to give the government more ability to regulate business. Some vocal factions of America want less government involvement in the market and react in a hostile manner to an incremental improvement like the Affordable Care Act. It is reasonable for the physicians to think that if incremental reforms are this controversial, then a more comprehensive reform is dead on arrival. Americans' distrust of government was the most frequently-mentioned theme among non-activists. They believe that the distrust of government and the commitment to individualism pervasive in American culture would prevent enough citizens from supporting a single-payer system, blocking its passage. And for the non-activists, if single-payer is an impossible outcome any effort designed to achieve such a system is done in vain. These non-activists have little hope for changing this sentiment in American culture.

Hence, they are unwilling to invest personal resources in the struggle if they do not think the outcome will be achieved. And they say the outcome will not be achieved due to the individualism prevalent in American culture and its preference for market solutions. Political Stalemate American culture was not the only obstacle to passing single-payer reform cited by non-activists. Non-activist physicians were also concerned about the feasibility of passing single-payer legislation through the government.

All respondents recognized that if we were to establish such a system, it would require a process that involved our elected officials. All non-activists, though, were very pessimistic about the possibility of our elected officials cooperating to make a single-payer system happen, even if the American public was in support of it. For example, a retired female OB/GYN stated, "So, could it happen? Yes. Do I think it will happen? No, not yet. I don't think so. Because I don't think there's the political will." She goes on to say that resources are not a barrier to expanding care, but the resistance to single-payer more deeply reflects the lack of commitment our government has for helping its citizens. In the next quote, the "we" she is referring to is our government and elected officials. She said, "We have plenty of money. It's our priorities that are fucked up. We have plenty of money." In other words, we have the financial capacity to enact single-payer, Congress simply refuses to do so. This is consistent with Mechanic's (2006:188) assessment of healthcare reform in the US: "Failure to overcome our health system dysfunctions is not a result of lack of knowledge or organizational capacity. It is an issue of will and commitment." This doctor's quote, again, illustrates how the unattainable outcome blocks her activism. Her perceived unwillingness of Congress to pass such a bill is a deciding factor in her choice to not become involved. Echoing the perceived ineptitude of Congress, a retired male in family medicine exclaimed, "It's just not gonna happen given Congress and the way it is. I mean they can't even do anything!" This sentiment is understandable given that during the course of these interviews, the federal government was "shut down" because Congress could not agree on a budget for the coming fiscal year. It is widely understood that contention over funding for the Affordable Care Act was a primary cause of the "shut down." Observing how contentious the ACA had become, even though it would bring only incremental improvements, colors the non-activists' views about achieving major healthcare reform. A statement made by a retired male whose specialty was critical care reflects this: "It's kind of hard to be super enthusiastic, and I love my friends who are super enthusiastic about single-payer, but realistically number one it isn't going to occur in this country with the political split that we have." The political split in the 113th Congress contributed to their notorious label as the "least productive Congress ever" (DeSilver 2013). Six out of seven mentioned the corrupting influence of money in politics and how this limits the possibility of passing the necessary legislation. They specifically mentioned the medical-industrial complex (MIC) and the vested interests that compose it which Relman (1980) first warned about. The MIC control massive financial resources and respondents discussed this undermines more progressive goals politics. Respondents said that these entities benefit from the current arrangement of healthcare and will use their resources to resist single-payer legislation. It appears that Relman's prescient warning that the MIC, whose interests are opposite those of patients and society, would rise to prominence and control healthcare reform has come true. A practicing female cardiologist explained the obstacles to single-payer legislation that she sees: "I think politics definitely [is an obstacle]. And I think capitalism definitely [is another obstacle]. I mean, there's so much money in healthcare. A lot of what I've been talking about is the physician-provider role, but there's just so much financial interest and so certainly big lobbying groups, Big PhRMA, insurance companies..." [limit the feasibility of passing single-payer.] She finds the amount of financial resources behind the

opposition to single-payer daunting and something that limits the efficacy of single-payer activism. Another female, a retired endocrinologist agreed, "I don't see it happening in my lifetime, I wish I did, among a lot of other things. Politics is, money and politics is in particular is interfering with everything. I'm not seeing that light at the end of the tunnel. [laughs] I don't know what to expect, I wish I could be more optimistic. Oh well." The non-activists view the quest for single-payer as a hopeless cause due to the big money interests that oppose single-payer. They think a grassroots movement will not be able to compete with the influence and reach of the MIC. Therefore, the non-activists view the political system necessary to pass and enact legislation as hopelessly corrupted by big money interests. The lack of passion for the issue is also clear in the last quote. Instead of reacting with outrage, she reluctantly accepts the situation by ending her discussion of these barriers with an "oh well." Given that all respondents felt a single-payer system would be better than what we have now and given the strong feeling that advocacy for single-payer does not result in meaningful change, it is not surprising that some non-activists were working to effect change in other areas of medicine. Three of these doctors had the mindset that, 'given that single-payer is not happening, what are other areas in which we could make improvements?' These doctors focused their efforts in areas that they felt were more likely to be successfully-reformed in the near future. There was a variety of other medical issues that non-activists were advocating for. For instance, a retired male family medicine doctor is involved in a physician organization that is working on issues related to gun violence, women's reproductive health issues, and eliminating gag laws related to the environmental practice of fracking. The female endocrinologist said she is concerned about what happens with patients' health information and privacy. She said, "That's the other thing I'm very concerned about, is patient privacy and what's happening with electronic records and all that kind of stuff." She has traveled to Salem and met with legislators and some nonprofit groups about this issue. She also wishes doctors would pay more attention to what patients have to pay for care. She said one of her goals is "...to craft a letter to the higherups at [a large HMO] here to push for that transparency between the doctor and patient about costs." A retired female in obstetrics and gynecology has chosen to focus her efforts on preserving access to safe abortion services. Speaking about her choice to focus in this area instead of single-payer she commented, "I mean, there's a limit. There was actually something refreshing about when I chose to become an activist in abortion care; it sort of frees up you up from having the responsibility of taking care of all the world's other problems. You know what I'm saying? Focus on one." The perceived futility in advocating for a single-payer system made activism for other issues more attractive. The doctors believed their activism in these areas was more likely to lead to changes that could be implemented relatively soon. In other words, they did not perceive there to be substantial barriers to enacting delivery reforms, but did view substantial barriers for attempting financing reforms. In addition, the last comment also demonstrates how there are limits to activism. The **doctors recognized that there are numerous areas that would benefit from advocacy and reform, but a person only has so much energy to devote to these causes and it can be a relief to limit what you advocate for** Due to this, the physicians chose to work for reform in **other areas of healthcare;** areas in which they felt they could effect change in a more reasonable time

Markets/Morality

Universal access to basic healthcare is a moral and cultural right – proclaiming these rights is necessary to implement legal policies. Even if these legal policies are not perfect, their advocacy of healthcare as a right can overcome pure theoretical abstraction.

Menzel 11 — Paul T. Menzel, Ph.D., is a Professor of Philosophy Emeritus at Pacific Lutheran University, xx-xx-xxxx ("The Cultural Moral Right to a Basic Minimum of Accessible Health Care" Kennedy Institute of Ethics Journal, Volume 21, Number 1, March 2011, pp. 79-119)

In the United States, amid the fractious politics of attempting to achieve something close to universal access to basic health care, two impressions are likely to feed skepticism about the status of a right to universal access: the moral principles that underlie any right to universal access may seem incredibly "ideal," not well rooted in the society's actual fabric, and the necessary practical and political attempts to limit the scope of universally accessible care to make its achievement realistic may seem marked less by moral rhyme and reason than by the pull of conflicting interests. I try to directly dispel the first of these impressions and to obliquely question [End Page 79] the second. The immense political barriers to achieving universal access to basic care should not be underestimated, but the moral landscape in which reform can work is not unpromising. The essential elements that imply a moral right to basic care already exist in U.S. culture, and those same elements give considerable shape to limits on the basic minimum of care that such a right covers. The Conception of a Cultural Moral Right The first of my larger claims is that as a cultural moral right, the right to universal access to basic care already exists in the United States.¹ The right that exists is not a legal right but a moral one, carrying the same capacity to criticize existing legal arrangements that all moral rights carry. This right is, however, a socially embedded moral fact, present in real aspects of U.S. law and culture. The first step in explaining and justifying this claim is to unpack the conception of a "cultural moral right." "Natural rights" or "human rights"—any rights that are not culturally relative—are claims people are justified in making to their fellow human beings and citizens regardless of the typical beliefs about morality that happen to be prevalent in their society. Such rights, which we might call transcendent, may appear to give the people who hold them the greatest moral power of any rights, for they are not contingent on the vagaries of moral opinion in the society in which they are asserted. Such rights, however, are often difficult to assert persuasively in actual social life precisely because conceptually they transcend the moral beliefs of people surrounding the claimant and rights holder. By contrast, nontranscendent senses of a moral right can give rights holders more persuasive power in making claims on their government and fellow citizens. Contractual rights and legislated rights, which refer to legal rights, are nontranscendent, but there is a nontranscendent sense of moral rights as well: moral claims on others that are logically implied by the combination of some already existing legal elements with various noncontractual, nonlegislated moral commitments and principles widely held in a given society.² Moral rights in this sense I call "cultural" moral rights, to call attention to the fact that they are embedded in a particular moral culture.³ Cultural moral rights may appear fragile, for they are contingent on the moral culture in which they exist and can be asserted. Moreover, since they are not legal rights, the surrounding members of society can usually, with impunity, refuse to recognize them. But in another respect they are powerful: insofar as they really do "exist"—that is, they really are implied [End Page 80] by various legal elements and widespread moral beliefs of people in that society—those who assert them are not fighting as uphill a battle as people asserting natural rights often are. The assertion of a cultural moral right, based on principles and values already prevalent in one's society, is an instance of what Michael Walzer calls "immanent" social criticism. Just as in the most effective personal criticism we measure friends and colleagues "against their own pretended ideals," charging them with hypocrisy or bad faith, the most effective social critics "hold up a mirror to society as a whole" (Walzer 1994, pp. 41–42). "Immanent" criticism, including the assertion of cultural moral rights, has special moral leverage with fellow citizens and can be a powerful source of social change.⁴ Like natural moral rights, cultural moral rights are often much harder to discern than legal rights (contractual or legislated). But just as the difficulty of discernment does not justify dismissing the possibility of the existence of natural moral rights, so also we should not dismiss the possibility of cultural moral rights. If the argument of this

paper is correct, failing to think in terms of cultural moral rights—failing even to look for them—is one of the reasons people typically fail to recognize that there is already operable in U.S. society a kind of right of universal access to basic health care. Because this right does not provide its holders with legal claims and protections, of course, one might think "so what?" Such a reaction to the prospect that a cultural moral right already exists would be premature. A cultural moral right is a "claim-right," and in the particular instance of the right to universal access to basic health care, it is partly an "affirmative" or "positive" right.⁵ It shares in the standard conceptual characteristics of both these kinds of rights. By definition a moral claim-right obtains in a society if and only if it is held by all individuals in that society. In turn, such a right in the case of health care access is held by all if and only if each and every person in the society can justifiably claim that morally they ought to be guaranteed access to basic health services. That moral claim to access is exercised either through purchase with one's own realistically available resources or, if one does not have such resources, through means of access provided by others. This last component is the "positive right" part, and it is crucial if the right is to real universal access. That said, however, it would be confusing and mistaken to think of the entire right as a positive right. The positive element characterizes the right for only some people covered by it. The scope of the right also includes persons who can gain access by purchasing insurance with resources of [End Page 81] their own that are adequate to the purpose and realistically available—as I demonstrate in the next section, that is the case for the cultural moral right to universal access to basic care as it is embedded in the U.S. social situation. For these other persons the practical import of the cultural moral right to basic health care is that it constitutes a moral obligation to insure themselves for basic care. Moreover, when bolstered by other moral principles widely held in the society, particularly an anti-free-riding principle, the state is justified in mandating the fulfillment of this obligation. Thus, part of the right to health care and the universal aspect of its content is compulsory health insurance. We are entirely accurate if we refer to this right not only as "the right to health care" but as "compulsory (affordable) health insurance." One portion of the right's demographic is "positive"—some people ought to be provided resources by others so they can gain access. The other portion is different: the holders of the right are morally obligated to obtain insurance for themselves (though they have this moral obligation only if insurers' ability to vary premiums by likelihood of illness is sharply limited). This two-dimensional right-and-obligation character of the moral situation is the correct way to state the matter in a multipayer health system in which individuals and sponsoring groups (such as employers) choose their insurer. The way the moral right to a basic minimum of accessible care is articulated in the context of a single-payer system will need to be somewhat different. The essential moral claims will still apply, with the "obligation" to purchase insurance shifting to an obligation to pay the taxes supporting the single-payer insurance. I have chosen to develop the argument for the moral right to universal access to basic care in a manner that applies explicitly to multipayer systems. For one thing, that is the immediate context of the United States. Another reason is that change to a multipayer insurance-mandate system is arguably a shorter, less difficult step to take within existing U.S. moral culture than change to a single-payer system. To be sure, even in the U.S. context considerations of efficiency and fairness beyond those that contribute to generating the basic moral right itself may ultimately pull the society toward a single-payer arrangement for providing universal access, but consideration of that possibility is beyond the scope of this paper.⁶ Before leaving this preliminary discussion, I need to address a major fundamental challenge to the notion of a cultural moral right. Cultural moral rights are alleged to work at a median level that is not transcendent but that is not institutional either. If they really are moral rights that, like [End Page 82] transcendent rights, retain the capacity to criticize existing arrangements in a society, how can they be anchored in the very factual elements of the society that make them cultural moral rights with a capacity for immanent social criticism? The elements that logically generate the right, after all, are just contingent facts in a society. What is their moral foundation and justification? Without one, the right implied is no moral right at all but only a cultural one at best. There are two plausible replies to this objection. (1) The societal elements that generate a particular cultural moral right—in this case, already existing universal access to emergency care and widely shared principles about unfair free riding and just sharing of costs between well and ill—may themselves have sound moral justification. In fact, I would claim, in this case they actually do, though articulating that foundation is largely outside the scope of this paper (for an account that lays out such a justification, consult Menzel forthcoming a). (2) Even if these societal elements are without a sound moral justification themselves, they provide the context in which morally poignant claims of consistency can be made. Immanent criticism works off the power of alleged inconsistency. The person asserting a cultural moral right is proclaiming to the society: "You are apparently committed to w ..., x ..., and y.... But you cannot be, authentically and with integrity, unless you also accept my claim z.... Either give up w, x, and y (which you likely won't), or acknowledge z." Consistency and integrity themselves carry moral weight (as a matter of both societal fact and rational justification, I suspect, though I do not provide the evidence and reasoning to back up such a claim here). Moral philosophers on the "purist" end of the discipline may continue to be suspicious, but others (like Walzer, e.g.) whose work speaks to actual social change and not merely ideal theory will readily avail themselves of such a "median" notion as cultural moral rights.

Single Payer is concrete proposal that would restructure conditions of healthcare and reduce burden on poor

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We have traced much of what ails people in the United States to the conditions in which people live and work. These problems are exacerbated by the expensive, inefficient US healthcare system dominated by the MIC. The cure for these illnesses may not be easy to achieve. In fact, it may be politically extremely difficult, involving a profound restructuring of power relationships between classes in the United States. Yet conceptually, the solutions are fairly straightforward. Many are successfully in place in other countries. This chapter puts forward three ambitious yet realistic changes to US political economy and healthcare that would drastically improve people's health. The policies are ambitious because they would mark a profound restructuring of the conditions in which people live and work and in their system of healthcare. They are also realistic, having been enacted in other nations. These already existing alternatives are more effective, efficient and egalitarian than the policies currently in place in the United States. ... UNIVERSAL, SINGLE-PAYER, PUBLIC HEALTH INSURANCE IN CANADA

The US healthcare system relies more on private, for-profit delivery of both insurance and services than other developed countries. The disappointing results of this approach were highlighted in Chapter 5. It has historically not guaranteed access to millions of its citizens who are uninsured, and even under the ACA, people will still be deterred from seeking medical care because of the payments associated with private insurance. It is also a very expensive system. Similar health results have been achieved with much lower costs in systems that rely less on for-profit delivery within the United States and in other nations. There are a wide variety of alternative mixtures of public and private, profit and non-profit ownership models in different countries, but one of the starker contrasts with the US system comes from its neighbor, Canada. Canadian health insurance (Medicare) is paid for out of tax revenue and administered by the government of each province. Comprehensive coverage—which essentially means all necessary hospital and physicians' costs—is provided to all citizens, who also have the option of purchasing supplemental private insurance. Unlike the US system, there is no cost sharing at the point of service. Canadians purchase supplementary private insurance because, depending on the specific provisions in each province, Medicare does not cover some drug costs, dental care, home care, and vision care. Single-payer national health insurance for the United States as envisioned by the Physicians for a National Health Program Single-payer national health insurance is a system in which a single public or quasi-public agency organizes health financing, but delivery of care remains largely private. Currently, the U.S. health care system is outrageously expensive, yet inadequate. Under a single-payer system, all Americans would be covered for all medically necessary services, including: doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs. Patients would retain free choice of doctor and hospital, and doctors would regain autonomy over patient care. Physicians would be paid fee-for-service according to a negotiated formulary or receive salary from a hospital or nonprofit HMO/group practice. Hospitals would receive a global budget for operating expenses. Health facilities and expensive equipment purchases would be managed by regional health planning boards. A single-payer system would be financed by eliminating private insurers and recapturing their administrative waste. Modest new taxes would replace premiums and out-of-pocket payments currently paid by individuals and business. Costs would be controlled through negotiated fees, global budgeting and bulk purchasing. (PHNP, n.d.) Service delivery in Canada is also heavily influenced by provincial governments. The ministers of health control hospital costs by approving and funding global operating budgets for individual hospitals. New facilities and equipment must also be approved and largely funded centrally from the same authority. This institutional arrangement has enabled Canada to contain the escalation of hospital costs relative to the United States. Physicians' fees are determined by means of bilateral monopoly negotiations between provincial medical associations and the ministries of health. Canadian physicians are not permitted to charge patients for anything extra: in other words the government fees represent payment in full. With the price fixed, provincial governments have set up committees to review the patterns of practice so as to identify physicians, and possibly regulate the activities of those who have practices significantly larger than the norm. In addition, some provinces have negotiated aggregate limits on physician billings. In demonstrating the shortcomings of the current US health system, we provided some evidence on its inefficiency and lack of access in Chapter 5. The private, for-profit portion of the US system fares poorly in comparison with both the public portion of the US system and the Canadian system described above. A single-payer public health system is generally viewed to be Superior to a multi-payer private system in terms of both efficiency and equity. Single-payer public systems can raise financing, administer claims, and spread risks over the population more efficiently than a multi-payer private system (Evans, 2000). A tax-financed single-payer system "combines in one authority both the incentive and

capacity to contain costs, to a greater degree that is possible in any of the other financing mechanism" (Evans, 2002: 17). Moreover, there are no "marketing expenses, no cost of estimating risk status in order to set differential premiums or decide whom to cover, and no allocations for shareholder profits" (Evans et al., 1989: 573). A comparative analysis of the healthcare costs in the OECD countries found that total healthcare expenditures are lower on average in systems predominantly funded through general taxation (OECD, 2002). We have already seen that overall healthcare costs are lower in countries with universal public insurance. Part of the reason for this decreased overall cost is reduced spending on healthcare administration. A study comparing the administrative costs (the amount above that paid out for medical care) of the US and Canadian healthcare systems found that 5.9 percent of total healthcare costs in the United States went to insurance administration compared with 1.9 percent in Canada. Further, within the United States, the overhead of private insurance was 11.7 percent compared with 3.6 percent for Medicare and 6.8 percent for Medicaid (Woolhandler, Campbell, and Himmelstein, 2003; see also Himmelstein and Woolhandler, 2008). Other studies have found that administrative costs account for nearly half of the difference between the share of resources allocated to the health sector in the two countries (Himmelstein and Woolhandler, 1986; Fuchs and Hahn, 1990; Himmelstein, Lewontin, and Woolhandler, 1996). There are additional costs to having private insurance as well. Businesses have to dedicate time and effort to administering healthcare plans. US businesses spent \$57 [dollars] per capita on healthcare consultants and the administrative costs of running their healthcare plans. Canadian firms spent a much more modest \$8 per capita on administering health benefits and supplemental private insurance (Woolhandler et al., 2003). Not only is a shift in the financing mix towards a multi-payer private system and away from a tax-financed systems associated with higher costs, it also means a more regressive distribution of payment burden. To the extent that insurance premiums are related to the risk of illness and that the users of care are required to make some financial contributions in the form of deductibles and co-insurance, such a shift in the financing mix involves some transfer of funds from the unhealthy and poor to the healthy and wealthy (Evans, 2000). In 1991, the CBO released two reports on the feasibility of implementing a single-payer public health insurance system. One compared the saving from two alternative reforms to US healthcare. Both reforms would apply Medicare's rates for all medical services and provide universal insurance. The first would do so while retaining the US system of multiple public and private insurance providers. The second would do so under a single-payer system. Under either reform, "all US residents might be covered by health insurance for roughly the current level of spending or even somewhat less, because of savings in administrative costs and lower payment rates for services used by the privately insured" (CBO, 1991a: 39). Further, the CBO found that, of the two reforms, a single-payer plan would create greater savings. The major drawback of the single-payer system was the possibility that "high-income people would probably pay more for coverage that might be less comprehensive than their current plans," which lays bare the distributional consequences of the health insurance debate (CBO, 1991a: 37). The second study explicitly drew lessons for the United States from Canada's experience with health insurance. It concluded that "If the US were to shift to a system of universal coverage and a single payer, as in Canada, the savings in administrative costs would be more than enough to offset the expense of universal coverage" (CBO, 1991b: 6). This included not only expanding coverage to those without insurance but also eliminating co-payments and deductibles.

Single-payer consolidates leftist political infrastructure and whets the appetite for future socialist victories

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Fighting for "Non-Reformist Reforms" For socialists, theory and practice must be joined at the hip. Socialists work for reforms that weaken the power of capital and enhance the power of working people, with the aim of winning further demands — what André Gorz called "non-reformist reforms." We want to move towards a complete break with the capitalist system. Socialists, unlike single-issue activists, know that democratic victories must be followed by more democratic victories, or they will be rolled back. Single-payer health care is a classic

example of a “non-reformist” reform, one that would pry our health system free from capital’s iron grip and empower the working class by nationalizing the private health insurance industry. But socialists conceive of this struggle differently than single-issue advocates of Medicare for All. Socialists understand that single payer alone cannot deal with the cost spiral driven by for-profit hospital and pharmaceutical companies. If we do achieve a national (or state-level) single-payer system, the fight wouldn’t be over; socialists would then fight for nationalization of the pharmaceutical industry. A truly socialized health care system (as in Britain and Sweden) would nationalize hospitals and clinics staffed by well-paid, unionized health care workers. Socialists can and should be at the forefront of fights like this today. To do so, we must gain the skills needed to define who holds power in a given sector and how to organize those who have a stake in taking it away from them. But we can’t simply be the best activists in mass struggles. Single-issue groups too often attack a few particularly bad corporate actors without also arguing that a given crisis cannot be solved without curtailing capitalist power. Socialists not only have to be the most competent organizers in struggle, but they have to offer an analysis that reveals the systemic roots of a particular crisis and offer reforms that challenge the logic of capitalism. Building a Majority As socialists, our analysis of capitalism leads us to not just a moral and ethical critique of the system, but to seeing workers as the central agents of winning change. This isn’t a random fetishizing of workers — it’s based on their structural position in the economy. Workers have the ability to disrupt production and exchange, and they have an interest in banding together and articulating collective demands. This makes them the key agents of change under capitalism. This view can be caricatured as ignoring struggles for racial justice, immigrant rights, reproductive freedom, and more. But nothing could be further from the truth. The working class is majority women and disproportionately brown and black and immigrant; fighting for the working class means fighting on precisely these issues, as well as for the rights of children, the elderly, and all those who cannot participate in the paid labor market. Socialists must also fight on the ideological front. We must combat the dominant ideology of market individualism with a compelling vision of democracy and freedom, and show how only in a society characterized by democratic decision-making and universal political, civil, and social rights can individuals truly flourish. If socialist activists cannot articulate an attractive vision of socialist freedom, we will not be able to overcome popular suspicion that socialism would be a drab, pseudo-egalitarian, authoritarian society. Thus we must model in our own socialist organizations the democratic debate, peaceful conflict, and social solidarity that would characterize a socialist world. A democratic socialist organization that doesn’t have a rich and accessible internal educational life will not develop an activist core who can be public tribunes for socialism. Activists don’t stay committed to building a socialist organization unless they can articulate to themselves and others why even a reformed capitalism remains a flawed, undemocratic society. The Power of a Minority But socialists must also be front and center in struggles to win the short-term victories that empower people and lead them to demand more. Socialists today are a minority building and pushing forward a potential, progressive anti-corporate majority. We have no illusions that the dominant wing of the Democrats are our friends. Of course, most levels of government are now run by Republicans well to the right of them. But taking on neoliberal Democrats must be part of a strategy to defeat the far right. Take the Democrats, who are showing what woeful supposed leaders of “the resistance” they are every day. Contrary to the party leadership’s single-note insistence, the Russians did not steal the election for Trump; rather, a tepid Democratic candidate who ran on expertise and competence lost because her corporate ties precluded her articulation of a program that would aid the working class — a \$15 minimum wage, Medicare for All, free public higher education. Clinton failed to gain enough working-class votes of all races to win the key states in the former industrial heartland; she ended up losing to the most disliked, buffoonish presidential candidate in history. If we remain enthralled to Democratic politics-as-usual, we’re going to continue being stuck with cretins like Donald Trump. Of course, progressive and socialist candidates who openly reject the neoliberal mainstream Democratic agenda may choose for pragmatic reasons to use the Democratic Party ballot line in partisan races. But whatever ballot line the movement chooses to use, we must always be working to increase the independent power of labor and the Left. Sanders provides an example: it’s hard to imagine him offering a radical opening to using the “s” word in American politics for his openly independent campaign if he had run on an independent line. Bernie also showed the strength of socialists using coalition politics to build a short-term progressive majority and to win people over to a

Medicare For All Master File

social-democratic program and, sometimes, to socialism. Sanders gained the support of six major unions; if we had real social movement unionism in this country, he would have carried the banner of the entire organized working-class movement. Bernie's weaker performance than Clinton among voters of color – though not among millennials of color – derived mostly from his being a less known commodity. But it also demonstrated that socialists need deeper social roots among older women and communities of color. That means developing the organizing strategies that will better implant us in the labor movement and working-class communities, as well as struggles for racial justice and gender and sexual emancipation. Socialists have the incumbent obligation to broaden out the post-Sanders, anti-corporate trend in US politics into a working-class "rainbow coalition." We must also fight our government's imperialist foreign policy and push to massively cut wasteful "defense" spending. We should be involved in multiracial coalitions, fighting for reforms like equitable public education and affordable housing. Democratic socialists can be the glue that brings together disparate social movement that share an interest in democratizing corporate power. We can see the class relations that pervade society and how they offer common avenues of struggle. But at 25,000 members, we can't substitute ourselves for the broader currents needed to break the power of both far-right nativist Republicans and pro-corporate neoliberal Democrats. We have to work together with broader movements that may not be anti-capitalist but remain committed to reforms. These movements have the potential to win material improvements for workers' lives. If we stay isolated from them, we will slide into sectarian irrelevance. Of course, Socialists should endeavor to build their own organizational strength and to operate as an independent political force. We cannot mute our criticism against business unionist trends in the labor movement and the middle-class professional leadership of many advocacy groups. But in the here and now, we must also help win those victories that will empower workers to conceive of more radical democratic gains. Our members are disproportionately highly educated, young, male, and white. To win victories, we must pursue a strategy and orientation that makes us more representative of the working class.

Movements snowball and empowers left since we free them of collective bargaining time suck

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CLASS INTERESTS: THE EVOLUTION OF THE MEDICAL INDUSTRIAL COMPLEX A private health-care industry of huge proportions could be a powerful political force in the country and could exert considerable influence on national health policy. A broad national health-insurance program, with the inevitable federal regulation of costs, would be anathema to the medical-industrial complex, just as a national disarmament policy is to the military-industrial complex. (Relman, 1980: 969) Like the conditions of work and the state of the environment, the healthcare system is influenced by the outcome of the conflict between groups with opposing interests. US healthcare has been shaped by the conflict between the general public's dissatisfaction with the private system and those who have a vested interest in that system. As we shall see in the following section, the specific mechanisms through which this conflict played out, and the specific groups that took the lead for each side, changed over time. However, this did not change the constant that a weak working class failed to win universal public health insurance in the face of a well-organized, powerful medical industry. In this conflict between US citizens and a specific faction of US industry, the broader business class, which once sided with the medical industry, has become more ambivalent in its support in recent years because of changing economic circumstances. The domination of US healthcare by the medical industry has resulted in an unresolved contradiction. What is desired by the industry has not been satisfactory to the general public. This has manifested itself in serious demands for universal health insurance five times in the 1900s. The early years: the AMA In the early decades of the 1900s, the forces of progressive reform called for expanded access to healthcare. In Europe, workers, their union organizations and the political parties that represented them were the driving force behind universal public insurance (see Table 5.1). Between 1883 and 1910 every Western European nation passed some form of sickness insurance (Hacker, 2002: 193). In these nations, the labor movement pressed for universal, healthcare systems with very specific characteristics. First, they wanted a universal, as opposed to means tested, or targeted, system. Second, they insisted on labor movement input into the direction of the healthcare system. Third, the state was to be in financial control of the system. Finally, it should be funded through a system of progressive income tax (Navarro, 1989). This structure contained two important principles for European workers: solidarity and redistribution. By making a uniform level of benefits available to the entire population, the unity of the labor movement was strengthened. Simultaneously, it strengthened the populations' commitment to public healthcare since the benefits did not only go to an unfortunate (or undeserving) minority of poor families, but to the entire population. Funding through progressive income tax was a deliberate strategy to redistribute income from high-earning business owners to lower-earning workers. Why were European workers able to get their demands for public health insurance implemented while US workers repeatedly failed in the United States? Table 5.1 Establishment of major trade union federations, socialist parties and first social (including health) insurance: selected European countries Source: (Navarro 1989: 140). It was not as though there was no pressure for health insurance in the United States. In 1912, Theodore Roosevelt endorsed compulsory health insurance. In 1916, the American Association for

Labor Legislation pushed for health insurance at the state level. Both of these proposals failed, while similar proposals in Europe succeeded. Vicente Navarro (1989) makes a convincing case that one of the major reasons for this difference is that, despite the increased strength of the working class in the United States during the Progressive period, it was still relatively much weaker than European labor. The percentage of unionized workers in the United States is lower than in Europe. For much of US history, unions were organized along weaker, more conservative craft lines, as opposed to industrial unions, and had no centralized bargaining process. US labor has never had a significant political party to represent working-class interests. As a result, any popular demands for a universal public system could not be channeled through established union organizations or political parties. In fact, the AFL, the largest union organization in the late 1800s and early 1900s, openly opposed any kind of publicly funded healthcare. The notoriously conservative president of the AFL, Samuel Gompers, was concerned that public healthcare (and any other government protection for that matter, from minimum wage to unemployment insurance) would diminish the influence of unions, since one of the principal benefits that unions could offer their members would be removed from the negotiating table and placed in the hands of the state (Starr, 1982: 250). While the US population did not have a ready vehicle to push forward its demands for health insurance, the opposition was unified and well organized. In contrast to workers' compensation, where employers were divided because many could see a potential benefit through a reduction in legal settlements arising from injuries at work, business could see no similar gains from public health insurance. Business groups were opposed to a public system because they were against public intervention in principle, concerned about being forced to pay for a public program, predicted it would create an increase in employee "malingering," and because they were worried that it would decrease employee loyalty to the firm that was created by employer-funded insurance (Hoffman, 2001: 113–14). From the workers' perspective, this "employee loyalty" was generated by the additional insecurity that came with losing health coverage along with their job.

Universal public insurance that would guarantee coverage even to those without work would reduce employers' power in the labor market.

The medical industry provided the vanguard of the opposition to compulsory health insurance. Although health insurance was in its infancy at this time, the insurance companies of Prudential and Metropolitan lobbied to prevent a national insurance program, worried that it would cut into their lucrative trade in life insurance which offered the working class a way of avoiding the dreaded "pauper's burial." During this period the drug companies also lined up in opposition out of concern that a government-run program would have considerable bargaining power over the price of pharmaceutical products. The most vocal opposition to health insurance came from the American Medical Association (AMA). Although it originally provided tentative support for the social reformers who wanted a national universal health insurance program in the 1910s, support was withdrawn over concerns that it eliminated doctors' discretion over their fees, and that fees for services would be changed to a salary or capitation system (a fixed sum per patient per year) under national insurance. One Buffalo doctor claimed that health insurance would create a "heartless, overworked, 15 cent-a-call contract physician" (Hoffman, 2001: 89). After its early flirtation with universal healthcare, the AMA led the opposition to any intrusion into its professional domain. As we saw in Chapter 2, the early decades of the twentieth century witnessed the formalization of the medical profession, part of which was the growing strength of its association. By 1930, 65 percent of doctors belonged to the AMA. By 1920, it issued a declaration opposed to any "system of compulsory contribution insurance" that was "provided, controlled or regulated" by the government (Hacker, 2002: 198). Indeed, at this point, doctors were also opposed to private, voluntary insurance, which they feared would interfere with their professional purview. Similar class alignments thwarted the next wave of health insurance proposals in the 1930s and 1940s. In 1935, health insurance was proposed as part of the New Deal that ushered in Social Security but was left out of the final Act. In the late 1940s the Wagner–Murray–Dingwall Bill, which would have introduced public universal insurance, also failed. The two major changes of this period were the growing strength of US workers and the fledgling development of the private health insurance industry. The pressure for reform again came from popular demands to ensure access to healthcare as the costs of medical care began to increase, in part because of the formalization and direction imposed by the Flexner Report (see Chapter 2). In 1943, 85 percent of people in the United States favored a system of healthcare modeled on Social Security. As organized labor moved to a more inclusive form of industrial unionism, it supported universal public health. However, this support was not unequivocal. Although the Congress of Industrial Organizations (CIO) decried voluntary insurance in 1949, and provided surface support for public insurance in the 1930s and 1940s, it made little concrete effort to win public, universal health insurance through political means. This was especially true after the Taft Hartley Act of 1947 purged unions of their more radical leaders, tactics, and ambitions. Public insurance would strip one of the fringe benefits that bread and butter unionism could use to attract workers in the more hostile post-Taft Hartley environment (Quadagno, 2004: 31).

While the union movement was the driving force behind universal public insurance in other nations, in the United States its efforts were channeled into getting private insurance through collective bargaining. Without the driving force of a fully committed union movement, public desire for universal public health insurance could not overcome entrenched opposition spearheaded by the AMA,

which followed a two-pronged approach. The first was to decry any public insurance. The AMA levied a \$25 fee on its members for an unprecedented multi-million-dollar campaign in the late 1940s, billing public insurance as a communist plot to bring "socialism" to the United States which would result in "low-grade assembly line medicine" (Quadagno, 2004: 30). It communicated its position through letter-writing campaigns, newspaper ads, and personal letters from doctors to their patients. In addition to shaping public opinion, it directly campaigned against politicians who were proposing public plans (Hacker, 2002: 225; Quadagno, 2004: 30). The AMA drew support from the other medical industry groups like the American Hospital Association (AHA), insurance companies, and drug manufacturers. Organizations representing the broader business class, like the Chamber of Commerce, also publicly opposed any government intrusion into private healthcare profits. The second prong was to offer **private insurance** as a deliberate tactic to ease the political pressure for the more odious, as far as the AMA was concerned, public alternative. In 1940 only 6 million people in the United States had any kind of medical insurance, but the figure expanded over 12 times, to 75 million by the end of the decade (Quadagno, 2004). Private insurance was palatable to doctors, in part because the medical profession was in control of early insurance organizations. First, the AHA (Blue Cross) and then the AMA (Blue Shield) set up non-profit organizations that offered early forms of voluntary insurance, but in a manner that avoided the medical profession's concern about third-party intervention in its professional decisions (Quadagno, 2004: 30). In some ways, hospitals even benefited from insurance. Early Blue Cross policies were, in effect, a prepayment for hospital services, where families would pay a monthly fee in exchange for free hospital stays of a certain length. For hospitals, this increased the number of patients that could use their services and created a smooth,

Medicare For All Master File

predictable revenue flow. While business was not keen on the increasing costs of employer-based health insurance, it preferred the voluntary private form of insurance over the public option. Like the paternalistic corporate efforts implemented in the Progressive period, firms felt that it would increase employee loyalty. This was especially true during the Second World War when wage controls encouraged firms to offer fringe benefits to attract employees in a tight labor market (Quadagno, 2004: 31). The failure of public insurance did not mean that government was not involved in healthcare spending. Rather, it was heavily involved, but in a manner that was amenable to the profitability of the private healthcare sector. In 1946, the Hospital Survey and Construction Act (or Hill-Burton Act) provided grants and loans for healthcare facility construction and modernization (Hoffman, 2001: 183). In exchange for this financial help, facilities had to offer a "reasonable volume" of services to area residents who would not otherwise be able to pay for medical care. The enforcement of the reasonable volume provisions was virtually nonexistent in the early years of this Act, meaning that those who could not pay did not necessarily get access to Hill-Burton funded hospitals. Yet the bill did permit the medical establishment to claim that it was increasing access for poorer members of the community, while increasing the supply of medical facilities in the country. After the defeat of Wagner-Murray-Dingwall, the employer-based system was firmly entrenched as the dominant method of insurance. Doctors,

hospitals, insurance companies, and employers all benefited from private insurance. **On top of this it had the added political bonus of neutralizing the demand for public insurance. Unions may have paid lip service to a public option, but their energies were dedicated to expanding private insurance to their members.** The supremacy of private insurance was further supported by the 1954 tax code change that made employer contributions to worker health plans tax exempt, a policy supported by the AMA and AHA. It was also supported by the CIO despite the fact that it would clearly benefit rich workers more than poor, and only those workers with employer coverage (Hacker, 2002: 204). As a result of these changes, the percentage of people covered by private insurance in the United States grew from 10 percent in 1940 to 70 percent in 1960 (Hacker, 2002: 214).

States will always be a neoliberal tool to protect commerce; they fail to protect the poor

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Despite the important shifts in constitutional law during the 20th century that Justice Ginsburg draws upon in Sebelius, the Constitution of the United States is no friend of democracy. The Constitution deliberately thwarts the coming together of democratic power by dispersing it temporally and institutionally, and it secures these anti-democratic tendencies by erecting high barriers to constitutional change via normal democratic processes.²⁶ Thus it is no surprise that Milton Friedman turns to the US Constitution as a model for protecting neoliberal “freedom” from the unfreedom heralded by the presence of democratic political power: How can we benefit from the promise of government while avoiding the threat to freedom? Two broad principles embodied in our Constitution give an answer that has preserved our freedom so far . . . First, the scope of government must be limited. Its major function must be to protect our freedom both from the enemies outside our gates and from our fellow citizens . . . The second broad principle is **that government power must be dispersed**. If government is to exercise power, better in the county than in the state, better in the state than in Washington.²⁷ In their dissenting opinion, Justices Kennedy, Scalia, Alito, and Thomas sought to nullify the ACA in its entirety and vindicate these two constitutional principles. They repeatedly returned to the “structural protections” of liberty, “notably the restraints imposed by federalism and the separation of powers.”²⁸ For them, the mandate was unconstitutional because it compelled economic activity rather than regulated it, and thus portended the transformation of the Commerce Clause into a general power to solve national problems.²⁹ The threat to withhold all federal Medicaid funding from States that did not agree to expand their programs in accord with the federal statute raised the specter of Congress “trampling on State’s sovereignty” and degenerating into a dreaded “parliament of the whole people.”³⁰ Rather than defer to democratic power in the realm of social and economic welfare legislation, the dissent imagined the role of the Court as stern schoolmaster of the Republic: Structural protections . . . are less romantic and have less obvious a connection to personal freedom than the Bill of Rights of the Civil War Amendments. Hence they tend to be undervalued or even forgotten by our citizens. It should be the responsibility of the Court to teach otherwise . . . Today’s decision should have vindicated, should have taught, this truth.³¹ **Neoliberal citizens are**, apparently, ignorant and stubborn, and **in need of constant reminders** and tutorials **that the acquisition of** their individual **freedom demands the surrender of** their political power. . . In light of the dissent’s constitutional theory, **how then does this constitute a departure from neoliberal ends?** Recall that Milton Friedman’s hostility to centralized political power offered a gradation of judgment about governmental power when governmental power was called for: county rather than state, state rather than federal. Unlike Medicare, which **is administered by the Federal Government**, Medicaid is a joint-project between the States and Federal Government, an example of “cooperative Federalism.”³² **Any State could withdraw from Medicaid and leave the poor in grave distress; no action by this or that State can threaten the distribution of health coverage provided by Medicare.** And as Justice

Ginsburg pointed out, the constitutionality of Medicare is on sound constitutional footing; it does not prod the States, it bypasses them via the Taxing and Spending power. By rendering federal attachments to federal funds constitutionally suspect, the dissent comes near to creating an either/or logic with respect to future Federal action: spend directly or do nothing. When doing nothing ceases to be a political option, nationalized public health care will be the surest legal path; after all, why risk the constitutional challenge when you can simply avoid it? Ironically, the dissent undermines federalism in the name of federalism and thus turns neoliberalism against itself. ... Individual liberty and limited government are considered to be neoliberal virtues, but limited government in neoliberal governance in fact means limits in some domains but real and robust power in others. As Wendy Brown has astutely noted, neoliberalism does not fight state power per se, but turns state power toward the creation of new neoliberal orders: "the state is not without a project in the making of the neoliberal subject."³³ Chile's simultaneous experience of neoliberalization and right-wing dictatorship helped set the historical mold for realizing Friedman's ordering of economic freedom as preceding and grounding other practices of freedom, and for unleashing the state as a productive force in building a marketized society. Following Brown's lead, we can see that the Pinochet dictatorship did not represent the emergence of a libertarian order of the state policing a naturally functioning market, but instead signaled an active neoliberal state of intervention and social engineering. A key policy triumph of the neoliberals in Chile was the privatization of the public pension system under the Pinochet dictatorship. The minister of labor in charge of that project, José Piñera, would also come to co-chair the Cato Institute's Project on Social Security Privatization in the United States. Chile replaced public pensions with "individually-owned, private investment accounts." The law established a "mandatory minimum savings level of 10% of wages" and all "new entrants to the labor force were required to enter the PSA system."³⁴ Workers, however, were 'free to choose' which financial services company they wanted to manage their mandatory individual pension savings account. To translate this into the language of the Sebelius case, the State has issued an individual mandate that all workers must purchase financial services products. The State does not disappear here; it simply appears in neoliberal form. But this appearance is precisely what the right-wing dissent in Sebelius held to be constitutionally impermissible. If the State can not only regulate economic "activity" but in fact can compel it, have we not then crossed the Rubicon from limited government into its very opposite? As the dissent put it, if the power of regulation includes the power to compel that which is regulated, "then the idea of a limited government power is at an end."³⁵ The capacity of the Federal Government to privatize Social Security along Chilean lines is thus constitutionally blocked. The dissenting opinion sings with neoliberal poetry only to potentially thwart a longstanding neoliberal dream. It has wandered into that vexing predicament where neoliberals have never been able to live with, or without, the state."³⁶

Natives

Native disparities in health-care are massive—Universal health-care solves

Trahant 17 (July 28th, 2017, Mark Trahant is the Charles R. Johnson Endowed Professor of Journalism at the University of North Dakota. He is an independent journalist and a member of the Shoshone-Bannock Tribes, “Mark Trahant: What's next for Indian health care after big fail in Congress?” <https://www.indianz.com/News/2017/07/28/mark-trahant-whats-next-for-indian-healt.asp>)

Senate Republicans campaigned against “Obamacare” for seven years. Yet there was never an alternative that had support from a majority of their own party. The problem is simple: Many (not all) Republicans see health care programs that help people — the Affordable Care Act, Medicaid, etc. — as welfare. Others look at the evidence and see these programs that are effective: Insuring people, creating jobs, supporting a rural economy, and actually resulting in better health outcomes. Evidence-based success stories. Of course Indian Country is squarely in the middle of this debate. Congress has never even considered, let alone acted, to fully fund Indian health programs. But the Affordable Care Act basically defined the Indian Health Service (and tribal, nonprofit, and urban operations) as health care delivery vehicles. And one way to pay for that delivery was by providing health insurance through an expanded Medicaid, no-cost insurance that tribal members could get through exchanges and employers. The ACA with all its faults sets out a plan to fully fund the Indian Health Service. That's the challenge now. Making sure that every American Indian and Alaska Native has insurance of some kind. Because of what happened (or, more accurately, what did not happen) in the Senate this week the money remains on autopilot. If you are eligible, the funding is there. Yet the uninsured rate for American Indians and Alaska Natives remains high, as a Kaiser Family Foundation report noted a couple of months ago. “The Affordable Care Act’s Medicaid expansion provides an opportunity to enhance this role by increasing coverage among American Indians and Alaska Natives and providing additional revenue to IHS- and Tribally-operated facilities,” The Kaiser report said. In states that do not expand Medicaid, American Indians and Alaska Natives will continue to face gaps in coverage and growing inequities. This is a problem that will grow because of congressional inaction. Nineteen states including Oklahoma, South Dakota, Wyoming, Idaho, Kansas, Nebraska, Florida, and Maine, have rejected Medicaid expansion. So a tribal citizen in those states gets fewer dollars for healthcare than some Indian health patients in North Dakota, Montana, Alaska, Arizona, New Mexico, or any other state that took advantage of the expansion. As Kaiser notes: “American Indians and Alaska Natives will continue to face gaps in coverage and growing inequities in states that do not expand Medicaid. In states that do not expand Medicaid, many poor adults remain without an affordable coverage option and will likely remain uninsured. Similarly, IHS providers in these states will not realize gains in Medicaid revenue.” This is the what's next? How does the country manage this divide, especially in Indian Country. (And, just as important, we also need to see the gap measured. What are the differences in treatment and outcome between Montana and Idaho or North Dakota and South Dakota? Data, please.) This is critical because under current law, third-party billing (including Medicaid) remains at the local service unit. There is now a funding inequity that needs to be addressed by state legislatures. Recently Rep. Tom Cole, R-Oklahoma, said he knows these states and they won’t expand Medicaid. (Back to the welfare, thinking.) I hope not. The Trump administration recently made it easier for states to get a 100 percent reimbursement for Indian health patients (enticing South Dakota to reconsider joining the ranks of expansion states.) So it's possible, and a challenge, to make sure that the law is implemented, and that innovation continues. The ACA gives much power to an administration to a state to change the rules. You will see a lot of that now. Indian Country needs to keep a sharp eye on that process and raise objections if the result is unsatisfactory. Allocation of Indian Health Service Program Funding, in Billions, FY2016. Source: Kaiser Family Foundation So why did the Senate bill fail? Sure, full credit should go to the heroic stands by Sen. Susan Collins, R-Maine, and Sen. Lisa Murkowski, R-Alaska. From the very beginning of the debate they were the party advocates for a Medicaid system that does produce better healthcare outcomes. And Alaska is a great example of that because nearly a quarter of the state’s population is served. This is how it should be across Indian Country and the nation. And, of course, there was Sen. John McCain’s dramatic late night thumb’s down. The Arizona Republican was a no vote when it counted. But that's not why the bill failed. Fact is it's remarkable that such nonsense got so far. It’s inconceivable that a plan was written at lunch the day before the vote. The bill failed because the Republicans, as a group, do not know where they want to lead the country on health care. They know they don’t want Obamacare (even though it’s based on conservative, market-based ideas). They sure as hell know they don't want universal health insurance, either Single Payer such as Medicare for All or a government health service like Great Britain’s. Yet when I listened to the debate yesterday so many of the complaints about insurance and costs could be solved by such a path. The problem here is that the United States made a huge mistake

with employer-based insurance and that left out people who work for themselves or small businesses.

The only way to fix that is a large pool of people spreading the costs, so that healthy people pay for sick people. The ACA tried to do that with mandates. Most countries

accomplish that goal with universal insurance. Another factor in the Republican plans — and another reason for the bill's failure — is their absolute certainty in a market-based solution. Healthcare delivery and free markets do not play well together. The proof of that is simple: How much is an empty hospital bed worth to a business? Yet that should be the goal. And how much is it worth to a hospital-as-a-business to help a patient not need surgery? What market incentives are there for people to eat better? Seven years ago, when I started writing a lot about health care, I did so because I saw the Indian Health Service as a fascinating example of government-run and managed healthcare. As we began this debate, I thought, let's

figure out what works and what needs work. But I was way wrong. IHS is no longer only a government-run system. Much of the agency

is now a funding mechanism for tribal, nonprofit, and urban operations). And that's where so much of the innovation and

excellence in Indian health exists. We need to learn more about what's working and why. Yet Congress (and the public narrative) continue to

think of an IHS that no longer exists. At least entirely. This might be a moment to focus on the latter part of what the agency does, improving the flow of funds, and adding more of our people to insurance rolls.

Here's the thing: We cannot do anything about universal health care. At least not yet. But we can have universal health care for Indian Country. It's a huge task, but the ACA remains the law and it's only a matter of execution (not a policy debate). Third-party collections now account for about \$1.8 billion out of the IHS' budget.

The dollars Congress appropriates is \$4.8 billion. The third-party portion can grow through more insurance coverage. The appropriations side will require hard fights in Congress and the outcome is uncertain. Back to the Senate. Texas Sen. John Cornyn, a member of the Republican leadership, joked that perhaps it's time for a new way of doing business. "I guess we ought to go back to Schoolhouse Rock," he said. That's been a clear message from both Republicans and Democrats throughout this messy project. Get a bill. Hold hearings. Let a committee debate alternatives. Then let the bill come to the floor. Regular order. Schoolhouse rock.

Health Care Key to Equality

Equal access to health care is critical to equality

Newsweek, September 11, 2009, Universal Health Care is a Moral Choice,
<http://www.newsweek.com/universal-health-care-moral-choice-79223>

Those Americans who die or go broke because they happened to get sick represent a basic moral decision our country has made. All the other rich countries have made a different decision: they cover everybody. A French physician, Dr. Valerie Newman, explained it this way: "You Americans say that everybody is equal," she said. "But this is not so. Some are beautiful, some aren't. Some are brilliant, some aren't. But when we get sick—then, yes: everybody is equal. That is something we can deal with on an equal basis. This rule seems so basic to the French: we should all have the same access to care when it comes to life and death."

Other nations adhere to the same principle, with slightly different explanations. For Switzerland—a rich, capitalist country that didn't create a universal health-care system until 1994—the underlying rationale is the concept of **solidarité**. That's a crucial word in the Swiss vocabulary, freighted with meanings that include "community," "equal treatment," and "despite our differences, we're all in this together."

"To have a great sense of **solidarité** among the people," former Swiss president Pascal Couchepin told me, "all must have an equal right—and particularly, a right to medical care. Because it is a profound need for people to be sure, if they are struck by the stroke of destiny, they can have a good health system."

That principle seems so obvious to people in Europe, Canada, and the East Asian democracies that health officials asked me over and over to explain why it isn't obvious to Americans as well. "The formula is so simple: health care for everybody, paid for by everybody," a deputy health minister in Sweden told me. "You Americans are so clever. Why haven't you figured that out?"

If inequality exists, the least advantaged should be treated first

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

John Rawls' Difference Principle is illustrated by the concept of vertical equity cited by the World Health Organization (WHO). The WHO concept of equity is twofold: Horizontal equity requires that all those who face the same health need will be treated alike; vertical equity obligates preferential treatment to those with the greatest need " p. 55). The latter concept seems compatible with John Rawls' Difference Principle, namely, if there is unequal distribution of social goods, it must favor the most disadvantaged (in this case, those with greatest health care needs). The concept is also similar to the notion of medical triage, which consists in assessing the severity of patients' conditions, hence urgency for priority treatment. The WHO also justifies public financing to achieve cross-subsidies: the wealthy subsidize the poor, and the healthy subsidize the sick (as any prepayment system will achieve in part) (WHO, 2000, p. 55; cf. viii). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5650-5655). AuthorHouse. Kindle Edition.

A2: Liberty More Important

Note: These are also useful libertarianism answers

Justice requires equality

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

It is important to recognize that while justice is distinct from both liberty and equality, it includes both. Liberty and equality are both necessary constituents of justice construed as a nonmoral value or desired good. This means that justice cannot exist apart from either liberty or equality. A satisfactory ethic based on justice includes both as indispensable elements held in balance so that neither value is affirmed exclusively or absolutely. Justice Requires Equality The idea of equality is central to many concepts of justice. It was emphasized in the previous formal definition of justice justice by Beauchamp and Childress (2001, p. 227). Three additional illustrations cited by Frankena (1973) will be sufficient to express this egalitarian concept of justice. One example of the principle of justice (expressed rather abstractly) is Sidgwick's *prima facie* principle: It cannot be right for A to treat B in a manner in which it would be wrong for B to treat A, merely on the ground that they are two different individuals, and without there being any difference between the natures or circumstances of the two which can be stated as a reasonable ground for difference of treatment. (As cited in Frankena, 1973, p. 17) A second example of an egalitarian view of justice is Rasdall's axiom of equity: "I ought " to regard the good of one man as of equal intrinsic value with the good of any one else." (p. 27). A third illustration from the Judeo-Christian tradition is the egalitarian principle expressed in the Golden Rule (Mt.7.12). Gensler (2002) used symbolic logic to establish the validity of his paraphrase of the Golden Rule: "Treat others only as you consent to be treated in the same situation" (pp. 235, 250f). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 4780-4784). AuthorHouse. Kindle Edition.

Unregulated liberty undermines justice for others, it is not unlimited

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

It is through just laws that the liberties of a people are secured and defended. But unlimited liberty becomes a license to deny the liberties of others, hence liberty must be regulated by balancing liberty with equality. The principle and value of justice implies everyone should have only as much liberty as justice allows, and no more than that... [and] a society should seek to achieve only as much of an equality of conditions as justice requires, and no more than that" (Adler, 1981, pp. 138-139). Justice both promotes and limits liberty and equality. A quote attributed to Jefferson Davis expresses the point: "Liberty consists in the right of each individual to exercise the greatest freedom of action up to, and not beyond, that point where it impinges upon the like exercise of freedom of action of every other man." In terms of the above syllogism, my freedom to choose my own health care provider must not prevent others from choosing theirs, nor must my freedom to access health care services deny or limit others freedom of access. To participate in, and to benefit from a health care system which denies others

freedom to access necessary services is a violation of the principle of liberty as well as equality. It is unjust. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 4807-4809). AuthorHouse. Kindle Edition.

Justice is more important than liberty

We act upon all three values in governing our social, political, and economic affairs: liberty, equality, and justice. From a teleological perspective, all three are considered as highly desirable goods, that is, they are "... real goods that we need to lead decent human lives in the pursuit of happiness" (Adler, 1981, p. 136). These are values that define a democratic society and constitute principles of good government. A good government is a just government. Nevertheless, liberty and equality are also limited goods.

Attempts to maximize one will minimize the other. Both must be limited by justice. Hence, of the three values, justice is the greater good because it synthesizes and balances the other two. Justice regulates our thinking about both liberty and equality. Moreover, unlike the latter two, justice is an unlimited good. "No society can be too just; no individual can act more justly than is good for him and for his fellowmen" (Adler, 1981, p. 137). The reader might note that this is an example of relating ethical principles and moral values by balancing and ranking them relative to each other. One way of ranking justice as sovereign is to argue that whereas liberty and equality are *prima facie* obligations, justice is a categorical imperative. We must act justly, do justice at all times, everywhere, with everyone.

Alternatively, all three values could be considered as *prima facie* principles, that is, principles we are obligated to always fulfill unless overridden by another *prima facie* principle such as beneficence. But a ranking among the three is also justified because justice itself includes, regulates, and balances principles of liberty and equality. Hence, justice is sovereign and the greater good because it reconciles what liberty allows and equality requires. Above all, a health care system must be just. Expressed in the categories of dialectical reasoning, we can consider maximizing liberty as the thesis, and maximizing equality as the antithesis. Justice is the synthesis that gives due regard for both. Justice is a dialectical dialectical concept which balances the other two. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Location 4827). AuthorHouse. Kindle Edition.

Equality of Opportunity

There must be fair equality of opportunity

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

In her essay “Universal Access to Healthcare” Lesley Jacobs examines whether an egalitarian such as Daniels or myself can justify universal care. Specifically she deals with Daniels’ argument for universal healthcare which she refers to as “the minimalist egalitarian strategy” (Jacobs, 333). In this approach Daniels argues for universal access to care on the grounds that it is a requirement of fair equality of opportunity. Also known as the second part of the difference principle, fair equality of opportunity was introduced by John Rawls as an alternative to formal equality of opportunity. Rawls considered the former to be an improvement on the latter in one important sense. Formal equality of opportunity holds that individuals with equal talents and motivations must have equal legal access to advantaged social positions. Rawls recognizes that this view is incomplete without taking into account the different socioeconomic starting points which individuals come from. This uneven footing is the reason that people of similar merit do not reach the same advantaged positions even though everyone has equal legal access. Fair equality of opportunity seeks to remedy this problem as it holds that people of equal merit should have equal prospects of success regardless of socioeconomic position. To this end Rawls argues everyone must have access to a system of education that serves to minimize the effects of one's socioeconomic class on ambitions and natural talents. The desired effect is a flattening of the socioeconomic gradient.

Health care needed to be provided to sustain a fair equality of opportunity

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

Daniels' strategy is to extend fair equality of opportunity to healthcare. He argues that choosing fair equality of opportunity over formal equality of opportunity in addition to public education requires access to healthcare. Ill health, like socioeconomic class, is a random circumstance of birth and should not affect one's ability to realize one's merit.

Disadvantage Answers

Health Care turns AreWrong

No harmful increased wait times or rationing – don't adversely affect clinical outcomes, neg evidence is exaggerated data based on self-reporting, overcrowding underreported in the US, comprehensive data demonstrates wait times have declined

Geyman 5 [John Geyman, M.D. is professor emeritus of family medicine at the University of Washington School of Medicine, a family physician with 21 years in academic medicine, Professor Emeritus of Family Medicine at the University of Washington School of Medicine, former editor of The Journal of the American Board of Family Medicine, member of the Institute of Medicine, now the National Academy of Medicine former president of Physicians for a National Health Program International Journal of Health Services, Volume 35, Number 1, Pages 63–90 2005 http://www.pnhp.org/facts/myths_memes.pdf]

Alleged myth no. 3: Countries with single-payer health insurance make health care available on the basis of need, rather than ability to pay.

The NCPA report raises the specter of rationing by government-run programs, then focuses on minorities of the populations in Britain, Canada, Australia, and New Zealand who seek private care outside publicly financed services. These are mainly patients not wanting to wait for elective or non-urgent care within the system, who gain access to private care through either private insurance or out-of-pocket payments. No evidence is presented that waiting times within the system adversely affect clinical outcomes, and no distinction is made between "need" and "desire" on the part of patients who bypass waiting lists. An exaggerated impression is given of both waiting lists and the "growing number" of Canadians traveling to the United States for medical care, based on a 1996 article (16).

The NCPA analysis fails to acknowledge the benefits of universal access to medical care—even without the ability to pay—in any of these countries, while omitting mention of ongoing access problems in the United States, due especially to financial barriers to care. Without question, the more a private system is used, to the benefit of smaller numbers of affluent patients, the more the public system may be threatened, to the detriment of larger numbers of people, in terms of adverse selection, limited resources, and longer waiting times. The following examples cast a different light on the NCPA report:

- Overcrowding of emergency rooms in Canada is increasingly mirrored by the same problem in the United States, though underreported in this country. Physicians at the Los Angeles County-USC Medical Center have testified that some emergency room patients can wait up to four days for a bed and that others may die before receiving care (17). Of the millions of Americans crowding U.S. emergency rooms, many have problems that could have been prevented by earlier care; they end up being charged the highest rates for emergency care, then are released with often inadequate follow-up care (18).
- Though admittedly the Canadian system is underfunded, and extended waits for some elective services may be a problem in some parts of the country, these problems are often exaggerated by its detractors based on unreliable self-reported data. In 1998, fewer than 1 percent of Canadians were on waiting lists, with fewer than 10 percent of these waiting longer than four months (19). Waiting times in the United States, even for the privately insured, are now increasing for checkups as well as for sick visits (20).
- Comprehensive and reliable provincial databases on waiting times show that in recent years, waiting times have decreased while services have increased. For example, coronary bypass surgery increased by 66 percent between 1991 and 1997 in Manitoba, while waiting times were reduced for that procedure and also shortened for five other elective procedures—carotid endarterectomy, cholecystectomy, hernia repair, tonsillectomy, and transurethral resection of the prostate (21).
- Although there is a widespread myth that many Canadians seek medical care in the United States, a three-state study reported in 2002 found that this number is very low for either outpatient or hospital care, and largely due to these Canadians needing medical care while traveling in the United States (22).

- As private interests lobby for an increased role in countries with national health insurance, their success adversely affects the public system. In Canada, for example, the waiting list for cataract surgery by surgeons who operate only in the public system is 10 weeks, compared with 26 weeks for those who operate in both the public and private systems as they preferentially care for private patients (23).

Eliminating costly, administrative bureaucracy solves DOC SHORTAGES

Hellander 17 [Ida Hellander, MD, is a former executive director and director of national health policy (1992–2017) at Physicians for a National Health Program, 8-16-2017
<https://www.thenation.com/article/can-medicare-for-all-succeed/>]

Holland assets that physicians will have to be paid less under single payer, which is false. There are many advantages to a single-payer system, not least of which is the saving of \$500 billion annually currently wasted on insurance overhead and excess provider bureaucracy—more than enough money to cover the extra costs of clinical care for the uninsured and underinsured, and to eliminate copays and deductibles for everyone, without cutting physician pay. Having said that, the single payer system will have the ability to shift more funding towards primary care over time, which would help with both access and costs down the road.

It's unique – shortage now from bureaucracy

Albright 15 [Logan Albright is Director of Fiscal Research at Capital Policy Analytics, Research Analyst for Freedom Works and a contributing editor for Mises Institute Canada, M.A. Economics – Georgia State University, 2-3-2015 <https://mises.org/library/how-government-helped-create-coming-doctor-shortage>]

For the last five years, attempts to reform America's health care system have focused primarily on the demand side of the market, and specifically on the market for insurance. Yet, these reforms have not achieved significant improvements in health care outcomes, nor reductions in cost. As health care specialist John C. Goodman has pointed out in Forbes, the slowed growth of health care spending in the United States is a trend that correlates most closely with supply side reforms such as the availability of health savings accounts. Reductions in spending or costs are certainly not an effect of the Affordable Care Act.

One of the most critical supply side issues in health care is the supply of qualified doctors. The Wall Street Journal has reported that the number of doctors per capita is in decline for the first time in two generations, and the American Association of Medical Colleges has predicted a shortage of 45,000 primary care physicians and 46,000 specialists by 2020.

In light of these statistics, it would seem prudent to adopt policies that streamline entry into the health care market, while keeping regulatory costs to a minimum. Regrettably, this is far from the case, with states erecting numerous barriers to would-be health care providers that contribute to the high prices and limited access currently set to cripple the American market. While some of these are familiar and even seem natural to most people, some of the ways in which governments act to restrict doctor supply will come as a surprise to many.

Tech advances without single payer undermine care

Geyman 16 – Dr. John Geyman, MD, Professor Emeritus of Family Medicine at the University of Washington School of Medicine, “Does More Technology Bring Us Better Health Care?”, PNHP Blog, 7-25, <http://pnhp.org/blog/2016/07/25/does-more-technology-bring-us-better-health-care/>

It is a common misperception that the U. S. has the best health care in the world, another example of “American exceptionalism.” By constant repetition over many years, this myth has become a meme, a part of our language without regard to its merit. It is assumed by many that our rapid adoption of high technology and high spending on health care must bring

us the best health care. However, as Drs. Elliott Fisher and Gilbert Welch of the Center for the Evaluative Clinical Sciences at Dartmouth Medical School pointed out early on, there are diminishing returns to many of these technological "advances". (1)

Lewis Thomas, a leading analyst of medical progress, saw this coming as early as 1975 when he described these three useful ways of looking at medical technologies:

Nontechnology—non-curative care for patients with advanced diseases whose natural history cannot be changed (e.g. intractable cancer, advanced cirrhosis).

Halfway technology—also care that is non-curative but may delay death (e.g. liver or heart transplants).

High technology—curative treatment or effective prevention techniques (e.g. polio vaccination). (2)

Unfortunately, most of our technological advances are of the halfway non-curative type, since they are often overused at great expense, this presents society a challenging task to manage their adoption in a cost-effective way.

How More Technology Does NOT Bring Us Better Health Care

These are some of the factors that undermine the quality of care in our profit-driven corporatized health care system:

Medicalization of preventive and therapeutic services, which are then promoted by direct to consumer advertising.

Examples abound, including widespread use of full-body CT scans as a screening procedure without approval by either the FDA or the American College of Radiology (3), and MRIs in completely asymptomatic patients finding "abnormalities"—one study found that one-half of young adults were found to have lumbar disc bulge without any back pain. (4)

Early adoption of technologies without adequate testing. Adverse events in robotic surgery give us one example. Between 2007 and 2013, more than 1.74 million robotic procedures were performed in the U. S., most commonly in gynecology and urology, with 144 deaths (1.4 percent), 1,391 patient injuries (13.1 percent) and more than 8,000 device malfunctions (75.9 percent). (5)

Corporate-friendly regulators. As one example, a large part of the budget of the FDA comes from user fees from the pharmaceutical and medical device industries, which are constantly pushing the FDA for earlier, accelerated approvals of their products. As a result, many products and procedures have to be withdrawn from the market as their harms become obvious, with these decisions often delayed by their manufacturers (e.g. withdrawal of morcellators for the treatment of uterine fibroids). (6)

Although many technological advances have been of great benefit to individual patients and society, such as replacement of hips and knees, coronary bypass surgery, and cataract surgery with prescription intra-ocular lens replacement, there are downsides to the rapid adoption of new technologies as well.

Despite our emphasis on technology, comparative studies of eleven health care systems around the world show how poorly we rank in terms of access and quality of care. (Table1) (7)

Can Health Care Technologies Be Managed in the Public Interest?

We have to ask why we haven't been more effective over the years in evaluating and regulating the adoption and use of medical technologies. The answer, not surprisingly, is the economic and political power of corporate stakeholders in our market-based system.

Two national organizations were established by Congress in the 1970s—the Office of Technology Assessment (OTA) in 1975 and the National Center for Health Care Technology (NCHCT) in 1978. Both were later abolished after a strong backlash from vested interests, especially the medical device industry and several professional medical societies. (8-10)

The FDA, as our major regulator for evaluation and approval of new health care technologies, has long been handcuffed by political forces preventing comparative evaluations of competing technologies based on required evidence for positive long-term outcomes. It has been underfunded, lacks sufficient authority, and is dependent on the industries it attempts to regulate through recurrent authorizations of user fees—a fox in the henhouse situation. There are many conflicts of interest among reviewers on its panels, and it is not permitted to use cost-effectiveness in its approval process. Health care industries collectively spent \$489 million on lobbying in 2014, about one-half of which was spent by the drug industry in its ongoing effort to gain more rapid FDA approval based on weaker evidence. (11) As just one example, the FDA allowed expanded marketing of off-label cancer drugs in 2009 despite the lack of clinical evidence of their effectiveness. (12)

These problems can be fixed when we come to understand their adverse impacts on patients, families and taxpayers, develop the political will to confront the power of corporate interests in the status quo, and enact legislation for universal access through single-payer national health insurance, together with a stronger science-based regulatory system free from lobbying and political interference.

Taxes Disadvantage Answers

Taxes won't hurt the economy because the \$ would have otherwise been spent on health care

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Overall then, as Table 18 shows, our bottom-line figure for all existing public funding sources available to finance Medicare for All is \$1.88 trillion (rounded down from \$1.884 trillion). This figure includes, again, 1) all available public insurance funds; 2) funds now provided for other public third-party payers; and 3) federal tax subsidies as well as health insurance spending on federal government employees. Given our estimate that the costs of providing universal coverage under Medicare for All would be \$2.93 trillion in 2017, we can then conclude that, for the U.S. economy as of 2017, we would need to raise an additional \$1.05 trillion in new taxes to fully fund Medicare for All. We show our simple derivation of this figure in Table 19. Of course, these new tax revenues would not constitute a net additional cost or spending burden on the U.S. economy. These funds would rather be serving to substitute for the loss of revenue into the U.S. health care system that presently come from existing private revenue sources— i.e. primarily private health insurance and out-of-pocket expenditures. These private revenue sources would no longer operate. We explore the net effects of this shift in spending sources later in this chapter. First, however, we consider measures for raising \$1.05 trillion in revenues within the U.S. economy as of 2017.

Answers to: "Increased Costs"

Universal care creates many paths towards savings. Any small increase in costs is justified

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

This rule of double effect could help to resolve dilemmas created by conflicting goals of health care policies. Ideally a health care system would provide the good effect of universal access without incurring a bad effect of increased cost. Containing costs is the rationale for many strategies of reform. Among them are (a) reducing fraud and waste in the health care system; (b) curtailing the inflationary rise in prices of pharmaceuticals (price controls); (c) imposing efficiencies in the delivery system obtained as benefits of information technology; (d) relying upon evidence-based practices that are more cost-effective; (e) reducing administrative costs resulting from duplications of underwriting, billing, claims processing services and excess marketing and lobbying by hundreds of private health plans and insurance companies; (f) excluding for-profit corporations from involvement in the health sector; or (g) limiting extravagant executive compensation and/or inflationary increases in providers' fees and hospital prices. All of these strategies could save billions of dollars sufficient to pay for the expansion of health insurance to cover all Americans. There have been several estimates of substantial savings in administrative costs alone that would result from a national single-payer system compared to the present private-public system in the United States (Himmelstein, Woolhandler, & Hellander, 2001; U.S. GAO, 1991a, 1991b; Woolhandler, Campbell, & Himmelstein, 2003; Woolhandler & Himmelstein, 1991, 1997, 2002). Opponents of universal health care challenge the estimates of cost savings, and they project substantial increases in costs of health care particularly under a publicly financed, single-payer plan. Nevertheless, according to the rule of double effect, if increased costs of a universal health care policy were foreseen, these cost increases could be permitted, though not intended because (a) the policy itself is good (providing universal access to health care is beneficent, utilitarian, and fair); (b) universal coverage is the good effect intended, not increased cost; (c) the increased cost is not the means to universal health care, but the effect of the above mentioned cost saving strategies; and (d) the good effect (universal health care) outweighs the bad effect (if costs increase). This line of reasoning is an example of applying the ethical rule of double effect. Of course, to be responsible one must estimate the cost increase associated with such "a health policy, plan how to pay for the additional costs, and estimate whether these costs can be contained over time so the program of universal health care is fiscally sustainable. Moreover, given a limited budget, the opportunity costs of policies must be considered. That is, one must assess what other social goods might be limited by increased health care expenditures (e.g., education, police, fire, and environmental protections, safe bridges and roads, employment, investments in economic growth, etc.) "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3434-3438). AuthorHouse. Kindle Edition.

Universal care encourages prevention, increasing cost savings

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

This observation does not abrogate individual responsibility, but it tempers a judgmental attitude that would lead to denial of their rights as citizens to medically necessary care. Acknowledging the shared responsibility leads to a recommendation of prevention as a goal and task for individuals, and as an essential element of public policy. Both prevention through public health initiatives and primary health care in our health care system would reduce overall costs substantially by limiting misuse and overuse of medical services. Unfortunately, in the present pluralistic market of payers and plans, there is a disincentive to emphasize prevention and health promotion because employers and their employees change health plans, hence the long term cost savings implemented by one health plan may end up benefitting another competitor (Power, 2011). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 6378-6381). AuthorHouse. Kindle Edition.

Based on the major standards of justice—treating people fairly, ensuring civil, natural, and moral rights, and distributive justice—the inescapable conclusion is that the U.S. health care system is unjust (Adler, 1981, pp. 186f, esp. p. 189). Its denial of the human right to medically necessary care also makes the American health care system harmful, immoral, and inhumane. I have discussed three concepts of justice that support universal health care: A utilitarian theory (chapter six), fairness-based justice (chapter seven), and rights-based justice in this chapter. The latter has been discussed in terms of both civil rights, natural (human) rights and moral rights, including the rights to social insurance and to a decent minimum of medically necessary health care. An implicit premise of all three types of arguments is that we have a duty to be just. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 6384-6389). AuthorHouse. Kindle Edition.

A2: Private Health Insurance Encourages More Care/Good to Encourage More Health Care

It doesn't help and makes death more likely

Leo Chan, Assistant Professor of Finance Department of Finance and Economics Woodbury School of Business, Utah Valley University, September 2010, It is the moral obligation of the state to provide basic health care for its citizens, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1578548 DOA: 6-26-16

Are patients getting healthier for all the additional medical procedures they receive and is the rapid growth in medical technology in-line with cost increases? Skinner, Staiger and Fisher (2006) show that while there was a brief period where increases in medical costs as a result of improvement in medical technology was worth the added cost, but that has not been the case since 1996. Fisher, Goodman, Skinner and Broner (2009), and Goodman and Grumbach (2009) show that more money spent on health care isn't necessarily better for the patients. A student of economics will know the law of diminishing returns: the value of an additional unit of good provides a lower benefit than the previous unit. The same law applies in most area of health care technological improvements. In fact, patients are more likely to die as more medical procedures are performed on them. A common practice that had been used to "cure" back pain called spinal fusion is found to have the same effect of a sugar pill. Yet more than \$17 billion had been spent in 2004 alone and caused more harm to patients (Tosteson et al. 2009). Perhaps the worst offended is the drug companies. The bar for patenting a new drug is set so low that a drug company can simply combine two drugs and create a new patent right that would protect the premium drug status. Adding a timed-release component to the drug is another way a patent can be extended. Furthermore, the so called "significant" improvement bar is set so low that a drug company doesn't really have to improve the quality of life for a patient that much in order to get a new drug approved. For example, a cancer drug that extends the life of a terminally ill patient by 30 days or more could count as significant improvement. It doesn't mean the patient can move around freely or go

home and spend time with family. It just means that the patient could be breathing another 90 days or more in a hospital bed, all the while adding about \$100,000 to \$200,000 to the medical bills to the patient's insurance company.

People in Hong Kong spend less on health care and live longer

Leo Chan, Assistant Professor of Finance Department of Finance and Economics Woodbury School of Business, Utah Valley University, September 2010, It is the moral obligation of the state to provide basic health care for its citizens, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1578548 DOA: 6-26-16

To see just how inefficient the US health care system is, let's look at Hong Kong. Hong Kong spends less than 8% of its GDP on health care (it has universal health care), produces a lot less knee, hip replacement and heart surgeries. But the people in Hong Kong are much, much healthier than the people in the US. Old people in Hong Kong exercise in the parks in the morning and in the evening. They have a much higher quality of life than their counterpart in the US. Yet, they spend only half as much on health care (Sutherland, Fisher and Skinner, 2009).

Link Turn – Debt

Employer-Based Health Insurance Bad

Insurance based system unfair to those who become unemployed

Leo Chan, Assistant Professor of Finance Department of Finance and Economics Woodbury School of Business, Utah Valley University, September 2010, It is the moral obligation of the state to provide basic health care for its citizens, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1578548 DOA: 6-26-16

Another unfair factor in the current employer sponsored health care insurance is that it is unfair to people who lose their job at a later part of their life, just when they need insurance the most. For example, if a person coming out of college at age 22 works for the next 40 years, but then at age 62, the economy experiences a deep recession like the one we currently experiencing; or the person's company files for bankruptcy (like most of the automakers); or the person loses his/her job, what happens? For the first 40 years, the employer contributed to the person's health care insurance in which the person utilized very little. There is a large build up of excess premiums for the first 40 years. This person anticipates drawing down that excess premium as he/she ages. But that could only happen if the person has a job until retirement, and the company is still around

Free Market Answers

Free market fails

Singer 17 – Lawrence Singer, Associate Dean, Online Learning; Director, Beazley Institute for Health Law and Policy; Associate Professor of Law., Spring 2017, “Health Care Is Not a Typical Consumer Good and We Should Not Rely on Incentivized Consumers to Allocate It,” 48 Loy. U. Chi. L.J. 703, Lexis

Introduction Many believe that health care is, or should be treated as, a "typical" economic good.¹ As such, its delivery and distribution should be governed by "standard economic theory,"² in the context of a "free"³ or [*704] "competitive"⁴ market.⁵ While each of these terms means something different, all of the terms share one characteristic: the primacy of consumers having "complete" or "perfect" knowledge of the good being sold.⁶ This knowledge is related to the "value" of the good - its price and quality - so that consumers can make informed choices.⁶ Even a cursory review of the attributes of the health care market, however, raises serious questions as to whether consumers have, or can ever have, the knowledge necessary for a competitive market to work in health care.⁷ Medical care is complicated, and insurance policies are dense documents. And because we habitually minimize risks that we cannot, or would rather not, contemplate,⁸ in a moment of need and [*705] vulnerability, the last thing one wants to do is negotiate prices pursuant to those dense and complicated documents.⁹ Of course, this is not to imply that the current health care market is working - at best, the market is characterized as a strange mixture of competition and "command and control" that is lacking in transparency.⁹ Prices continue to rise;¹⁰ consumers still find the individual insurance market challenging to navigate;¹¹ many individuals still lack high-quality, accessible health care services;¹² and many common measures of public health in the United States rival those of third world countries.¹³ Still, there is a worry that the current movement toward more fully embracing competition as the means to allocate health care services is fraught with peril. Wrong choices made by patients acting as consumers [*706] lead to delays in accessing services. Even further, some companies may capitalize on the fact that these patients-consumers make wrong choices and might not thoroughly consider all options by incentivizing avenues of care that may be suboptimal with enormous consequences.¹⁴ This Essay advocates that health care should not be treated like any other good and that the vagaries of a competitive free market should not be the approach to achieve health care's so-called "Triple Aim": high-quality, low-cost, accessible health care.¹⁴ This Essay's concerns about the role of competition are further heightened given the current movement toward "consumer directed"¹⁵ or "defined contribution"¹⁶ health care - the idea being that consumers should be empowered to make cost/benefit choices on their desired (if any) type of insurance coverage and then fully bear the implications of those choices. This is very much a competitive market approach, as it assumes that the industry must empower consumers to make self-interested choices to improve quality and reduce the cost of health care. In this defined contribution world, employers will no longer provide health care insurance to workers,¹⁷ but rather will provide a fixed amount¹⁸ of money that an employee can deposit into a health savings account¹⁹ - along with the employee's own money - to pay health care expenses.¹⁸ Coupled with a high-deductible health plan, whereby the employee is required to pay a minimum deductible of \$ 1,300 (individual) and \$ 2,600 (family) for catastrophic health care coverage,¹⁹ this "skin in the game" is designed to interject a degree of value consciousness into health care purchasing to parallel any other consumer good.²⁰ In considering the impact of this expansion of consumer-directed health care and its increased cost-sharing obligations, one must realize that insurance is not just a payment mechanism, but rather the key to entering the health care marketplace. Health care services are expensive, and few can afford a

long course of treatment without insurance coverage. 21 While private hospitals have a legal obligation to provide care, this only arises in the context of an emergency or a possible urgent [*708] condition. 22 Private physicians, pharmaceutical companies, and many other health care providers have no legal obligation to provide services or products for free or reduced costs. Therefore, one must present an insurance card within five minutes of visiting a physician. By design,

pulling back the scope and level of coverage will cause patients-consumers to consider their need for care. While to some extent, benefit levels and cost sharing have always impacted health care access, the higher level of cost sharing brings affordability of health care to a point where patients-consumers cannot access essential services because patients-consumers are considering the costs of their health care before the service is rendered.

Not only has defined contribution thinking taken sway amongst private employers, 23 but it appears to be gaining headway in possible Medicare and Medicaid program reforms. While the views of President Trump's administration continue to be unclear, 24 House Speaker Paul Ryan calls for the implementation of Medicare vouchers, which would enable beneficiaries to shop the private insurance market for the type of coverage they would prefer. 25 And some state Medicaid programs, such as [*709] Arkansas, 26 implemented a version of Medicaid vouchers in addition to the Centers for Medicare and Medicaid Services ("CMS") approving similar programs in Iowa, Indiana, Michigan, and Pennsylvania. 27 Given the significant cost savings associated with a defined contribution approach, the idea is likely to gain even further sway. 28 This Essay argues that Overall reliance on competition and free market thinking (particularly value-incentivized consumers) to achieve an appropriate, fair allocation of health care services will cause significant harm to many people.

In arguing this proposition, this Essay focuses specifically on the lack of transparency in health care; this lack of transparency means that the sine qua non of a free market - educated, self-interested consumers - is lacking. This Essay also contends that the free market approach will not work because it ignores the reality that invariably society will intercede to "rescue"

individuals who made poor choices regarding their scope of insurance coverage, ultimately increasing the cost of every other patient-consumer's health care services. 29 Finally, reliance on this approach [*710] serves to further erode the social compact where everyone should be entitled to the basic building blocks of life to make their way in the world. 30 I. Health Care Lacks Transparency The health care industry is not transparent with respect to price or quality, 31 and its primary beneficiary - the patient - often lacks the capability and capacity to make informed choices. 32 Because an informed consumer able to make value judgments is lacking, the very foundation necessary for a competitive market to work is absent, causing the market to fail. The lack of transparency regarding the quality and price of health care [*711] services has been long known and lamented. 33 And there is a legitimate concern that this lack of transparency will create severely detrimental consequences in the new world of limited health insurance.

34 The nature of health insurance is changing: health plans are minimizing coverage and consumers can expect to bear more of the cost of care and to comparison shop cost and quality to a degree never expected. Invariably, these burdens will result in choices to delay care or seek less competitive, lower-quality options, causing harm. 35 The lack of transparency in large part results from health insurance historically shielding beneficiaries from the full cost of care. 36 Thus, unlike other types of common insurance where coverage is purchased for catastrophic events and rarely used, health insurance has traditionally been designed for the patient-consumer to pay for low-risk, often-encountered occurrences.

While society may not agree that everyone has a right to health care, 37 insured individuals seem to agree that this right [*712] exists, because once coverage is secured, they often immediately seek health care services. 38 Indeed, while an important part of the difficulty in pricing insurance products on the exchanges is the lack of younger, healthier individuals opting into the market, 39 another significant factor is the higher-than-expected utilization of services as newly covered individuals seek (presumably delayed) medical care. 40 Government and private insurers have largely focused their efforts on cost containment, giving much shorter shrift to quality. 41 The Institute [*713] of Medicine's 2000 report, To Err Is Human, 42 sounded a clarion call on the poor quality of health care services - likening the number of deaths caused by provider error to a daily crashing of a Boeing 747. 43 Sixteen years later, however, it is fair to say that quality initiatives are still at a fairly basic level of development and implementation. 44 Consumers are traditionally shielded from cost and have focused little on quality. Because of this shielding, there is little consumer demand for tools to assist consumers' assessment of quality providers. 45 [*714] Widespread disparities relating to price and quality, seemingly unhinged from outcomes, are rampant. 46 For many years, the Dartmouth Atlas highlighted significant treatment differences in a wide variety of health care procedures, including tonsillectomies, coronary, stents, and hip fractures - all with no discernable link to quality. 47 Researchers long ago concluded that physician training and practice patterns were responsible for care variation, and that if the nation adopted best practices, then savings associated with standardized approaches would be [*715] immense. 48 Serious efforts at the federal, state, and private levels are underway to provide consumers with quality and price information to enable intelligent choices.

For example, on a federal level, CMS' Quality Initiative provides consumers with quality-of-care information and provides the Hospital Compare 49 online platform for consumers to research hospital quality, patient satisfaction, and pricing. 50 In addition, the Patient Protection and Affordable Care Act ("ACA") allotted \$ 250 million in state funds for the improvement of price transparency and requires CMS to make standardized extracts of Medicare claims available for provider

evaluation. 51 States (e.g., Massachusetts and New Hampshire) 52 have also led the charge to provide information to consumers. 53 Massachusetts pioneered with its October 2013 legislation, which required insurers, physicians, and hospitals to provide health care consumers with the costs of health care procedures ranging from office visits at a primary care provider's office to surgical procedures. 54 In [*716] 2005, New Hampshire passed legislation that created the New Hampshire Comprehensive Health Care Information System, and mandated the creation of an all-payer claims data base ("APCD") and a consumer-friendly public website. 55 This information system collects provider data from a broad array of providers and services, and the New Hampshire APCD lists total and out-of-pocket costs for consumers. 56 Private insurers have also moved to empower consumers. For example, Blue Cross Blue Shield of Illinois provides detailed information on comparisons of in-network versus out-of-network provider services, ranging from CT scans to preferred brand drugs for certain medical conditions. 57 All of these initiatives are supported by incentivizing consumers to focus more deeply on the quality and cost of their care through increases in their out-of-pocket health care expenditures. Even if a consumer wishes to secure price and quality information, however, their ability to appropriately interpret this data may be rudimentary at best. 58 And, in many cases involving elderly, vulnerable, or frail individuals, the expectation of seeking and interpreting data may be completely unreasonable. [*717] To date, for example, leading quality indicators used by the federal government to determine value-based Medicare payments include percutaneous coronary intervention ("PCI") received within 120 minutes of hospital arrival, thrombolytic agent received within thirty minutes of hospital arrival, and ACE Inhibitor or Angiotensin Receptor Blocker for Left Ventricular Systolic Dysfunction and Beta Blocker prescribed at discharge for a heart attack. 59 These particular measurements, however, have very little resonance with consumers desiring to learn the quality reputation of potential providers whose care they may solicit. 60 "Star" ratings, on a one-to-five scale, are more meaningful as they distill a multiplicity of factors in a consumer-friendly manner. 61 But even these ratings may capture areas of little or no concern to a particular consumer, or oversimplify issues causing the rating to be misleading. And, ratings may fail to equalize across patient characteristics, thus incorrectly identifying providers as substandard, for example, because

[*718] their patient population is sicker and consequently more prone to poorer outcomes. In sum, meaningful measures of value are lacking in the health care arena. Serious questions also arise regarding consumers' abilities to correctly interpret the available data so as to make reasonable choices impacting their access to quality care.

II. There is no Available Proxy having an Interest Unified with Consumers to Evaluate Quality and Cost Data If we grant the notion that consumers may not be able to possess the knowledge necessary for a free market in health care to function, we might next look to see if there is an available agent, or proxy, able to fill this role on consumers' behalves. Logical agents include the government (in the case of Medicare and Medicaid beneficiaries), private insurers, or employers. And yet, the same tangle of relationships responsible for the regulatory burden and confusing incentives rife within health care come to the fore here. 62 The government certainly has mixed incentives that may not give patient interest its deserved primacy. While there are many regulations focused on care quality, at their root, Medicare and Medicaid are insurance programs that have a goal of cost containment. 63 While higher [*719] expenses, of course, do not necessarily equate with higher quality, neither are the two concepts divorced. Thus, the potential competing motivators of cost control and quality enhancement may cause these programs to not always align with patient interests. 64 Private insurers have the exact same issue. The tension between cost and quality in insurer goals is readily apparent in numerous lawsuits over many years. These lawsuits challenged the propriety of payment incentives on physician behavior, where insurers were accused of corrupting physician judgment by compensation formulas incentivizing less, and lower-quality, medical care. 65 The ACA further highlighted this tension by limiting the "medical loss ratio" - the portion of the insurance premium spent on insurer administrative expenses - to 20 percent. 66 In addition, given the high degree of turnover within an insured population, [*720] insurance companies take a decidedly short-term perspective on patient outcomes, often in conflict with a patient's long-term perspective on their health. 67 And, of course, insurance companies function by carefully defining, and thereby limiting, the financial risk they assume, so transferring risk to consumers by definition benefits the insurer. Finally, for many of the reasons articulated above regarding the government and insurers, employers too seem conflicted in their allegiance to access and health care quality. 68 Thus, the industry lacks a proxy with a unified interest with consumers. There is no unbiased, credible party able to make value judgments on behalf of patients-consumers. III. Relying on the

Market to Allocate Health Care Is Wrong As the industry continues to move toward a defined contribution era where each patient-consumer is expected to conduct one's own research, balance cost and quality, and shop around, one must remember that not all consumers are equipped to manage these new

responsibilities. The ability to access this type of information, process, and make an intelligent decision requires a level of sophistication that many people simply do not possess. 69 Further, unique aspects of an individual's medical condition may render it difficult for patients to properly evaluate competing criteria in a manner that facilitates free market choice. 70 [*721] Because of the highly personalized nature of health care services, the influence of procompetitive forces may actually cause harm to a patient. A patient may gravitate toward an option based on inappropriately weighing the cost of the service, without sufficiently considering the likely outcomes from a quality of life perspective. 71 Finally, even if one wants to assume that an educated consumer can make informed choices in a competitive market, the attendant costs associated with this assumption may be hard to swallow. Externalities abound in health care, as one's health status can have a significant impact on others. Individuals unable to pay for their care may be able to hold off on certain types of medical care for some time, but this often leads to very serious, more expensive consequences. 72 From both an ethical and legal perspective, the industry is not going

to deny care to individuals presenting in an emergent situation, even if there is no payor and the cost is high.⁷³ In the end, however, the nation does not want individuals inflicting the social cost of their care - public health issues, accidents, and the like - on society merely because they were unable to make informed health care choices.⁷⁴ Even if we adopt a view of "buyer beware" - leading to high incidences of medical debt - this, too, has significant costs on society. In the end, delayed care is likely to be provided, but at a cost to society higher than might have been borne if it had been provided when first [*722] needed. It is simply unimaginable that there will be an ethos amongst our caregivers, health care institutions, and the public that will accept otherwise. There certainly is a place in health care for a consumer focus on cost and quality. An educated consumer is a good thing. We need to be mindful, however, that we do not attribute to the market a sophistication that it lacks when it comes to allocating as essential a service as health care.

Free market is a terrible idea for healthcare

Gaffney et al 16 [Adam Gaffney, Division of Pulmonary and Critical Care Medicine, Department of Medicine, Cambridge Health Alliance. Philip Verhoef, Section of Pulmonary and Critical Care Medicine, University of Chicago. Jesse Hall, Section of Pulmonary and Critical Care Medicine, University of Chicago.] "Rebuttal From Drs Gaffney, Verhoef, and Hall" Chest, Volume 150, Issue 1, July 2016, Pages 14–15 (<https://doi.org/10.1016/j.chest.2016.02.661>) - MZhu

Dr Berdine 1 argues that in an unhindered competitive health-care marketplace, the market will clear at a price and quantity of goods/services that, as if by definition, leaves all parties maximally satisfied. This argument is little more than a tautology that would, if possible, result in a health-care dystopia that society would not accept. Low-income individuals might "choose" to spend their money on food instead of asthma inhalers. By Dr Berdine's logic, this scenario is as it should be, and any intervention by government would only make things worse. Those dying of status asthmaticus might beg to differ, if they were able, as might patients with hypertension who suffer strokes because they elected to cover their rent instead of paying for physician visits

He argues that government involvement in the health care realm has "priced health care beyond the reach of the average person."¹ It is a rather curious point, because the United States already has a relatively privatized and unregulated health-care system (compared with other high-income nations) while also having the highest costs.² Furthermore, \$375 billion of our expenditures can be attributed to wasteful administrative costs associated with our multipayer insurance market.³

Dr Berdine 1 does make a good point when he notes that government-granted patent monopolies can result in high drug prices. To address this issue, a single-payer national health program would directly negotiate with pharmaceutical companies over drug prices. Indeed, the Veterans Health Administration pays 40% less for prescription drugs compared with Medicare, indicating that substantial cost-savings could be achieved by facilitating such negotiations.⁴

A free market for health care is not only undesirable: it is, as economists have noted for decades, a fantasy. Fundamentally, the degree of information asymmetry between the buyer (the patient) and the seller (the provider) prevents health care from conforming to the theoretical tenets of free-market

economics. Kenneth Arrow famously contended that the uncertainty intrinsic to health care makes it unique from other goods and services.⁵ The health economist Bob Evans has argued that not only has there never been a pure free market in health care but that “inherent characteristics of health and health care make it impossible that there ever could be.”⁶ On the contrary, he argues, attempts to inject market mechanisms into health care are fundamentally about redistribution. As health-care costs are shifted from public to out-of-pocket sources, those with higher incomes invariably benefit.

The US divergence from other high-income nations is a disaster. We contend with uninsurance and underinsurance, a lack of coverage for critical benefits, worse outcomes, and higher overall costs. As others have noted, the savings made possible through a single-payer system⁷ would allow extension of health care as a social right to the entire nation. In contradistinction with a fantastical health-care free market, such a program is both attainable and desirable

Free-market fails in healthcare

Frankford and Rosenbaum 17 [David M. Frankford is a specialist in bioethics and health care law, a professor at the Rutgers Institute for Health, Health Care Policy and Aging Research, faculty director at Camden of the Center for State Health Policy and the editor of Behind the Jargon at the Journal of Health Politics, Policy and Law, having previously served as book review and associate editor. Sara Rosenbaum J.D. is the Harold and Jane Hirsh Professor of Health Law and Policy and Founding Chair of the Department of Health Policy at the Milken Institute School of Public Health, George Washington University. She also holds professorships in the Trachtenberg School of Public Policy and Public Administration and the Schools of Law and Medicine and Health Sciences.] “Taming Healthcare Spending: Could State Rate Setting Work?” Rutgers Law School and George Washington University, Milken Institute School of Public Health Issue Briefs, March 2017
(<http://www.cshp.rutgers.edu/publications/taming-healthcare-spending-could-state-rate-setting-work>)
- MZhu

This effort to use markets to control spending faces numerous obstacles because it is widely recognized that health care markets deviate substantially from more ordinary markets, even relatively complex ones that produce custom products. If health care markets fail, then their use cannot control expenditures. Six features of health care markets, discussed below—and many of which overlap—contribute to this failure.

1. Heterogeneity everywhere. Compare the purchase of eyeglasses to health care.³ There are many distinctive features to different eyeglasses: size, shape, color, material, texture, weight and brand names (like fancy designers). Ordinary people, looking for eyeglasses, can easily discern these features and have much or all of the necessary knowledge to make educated choices among them; and shoppers can try eyeglasses prior to purchase simply by putting them on. Eyeglasses are relatively “homogeneous” and quintessentially “shoppable.”

By contrast, health care goods and services are most often extremely “heterogeneous.” A multitude of possible treatments exist for any given “condition”—e.g., for back pain, one might buy different furniture, use aspirin, use an NSAID like ibuprofen, try physical therapy, or be given multiple surgical options. Moreover, a “condition” can be treated in a multitude of ways in different persons—e.g., compare stroke treatment in an otherwise healthy and active 45-year-old man (with a family history) to treatment for a 75-year-old woman who is institutionalized quite often but otherwise lives alone on the

third floor of a building without an elevator, and who also has hypertension and diabetes and moderate congestive heart failure. Finally, there is often vast variation in the price and quality offered by different providers. Purchasing in the face of such a huge number of contingencies and options is extremely difficult at best, especially for laypersons who know only that they need care.⁴

2. Dependence and agency. To make even relatively rudimentary choices in treating complex, high-cost conditions, patients need expertise, but they are not experts. They might know something is wrong—being tired, feeling a lump, experiencing pain and so on—but they don't know what the problem is (if they even know that a problem exists). Furthermore, one's condition—purposely put in quotes above—cannot be known without diagnosis. To even know which of the multitude of different goods and services are needed, one needs to know the diagnosis before sorting through the options. To diagnose and treat most illness, therefore, patients need experts, aka “agents,” but they are dependent on those agents because they don't know what the experts know. This problem is referred to as “**information asymmetry**.”

Necessarily, the problem arises, “How am I to choose an agent if I am not an expert?” Below we discuss the possibility of using insurers or employers, sophisticated buyers, as agents, but here we focus on consumers’ directly making choices among providers.

One way for consumers to overcome their ignorance is to try a product before choosing, as in our eyeglass example above. Most often, however, consumers don't know what they need and therefore what they should try. Moreover, one cannot try a service in advance of the production of a service. One can't try a surgeon without having surgery. The simultaneous production and consumption of health care makes such a strategy quite perilous.

Some health economists argue that providing consumers with information directly will lead to less reliance on agents. However, the dependence on agents stems from much more than lack of expertise. Patients are vulnerable not just because of their lack of knowledge but because they are necessarily emotionally involved. For this reason, some type of agent becomes essential, given the impossible task of choosing when one is sick and vulnerable. The necessary decisions do not resemble the discretionary purchase of a high-end television; it is selecting among costly approaches with unknown effects, for conditions whose true nature might not even be understood and the consequences of which can be disability or death.

The extreme heterogeneity coupled with the lack of consumer wherewithal to navigate among options (with perhaps limited exceptions for relatively discretionary health purchases that entail information that can be used by lay people) means that very few services are “shoppable.” A recent definition of “shoppable” is the following: “For a health care service to be ‘shoppable,’ it must be a common health care service that can be researched (‘shopped’) in advance; multiple providers of that service must be available in a market (i.e., competition); and sufficient data about the prices and quality of services must be available” (Frost and Newman 2016). One recent study has estimated that at most roughly one-third of total expenditures on health care are for shoppable services (White and Eguchi 2014).

Even for those services, consumers will shop only if the amount of their “skin in the game” makes the effort worthwhile. Insurance with first-dollar coverage obviously makes nothing worth shopping, while complete lack of insurance makes much, much more shoppable. A recent study from the Health Care Cost Institute examined employer-provided insurance from 2011 and reached the following conclusions

again as maximums: (1) of the \$524.2 billion in expenditures, 43 percent, \$225.4 billion, was spent on shoppable services; (2) 15 percent of total expenditures were out of pocket; and (3) only \$37.7 billion, 7 percent of total out-of-pocket expenditures, was spent on shoppable services (Frost and Newman 2016). The take-away is that unless out-of-pocket costs are very significantly increased—with the limit being complete de-insurance—relatively little is to be gained from consumer shopping.

Moreover, recent evidence shows that even when consumers are given the incentive to shop by the use of high deductible plans, their choices are perverse and their choices don't improve with experience. Consistent with the findings from the RAND Health Insurance Experiment of many years ago, relatively high-income, sophisticated consumers did not respond to the incentives of high deductibles by shopping but instead simply reduced the quantity of their care across the board, failing to differentiate among services that have value from those that did not (Brot-Goldberg et al. 2015). Consequently, consumers chose to forego even high-value care.

3. Shortage of sophisticated purchasers/agents. The situation might be totally different, however, if consumers could rely on sophisticated purchasers as their agents in choosing among providers and in choosing among services. A leading choice for this position is, of course, insurers. However, that just pushes the agency problem back by a degree, because now consumers need agents to pick their insurers as the agents that in turn pick their covered providers and treatments. In other words, consumers lack the knowledge or information to pick their insurer agents (who pick their providers as agents) because consumers lack the needed knowledge—much less the information—to choose this agent.

The evidence that this problem exists—regardless of how consumer-friendly mechanisms like the ACA Marketplaces are made—is more than substantial. Numerous studies show that even relatively sophisticated persons choosing among insurance products get overloaded by too many choices and too much information, and they lack even rudimentary understanding of basic features of insurance products such as coinsurance, deductibles and networks (e.g., Bhargava, Loewenstein, and Sydnor 2015; Loewenstein et al. 2013).

For the most part in the United States employers have been the dominant agents shopping for insurance for their employees. However, this solution has proved inadequate for a number of reasons. First, the employer system leaves out millions, who in turn depend on public programs such as Medicare and Medicaid to act as their agents. Furthermore, employer-provided insurance and the segment of the population it covers has been declining. At its zenith in the late 1970s and early 1980s, employer-sponsored insurance covered approximately 70 percent of the non-elderly population (e.g., Gabel 1999, 65). Since then there has been a relatively steady march downward, with coverage of the non-elderly population falling as low as 58.4 percent in 2011 during the Great Recession but rebounding to, and possibly stabilizing at, 60 percent in 2013-2014 (Fronstin 2015b, 7).

Moreover, even when employers sponsor insurance, huge variation exists in terms of their incentives or capacity to serve as adequate agents for their employees. To function as agents, employers must be willing to invest in their employees, which means that in order to benefit from that investment they must have expectations of a fairly stable workforce (e.g., Fronstin and Helman 2003). These incentives vary across sectors of the economy and employers within one sector may have different incentives depending on such factors as firm size, the size, mixture and age of a firm's workforce, and local labor market conditions (e.g., Buchmueller, Carey, and Levy 2013; Christianson and Trude 2003; Fronstin

2007; Moran, Chernew, and Hirth 2001). Thus, even among many employers offering insurance, incentives are relatively short term (e.g., Adams and Salisbury 2014); what may be good for the employer may not be good for employees over the long run.

Large employers and employer coalitions engage in serious efforts to understand their employees' preferences and incorporate those preferences into plan designs (Peele et al. 2000). By focusing on dimensions of care like quality and satisfaction, instead of just on their own bottom line, these plan sponsors have acted as "responsible purchasers" (Lo Sasso et al. 1999) when they arrange for insurance or buy care directly from providers (e.g., Eggbeer, Morris, and Sukenik 2016). However, most employers lack this incentive or capability, particularly as scale decreases (e.g., Cebul et al. 2011; Rosenthal et al. 2007), and most workers are not employed by the large firms that have the capacity—technical skill and market power—to control expenditures. As a result, most employers have little choice but to turn to tools developed by the insurance industry itself to hold down premiums—high deductible plans and narrow networks—simply to cut their expenditures.

4. Fragmentation among payers. This then brings us to the most important point, the extreme fragmentation of the financing system. With more than one million health plans sponsored by private employers, thousands of plans sponsored by public employers, thousands of Marketplace plans, 51 state Medicaid programs, nearly as many CHIP programs, and Medicare, payment is fractured and lacks more than minimal cooperation despite efforts by some states and CMS to begin to develop multi-payer initiatives.

Even if these initiatives are successful to some degree in controlling expenditures—and the evidence so far is not very promising (e.g., Dale et al. 2016)—they remain few in number and, moreover, they are voluntary, relying on governments' enticement of private parties rather than a direct exercise of state power by such means as rate setting.

Thus, almost universally every payer fends for itself and has incentives with regard only to the insurance pools for which its plans are responsible. As discussed above, even a payer as large as Medicare attends only to its budget, obligated from its inception to pay only its "fair share" of costs. No payer has the incentive or capability to control expenditures overall. Instead, payers—and risk-bearing providers too—most often take a path of least resistance, which is to reduce expenditures by pushing risk and cost to someone else, rather face down powerful interests, overcome problems of collective action or challenge an organization's fundamental way of doing things (e.g., Evans 1990; Marmor 2010). Externalities abound.

This (non)system of payment stands in stark contrast with those of other wealthy democracies, which accomplish risk pooling using government sponsorship or governmentregulated social organizations (or both), thereby creating systems grounded in social solidarity and social security. In Western Europe, with its strong tradition of solidarity and mutual aid, the risk of illness is pooled in the sickness funds, which cooperate voluntarily and with varying degrees of state coercion in collecting revenues, spreading risk, and paying providers. In national health system countries, like the United Kingdom and the Scandinavian countries, national governments unite all citizens into a single risk pool. In Canada, Canadian Medicare brings the population together into the risk-pooling systems of the provinces and territories, with some degree of federal subsidization. All advanced, industrialized countries socialize the

risk-pooling function, and they pay with one voice, either as a **single payer** or as coordinated payers
(e.g., White 2013).

Public Health Care Doesn't Destroy Free Trade

General patterns of compliance overwhelm individual violations

Grunfeld 7 – Michael Grunfeld, J.D. Candidate, Columbia University School of Law, “DON’T BET ON THE UNITED STATES’S INTERNET GAMBLING LAWS: THE TENSION BETWEEN INTERNET GAMBLING LEGISLATION AND WORLD TRADE ORGANIZATION COMMITMENTS”, Columbia Business Law Review, 2007 COLUM. BUS. L. REV. 439, Lexis

In response to this decision, the United States can still appeal to the AB. n174 If the final ruling is that the United States is not in compliance, then Antigua can request the imposition of countermeasures against the United States. Ultimately, even if Antigua chooses to pursue countermeasures, these countermeasures against the United States would have little effect on the U.S. economy. n175 However, the United States would face the indirect consequence of the reputational cost of not complying with its free trade commitments. But if this breach is seen as an insignificant exception to a general pattern of compliance, then it likely will not considerably affect the United States's overall reputation in this area. n176

Canada NHI and the ACA thump and disprove the DA – they committed health insurance to GATS and have had zero challenges

Trade doesn't solve war

Miller 14 – Charles Miller, Lecturer at the Strategic and Defence Studies Centre at the Australian National University, “Globalisation and War”, April, <http://www.aspistrategist.org.au/globalisation-and-war/>

John O’Neal and Bruce Russett’s work is perhaps the best known in this regard—and Steven Pinker cites them approvingly in his book The Better Angels of Our Nature. Analysing trade and conflict data from the nineteenth to the twenty-first centuries, they found that trade flows do have a significant impact in reducing the chances of conflict, even when taking a variety of other factors into account. But their conclusions have in turn been questioned by other scholars. For one thing, their model failed to take three things into account. First, it’s quite possible that peace causes trade rather than the other way around—no company wants to start an export business to another country if it anticipates that business linkages will be cut off by war further down the line. Second, conflict behaviour exhibits what’s called ‘network effects’—if France and Germany are at peace, chances are Belgium and Germany will be too. And third, both the likelihood of conflict and the level of trade are influenced by the number of years a pair of countries has already been at peace—because prolonged periods of peace increase mutual trust. Take any of these factors into account, and studies have shown (here and here) that the apparent relationship between trade flows and peace disappears. Perhaps, though, conceiving of globalisation solely in terms of trade flows is mistaken. Alternative indicators of globalisation include foreign direct investment, financial openness and the levels of government intervention in economic relations with the rest of the world. Data on those variables is less extensive than on trade flows, usually dating back only to the post World War II period. But some analysts, such as Patrick McDonald and Erik Gartzke, have argued that a significant correlation can be found between them and a reduction in the probability of conflict. Those findings, newer than O’Neal and Russett’s, haven’t yet been subjected to the same intense scrutiny, so may in turn be qualified by future research. What does all that mean for the policy-

maker? The statistical evidence certainly doesn't tell us that globalisation has made war in East Asia impossible. 'Cromwell's law' counsels us that a logically conceivable event should never be assigned a probability of zero. The most we could conclude is that globalisation has made such an occurrence much less likely. There's some hopeful numerical evidence that globalisation does indeed have that effect, but the evidence isn't so compelling that we can substitute an economic engagement policy for a security policy. By all means, let's continue to promote trade in the Asia-Pacific. But we should also continue to be prepared for scenarios which are unlikely but would be hugely damaging if they were to occur.

Gambling thumps – WTO's first case set the precedent of DSB failure to force compliance – outweighs any link to the aff

US can get HC out of or alter the rules of GATS easily – and dispute settlement costs would be minimal

Reeves 6 Terrie C., assistant professor in health care management at the University of Wisconsin-Milwaukee's School of Business Administration, "International Trade and Health Policy: Implications of the GATS for US Healthcare Reform," *Journal of Business Ethics*, Volume 63, 2006, pp. 313-332

This paper has argued that trade-offs between health policy and trade policy are being mediated within a political and institutional context that favors commercial interests over health priorities. In theory, it would be possible to take healthcare off the GATS negotiating table. In the near term, this could be accomplished in two ways. First, the US could withdraw existing 'specific commitments' in the health insurance and hospital sectors. Although the US would be required to compensate its trading partners for losses if commitments in health-related services are withdrawn, compensation would be relatively small until such time as foreign providers acquire a larger share of the US markets. Secondly, the US could oppose 'necessity testing' in all service sectors – including accountancy, engineering and architecture – during the current GATS negotiating round. A defeat for the first, precedent setting attempt to established WTO 'disciplines' over domestic regulation of professional licensing, regulation and standard setting would limit the WTO powers to intervene in the domestic affairs of member states. These actions, however, would require a major shift in US trade policy, a shift that is not likely to occur in the absence of political demands.

WTO and GATS not key to trade – globalization creates incentives for economic gain

Trade's resilient

Siles 14 – Gabriel Siles-Brügge, Lecturer in Politics at the University of Manchester, "Explaining the Resilience of Free Trade: The Smoot–Hawley Myth and the Crisis", *Review of International Political Economy*, 21(3), Taylor & Francis

Despite the onset of the current economic crisis there has been no significant move towards protectionism amongst most of the world's economies. Although rational institutionalist explanations point to the role played by the constraining rules of the World Trade Organisation, countries have largely remained open in areas where they have not legally bound their liberalisation. While accounts emphasising the increasing interdependence of global supply chains have some merit, I show that such explanations do not tell the full story, as integration into the global economy is not always associated with support for free trade during the crisis. In response, I develop a constructivist argument which highlights how particular ideas about the global trading system have become rooted in policy-making discourse, mediating the response of policy elites to protectionist pressures and temptations. Trade

policy-makers and a group of leading economists have constructed an ideational imperative for continued openness (and for concluding the Doha Round, albeit less successfully) by drawing on a questionable reading of economic history (the Smoot–Hawley myth); by continually stressing protectionism's role as one of the causes of the Great Depression non-liberal responses to the current crisis have been all but ruled out by all except those willing to question the received wisdom.

Free Market Answers

Free market fails

Singer 17 – Lawrence Singer, Associate Dean, Online Learning; Director, Beazley Institute for Health Law and Policy; Associate Professor of Law., Spring 2017, “Health Care Is Not a Typical Consumer Good and We Should Not Rely on Incentivized Consumers to Allocate It,” 48 Loy. U. Chi. L.J. 703, Lexis

Introduction Many believe that health care is, or should be treated as, a "typical" economic good.¹ As such, its delivery and distribution should be governed by "standard economic theory,"² in the context of a "free"³ or [*704] "competitive"⁴ market.⁵ While each of these terms means something different, all of the terms share one characteristic: the primacy of consumers having "complete" or "perfect" knowledge of the good being sold.⁶ This knowledge is related to the "value" of the good - its price and quality - so that consumers can make informed choices.⁶ Even a cursory review of the attributes of the health care market, however, raises serious questions as to whether consumers have, or can ever have, the knowledge necessary for a competitive market to work in health care.⁷ Medical care is complicated, and insurance policies are dense documents. And because we habitually minimize risks that we cannot, or would rather not, contemplate,⁸ in a moment of need and [*705] vulnerability, the last thing one wants to do is negotiate prices pursuant to those dense and complicated documents.⁹ Of course, this is not to imply that the current health care market is working - at best, the market is characterized as a strange mixture of competition and "command and control" that is lacking in transparency.⁹ Prices continue to rise;¹⁰ consumers still find the individual insurance market challenging to navigate;¹¹ many individuals still lack high-quality, accessible health care services;¹² and many common measures of public health in the United States rival those of third world countries.¹³ Still, there is a worry that the current movement toward more fully embracing competition as the means to allocate health care services is fraught with peril. Wrong choices made by patients acting as consumers [*706] lead to delays in accessing services. Even further, some companies may capitalize on the fact that these patients-consumers make wrong choices and might not thoroughly consider all options by incentivizing avenues of care that may be suboptimal with enormous consequences.¹⁴ This Essay advocates that health care should not be treated like any other good and that the vagaries of a competitive free market should not be the approach to achieve health care's so-called "Triple Aim": high-quality, low-cost, accessible health care.¹⁴ This Essay's concerns about the role of competition are further heightened given the current movement toward "consumer directed"¹⁵ or "defined contribution"¹⁶ health care - the idea being that consumers should be empowered to make cost/benefit choices on their desired (if any) type of insurance coverage and then fully bear the implications of those choices. This is very much a competitive market approach, as it assumes that the industry must empower consumers to make self-interested choices to improve quality and reduce the cost of health care. In this defined contribution world, employers will no longer provide health care insurance to workers,¹⁷ but rather will provide a fixed amount¹⁸ of money that an employee can deposit into a health savings account - along with the employee's own money - to pay health care expenses.¹⁸ Coupled with a high-deductible health plan, whereby the employee is required to pay a minimum deductible of \$ 1,300 (individual) and \$ 2,600 (family) for catastrophic health care coverage,¹⁹ this "skin in the game" is designed to interject a degree of value consciousness into health care purchasing to parallel any other consumer good.²⁰ In considering the impact of this expansion of consumer-directed health care and its increased cost-sharing obligations, one must realize that insurance is not just a payment mechanism, but rather the key to entering the health care marketplace. Health care services are expensive, and few can afford a

long course of treatment without insurance coverage. 21 While private hospitals have a legal obligation to provide care, this only arises in the context of an emergency or a possible urgent [*708] condition. 22 Private physicians, pharmaceutical companies, and many other health care providers have no legal obligation to provide services or products for free or reduced costs. Therefore, one must present an insurance card within five minutes of visiting a physician. By design,

pulling back the scope and level of coverage will cause patients-consumers to consider their need for care. While to some extent, benefit levels and cost sharing have always impacted health care access, the higher level of cost sharing brings affordability of health care to a point where patients-consumers cannot access essential services because patients-consumers are considering the costs of their health care before the service is rendered.

Not only has defined contribution thinking taken sway amongst private employers, 23 but it appears to be gaining headway in possible Medicare and Medicaid program reforms. While the views of President Trump's administration continue to be unclear, 24 House Speaker Paul Ryan calls for the implementation of Medicare vouchers, which would enable beneficiaries to shop the private insurance market for the type of coverage they would prefer. 25 And some state Medicaid programs, such as [*709] Arkansas, 26 implemented a version of Medicaid vouchers in addition to the Centers for Medicare and Medicaid Services ("CMS") approving similar programs in Iowa, Indiana, Michigan, and Pennsylvania. 27 Given the significant cost savings associated with a defined contribution approach, the idea is likely to gain even further sway. 28 This Essay argues that Overall reliance on competition and free market thinking (particularly value-incentivized consumers) to achieve an appropriate, fair allocation of health care services will cause significant harm to many people.

In arguing this proposition, this Essay focuses specifically on the lack of transparency in health care; this lack of transparency means that the sine qua non of a free market - educated, self-interested consumers - is lacking. This Essay also contends that the free market approach will not work because it ignores the reality that invariably society will intercede to "rescue"

individuals who made poor choices regarding their scope of insurance coverage, ultimately increasing the cost of every other patient-consumer's health care services. 29 Finally, reliance on this approach [*710] serves to further erode the social compact where everyone should be entitled to the basic building blocks of life to make their way in the world. 30 I. Health Care Lacks Transparency The health care industry is not transparent with respect to price or quality, 31 and its primary beneficiary - the patient - often lacks the capability and capacity to make informed choices. 32 Because an informed consumer able to make value judgments is lacking, the very foundation necessary for a competitive market to work is absent, causing the market to fail. The lack of transparency regarding the quality and price of health care [*711] services has been long known and lamented. 33 And there is a legitimate concern that this lack of transparency will create severely detrimental consequences in the new world of limited health insurance. 34 The nature of health insurance is changing: health plans are minimizing coverage and consumers can expect to bear more of the cost of care and to comparison shop cost and quality to a degree never expected. Invariably, these burdens will result in choices to delay care or seek less competitive, lower-quality options, causing harm. 35 The lack of transparency in large part results from health insurance historically shielding beneficiaries from the full cost of care. 36 Thus, unlike other types of common insurance where coverage is purchased for catastrophic events and rarely used, health insurance has traditionally been designed for the patient-consumer to pay for low-risk, often-encountered occurrences.

While society may not agree that everyone has a right to health care, 37 insured individuals seem to agree that this right [*712] exists, because once coverage is secured, they often immediately seek health care services. 38 Indeed, while an important part of the difficulty in pricing insurance products on the exchanges is the lack of younger, healthier individuals opting into the market, 39 another significant factor is the higher-than-expected utilization of services as newly covered individuals seek (presumably delayed) medical care. 40 Government and private insurers have largely focused their efforts on cost containment, giving much shorter shrift to quality. 41 The Institute [*713] of Medicine's 2000 report, To Err Is Human, 42 sounded a clarion call on the poor quality of health care services - likening the number of deaths caused by provider error to a daily crashing of a Boeing 747. 43 Sixteen years later, however, it is fair to say that quality initiatives are still at a fairly basic level of development and implementation. 44 Consumers are traditionally shielded from cost and have focused little on quality. Because of this shielding, there is little consumer demand for tools to assist consumers' assessment of quality providers. 45 [*714] Widespread disparities relating to price and quality, seemingly unhinged from outcomes, are rampant. 46 For many years, the Dartmouth Atlas highlighted significant treatment differences in a wide variety of health care procedures, including tonsillectomies, coronary, stents, and hip fractures - all with no discernable link to quality. 47 Researchers long ago concluded that physician training and practice patterns were responsible for care variation, and that if the nation adopted best practices, then savings associated with standardized approaches would be [*715] immense. 48 Serious efforts at the federal, state, and private levels are underway to provide consumers with quality and price information to enable intelligent choices.

For example, on a federal level, CMS' Quality Initiative provides consumers with quality-of-care information and provides the Hospital Compare 49 online platform for consumers to research hospital quality, patient satisfaction, and pricing. 50 In addition, the Patient Protection and Affordable Care Act ("ACA") allotted \$ 250 million in state funds for the improvement of price transparency and requires CMS to make standardized extracts of Medicare claims available for provider

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evaluation. 51 States (e.g., Massachusetts and New Hampshire) 52 have also led the charge to provide information to consumers. 53 Massachusetts pioneered with its October 2013 legislation, which required insurers, physicians, and hospitals to provide health care consumers with the costs of health care procedures ranging from office visits at a primary care provider's office to surgical procedures. 54 In [*716] 2005, New Hampshire passed legislation that created the New Hampshire Comprehensive Health Care Information System, and mandated the creation of an all-payer claims data base ("APCD") and a consumer-friendly public website. 55 This information system collects provider data from a broad array of providers and services, and the New Hampshire APCD lists total and out-of-pocket costs for consumers. 56 Private insurers have also moved to empower consumers. For example, Blue Cross Blue Shield of Illinois provides detailed information on comparisons of in-network versus out-of-network provider services, ranging from CT scans to preferred brand drugs for certain medical conditions. 57 **All of these initiatives are supported by incentivizing consumers to focus more deeply on the quality** and cost of their care through increases in their out-of-pocket health care expenditures. Even if a consumer wishes to secure price and quality information, however, their ability to appropriately interpret this data may be rudimentary at best. 58 And, in many cases involving elderly, vulnerable, or frail individuals, the expectation of seeking and interpreting data may be completely unreasonable. [*717] To date, for example, leading quality indicators used by the federal government to determine value-based Medicare payments include percutaneous coronary intervention ("PCI") received within 120 minutes of hospital arrival, thrombolytic agent received within thirty minutes of hospital arrival, and ACE Inhibitor or Angiotensin Receptor Blocker for Left Ventricular Systolic Dysfunction and Beta Blocker prescribed at discharge for a heart attack. 59 These particular measurements, however, have very little resonance with consumers desiring to learn the quality reputation of potential providers whose care they may solicit. 60 "Star" ratings, on a one-to-five scale, are more meaningful as they distill a multiplicity of factors in a consumer-friendly manner. 61 **But even these ratings may capture areas of little or no concern to a particular consumer, or oversimplify issues causing the rating to be misleading.** And, ratings may fail to equalize across patient characteristics, thus incorrectly identifying providers as substandard, for example, because

[*718] **their patient population is sicker and consequently more prone to poorer outcomes.** In sum, meaningful measures of value are lacking in the health care arena. Serious questions also arise regarding consumers' abilities to correctly interpret the available data so as to make reasonable choices impacting their access to quality care.

II. There is no Available Proxy having an Interest Unified with Consumers to Evaluate Quality and Cost Data If we grant the notion that consumers may not be able to possess the knowledge necessary for a free market in health care to function, we might next look to see if there is an available agent, or proxy, able to fill this role on consumers' behalves. Logical agents include the government (in the case of Medicare and Medicaid beneficiaries), private insurers, or employers. And yet, the same tangle of relationships responsible for the regulatory burden and confusing incentives rife within health care come to the fore here. 62 The government certainly has mixed incentives that may not give patient interest its deserved primacy. While there are many regulations focused on care quality, at their root, Medicare and Medicaid are insurance programs that have a goal of cost containment. 63 While higher [*719] expenses, of course, do not necessarily equate with higher quality, neither are the two concepts divorced. Thus, the potential competing motivators of cost control and quality enhancement may cause these programs to not always align with patient interests. 64 Private insurers have the exact same issue. The tension between cost and quality in insurer goals is readily apparent in numerous lawsuits over many years. These lawsuits challenged the propriety of payment incentives on physician behavior, where insurers were accused of corrupting physician judgment by compensation formulas incentivizing less, and lower-quality, medical care. 65 The ACA further highlighted this tension by limiting the "medical loss ratio" - the portion of the insurance premium spent on insurer administrative expenses - to 20 percent. 66 In addition, given the high degree of turnover within an insured population, [*720] insurance companies take a decidedly short-term perspective on patient outcomes, often in conflict with a patient's long-term perspective on their health. 67 And, of course, insurance companies function by carefully defining, and thereby limiting, the financial risk they assume, so transferring risk to consumers by definition benefits the insurer. Finally, for many of the reasons articulated above regarding the government and insurers, employers too seem conflicted in their allegiance to access and health care quality. 68 Thus, the industry lacks a proxy with a unified interest with consumers. There is no unbiased, credible party able to make value judgments on behalf of patients-consumers. III. Relying on the

Market to Allocate Health Care Is Wrong As the industry continues to move toward a defined contribution era where each patient-consumer is expected to conduct one's own research, balance cost and quality, and shop around, one must remember that not all consumers are equipped to manage these new

responsibilities. The ability to access this type of information, process, and make an intelligent decision requires a level of sophistication that many people simply do not possess. 69 Further, unique aspects of an individual's medical condition may render it difficult for patients to properly evaluate competing criteria in a manner that facilitates free market choice. 70 [*721] Because of the highly personalized nature of health care services, the influence of procompetitive forces may actually cause harm to a patient. A patient may gravitate toward an option based on inappropriately weighing the cost of the service, without sufficiently considering the likely outcomes from a quality of life perspective. 71 Finally, even if one wants to assume that an educated consumer can make informed choices in a competitive market, the attendant costs associated with this assumption may be hard to swallow. Externalities abound in health care, as one's health status can have a significant impact on others. Individuals unable to pay for their care may be able to hold off on certain types of medical care for some time, but this often leads to very serious, more expensive consequences. 72 From both an ethical and legal perspective, the industry is not going

to deny care to individuals presenting in an emergent situation, even if there is no payor and the cost is high.⁷³ In the end, however, the nation does not want individuals inflicting the social cost of their care - public health issues, accidents, and the like - on society merely because they were unable to make informed health care choices.⁷⁴ Even if we adopt a view of "buyer beware" - leading to high incidences of medical debt - this, too, has significant costs on society. In the end, delayed care is likely to be provided, but at a cost to society higher than might have been borne if it had been provided when first [*722] needed. It is simply unimaginable that there will be an ethos amongst our caregivers, health care institutions, and the public that will accept otherwise. There certainly is a place in health care for a consumer focus on cost and quality. An educated consumer is a good thing. We need to be mindful, however, that we do not attribute to the market a sophistication that it lacks when it comes to allocating as essential a service as health care.

Free market is a terrible idea for healthcare

Gaffney et al 16 [Adam Gaffney, Division of Pulmonary and Critical Care Medicine, Department of Medicine, Cambridge Health Alliance. Philip Verhoef, Section of Pulmonary and Critical Care Medicine, University of Chicago. Jesse Hall, Section of Pulmonary and Critical Care Medicine, University of Chicago.] "Rebuttal From Drs Gaffney, Verhoef, and Hall" Chest, Volume 150, Issue 1, July 2016, Pages 14–15 (<https://doi.org/10.1016/j.chest.2016.02.661>) - MZhu

Dr Berdine 1 argues that in an unhindered competitive health-care marketplace, the market will clear at a price and quantity of goods/services that, as if by definition, leaves all parties maximally satisfied. This argument is little more than a tautology that would, if possible, result in a health-care dystopia that society would not accept. Low-income individuals might "choose" to spend their money on food instead of asthma inhalers. By Dr Berdine's logic, this scenario is as it should be, and any intervention by government would only make things worse. Those dying of status asthmaticus might beg to differ, if they were able, as might patients with hypertension who suffer strokes because they elected to cover their rent instead of paying for physician visits

He argues that government involvement in the health care realm has "priced health care beyond the reach of the average person."¹ It is a rather curious point, because the United States already has a relatively privatized and unregulated health-care system (compared with other high-income nations) while also having the highest costs.² Furthermore, \$375 billion of our expenditures can be attributed to wasteful administrative costs associated with our multipayer insurance market.³

Dr Berdine 1 does make a good point when he notes that government-granted patent monopolies can result in high drug prices. To address this issue, a single-payer national health program would directly negotiate with pharmaceutical companies over drug prices. Indeed, the Veterans Health Administration pays 40% less for prescription drugs compared with Medicare, indicating that substantial cost-savings could be achieved by facilitating such negotiations.⁴

A free market for health care is not only undesirable: it is, as economists have noted for decades, a fantasy. Fundamentally, the degree of information asymmetry between the buyer (the patient) and the seller (the provider) prevents health care from conforming to the theoretical tenets of free-market

economics. Kenneth Arrow famously contended that the uncertainty intrinsic to health care makes it unique from other goods and services.⁵ The health economist Bob Evans has argued that not only has there never been a pure free market in health care but that “inherent characteristics of health and health care make it impossible that there ever could be.”⁶ On the contrary, he argues, attempts to inject market mechanisms into health care are fundamentally about redistribution. As health-care costs are shifted from public to out-of-pocket sources, those with higher incomes invariably benefit.

The US divergence from other high-income nations is a disaster. We contend with uninsurance and underinsurance, a lack of coverage for critical benefits, worse outcomes, and higher overall costs. As others have noted, the savings made possible through a single-payer system⁷ would allow extension of health care as a social right to the entire nation. In contradistinction with a fantastical health-care free market, such a program is both attainable and desirable

Free-market fails in healthcare

Frankford and Rosenbaum 17 [David M. Frankford is a specialist in bioethics and health care law, a professor at the Rutgers Institute for Health, Health Care Policy and Aging Research, faculty director at Camden of the Center for State Health Policy and the editor of Behind the Jargon at the Journal of Health Politics, Policy and Law, having previously served as book review and associate editor. Sara Rosenbaum J.D. is the Harold and Jane Hirsh Professor of Health Law and Policy and Founding Chair of the Department of Health Policy at the Milken Institute School of Public Health, George Washington University. She also holds professorships in the Trachtenberg School of Public Policy and Public Administration and the Schools of Law and Medicine and Health Sciences.] “Taming Healthcare Spending: Could State Rate Setting Work?” Rutgers Law School and George Washington University, Milken Institute School of Public Health Issue Briefs, March 2017
(<http://www.cshp.rutgers.edu/publications/taming-healthcare-spending-could-state-rate-setting-work>)
- MZhu

This effort to use markets to control spending faces numerous obstacles because it is widely recognized that health care markets deviate substantially from more ordinary markets, even relatively complex ones that produce custom products. If health care markets fail, then their use cannot control expenditures. Six features of health care markets, discussed below—and many of which overlap—contribute to this failure.

1. Heterogeneity everywhere. Compare the purchase of eyeglasses to health care.³ There are many distinctive features to different eyeglasses: size, shape, color, material, texture, weight and brand names (like fancy designers). Ordinary people, looking for eyeglasses, can easily discern these features and have much or all of the necessary knowledge to make educated choices among them; and shoppers can try eyeglasses prior to purchase simply by putting them on. Eyeglasses are relatively “homogeneous” and quintessentially “shoppable.”

By contrast, health care goods and services are most often extremely “heterogeneous.” A multitude of possible treatments exist for any given “condition”—e.g., for back pain, one might buy different furniture, use aspirin, use an NSAID like ibuprofen, try physical therapy, or be given multiple surgical options. Moreover, a “condition” can be treated in a multitude of ways in different persons—e.g., compare stroke treatment in an otherwise healthy and active 45-year-old man (with a family history) to treatment for a 75-year-old woman who is institutionalized quite often but otherwise lives alone on the

third floor of a building without an elevator, and who also has hypertension and diabetes and moderate congestive heart failure. Finally, there is often vast variation in the price and quality offered by different providers. Purchasing in the face of such a huge number of contingencies and options is extremely difficult at best, especially for laypersons who know only that they need care.⁴

2. Dependence and agency. To make even relatively rudimentary choices in treating complex, high-cost conditions, patients need expertise, but they are not experts. They might know something is wrong—being tired, feeling a lump, experiencing pain and so on—but they don't know what the problem is (if they even know that a problem exists). Furthermore, one's condition—purposely put in quotes above—cannot be known without diagnosis. To even know which of the multitude of different goods and services are needed, one needs to know the diagnosis before sorting through the options. To diagnose and treat most illness, therefore, patients need experts, aka “agents,” but they are dependent on those agents because they don't know what the experts know. This problem is referred to as “**information asymmetry**.”

Necessarily, the problem arises, “How am I to choose an agent if I am not an expert?” Below we discuss the possibility of using insurers or employers, sophisticated buyers, as agents, but here we focus on consumers’ directly making choices among providers.

One way for consumers to overcome their ignorance is to try a product before choosing, as in our eyeglass example above. Most often, however, consumers don't know what they need and therefore what they should try. Moreover, one cannot try a service in advance of the production of a service. One can't try a surgeon without having surgery. The simultaneous production and consumption of health care makes such a strategy quite perilous.

Some health economists argue that providing consumers with information directly will lead to less reliance on agents. However, the dependence on agents stems from much more than lack of expertise. Patients are vulnerable not just because of their lack of knowledge but because they are necessarily emotionally involved. For this reason, some type of agent becomes essential, given the impossible task of choosing when one is sick and vulnerable. The necessary decisions do not resemble the discretionary purchase of a high-end television; it is selecting among costly approaches with unknown effects, for conditions whose true nature might not even be understood and the consequences of which can be disability or death.

The extreme heterogeneity coupled with the lack of consumer wherewithal to navigate among options (with perhaps limited exceptions for relatively discretionary health purchases that entail information that can be used by lay people) means that very few services are “shoppable.” A recent definition of “shoppable” is the following: “For a health care service to be ‘shoppable,’ it must be a common health care service that can be researched (‘shopped’) in advance; multiple providers of that service must be available in a market (i.e., competition); and sufficient data about the prices and quality of services must be available” (Frost and Newman 2016). One recent study has estimated that at most roughly one-third of total expenditures on health care are for shoppable services (White and Eguchi 2014).

Even for those services, consumers will shop only if the amount of their “skin in the game” makes the effort worthwhile. Insurance with first-dollar coverage obviously makes nothing worth shopping, while complete lack of insurance makes much, much more shoppable. A recent study from the Health Care Cost Institute examined employer-provided insurance from 2011 and reached the following conclusions

again as maximums: (1) of the \$524.2 billion in expenditures, 43 percent, \$225.4 billion, was spent on shoppable services; (2) 15 percent of total expenditures were out of pocket; and (3) only \$37.7 billion, 7 percent of total out-of-pocket expenditures, was spent on shoppable services (Frost and Newman 2016). The take-away is that unless out-of-pocket costs are very significantly increased—with the limit being complete de-insurance—relatively little is to be gained from consumer shopping.

Moreover, recent evidence shows that even when consumers are given the incentive to shop by the use of high deductible plans, their choices are perverse and their choices don't improve with experience. Consistent with the findings from the RAND Health Insurance Experiment of many years ago, relatively high-income, sophisticated consumers did not respond to the incentives of high deductibles by shopping but instead simply reduced the quantity of their care across the board, failing to differentiate among services that have value from those that did not (Brot-Goldberg et al. 2015). Consequently, consumers chose to forego even high-value care.

3. Shortage of sophisticated purchasers/agents. The situation might be totally different, however, if consumers could rely on sophisticated purchasers as their agents in choosing among providers and in choosing among services. A leading choice for this position is, of course, insurers. However, that just pushes the agency problem back by a degree, because now consumers need agents to pick their insurers as the agents that in turn pick their covered providers and treatments. In other words, consumers lack the knowledge or information to pick their insurer agents (who pick their providers as agents) because consumers lack the needed knowledge—much less the information—to choose this agent.

The evidence that this problem exists—regardless of how consumer-friendly mechanisms like the ACA Marketplaces are made—is more than substantial. Numerous studies show that even relatively sophisticated persons choosing among insurance products get overloaded by too many choices and too much information, and they lack even rudimentary understanding of basic features of insurance products such as coinsurance, deductibles and networks (e.g., Bhargava, Loewenstein, and Sydnor 2015; Loewenstein et al. 2013).

For the most part in the United States employers have been the dominant agents shopping for insurance for their employees. However, this solution has proved inadequate for a number of reasons. First, the employer system leaves out millions, who in turn depend on public programs such as Medicare and Medicaid to act as their agents. Furthermore, employer-provided insurance and the segment of the population it covers has been declining. At its zenith in the late 1970s and early 1980s, employer-sponsored insurance covered approximately 70 percent of the non-elderly population (e.g., Gabel 1999, 65). Since then there has been a relatively steady march downward, with coverage of the non-elderly population falling as low as 58.4 percent in 2011 during the Great Recession but rebounding to, and possibly stabilizing at, 60 percent in 2013-2014 (Fronstin 2015b, 7).

Moreover, even when employers sponsor insurance, huge variation exists in terms of their incentives or capacity to serve as adequate agents for their employees. To function as agents, employers must be willing to invest in their employees, which means that in order to benefit from that investment they must have expectations of a fairly stable workforce (e.g., Fronstin and Helman 2003). These incentives vary across sectors of the economy and employers within one sector may have different incentives depending on such factors as firm size, the size, mixture and age of a firm's workforce, and local labor market conditions (e.g., Buchmueller, Carey, and Levy 2013; Christianson and Trude 2003; Fronstin

2007; Moran, Chernew, and Hirth 2001). Thus, even among many employers offering insurance, incentives are relatively short term (e.g., Adams and Salisbury 2014); what may be good for the employer may not be good for employees over the long run.

Large employers and employer coalitions engage in serious efforts to understand their employees' preferences and incorporate those preferences into plan designs (Peele et al. 2000). By focusing on dimensions of care like quality and satisfaction, instead of just on their own bottom line, these plan sponsors have acted as "responsible purchasers" (Lo Sasso et al. 1999) when they arrange for insurance or buy care directly from providers (e.g., Eggbeer, Morris, and Sukenik 2016). However, most employers lack this incentive or capability, particularly as scale decreases (e.g., Cebul et al. 2011; Rosenthal et al. 2007), and most workers are not employed by the large firms that have the capacity—technical skill and market power—to control expenditures. As a result, most employers have little choice but to turn to tools developed by the insurance industry itself to hold down premiums—high deductible plans and narrow networks—simply to cut their expenditures.

4. Fragmentation among payers. This then brings us to the most important point, the extreme fragmentation of the financing system. With more than one million health plans sponsored by private employers, thousands of plans sponsored by public employers, thousands of Marketplace plans, 51 state Medicaid programs, nearly as many CHIP programs, and Medicare, payment is fractured and lacks more than minimal cooperation despite efforts by some states and CMS to begin to develop multi-payer initiatives.

Even if these initiatives are successful to some degree in controlling expenditures—and the evidence so far is not very promising (e.g., Dale et al. 2016)—they remain few in number and, moreover, they are voluntary, relying on governments' enticement of private parties rather than a direct exercise of state power by such means as rate setting.

Thus, almost universally every payer fends for itself and has incentives with regard only to the insurance pools for which its plans are responsible. As discussed above, even a payer as large as Medicare attends only to its budget, obligated from its inception to pay only its "fair share" of costs. No payer has the incentive or capability to control expenditures overall. Instead, payers—and risk-bearing providers too—most often take a path of least resistance, which is to reduce expenditures by pushing risk and cost to someone else, rather face down powerful interests, overcome problems of collective action or challenge an organization's fundamental way of doing things (e.g., Evans 1990; Marmor 2010). Externalities abound.

This (non)system of payment stands in stark contrast with those of other wealthy democracies, which accomplish risk pooling using government sponsorship or governmentregulated social organizations (or both), thereby creating systems grounded in social solidarity and social security. In Western Europe, with its strong tradition of solidarity and mutual aid, the risk of illness is pooled in the sickness funds, which cooperate voluntarily and with varying degrees of state coercion in collecting revenues, spreading risk, and paying providers. In national health system countries, like the United Kingdom and the Scandinavian countries, national governments unite all citizens into a single risk pool. In Canada, Canadian Medicare brings the population together into the risk-pooling systems of the provinces and territories, with some degree of federal subsidization. All advanced, industrialized countries socialize the

risk-pooling function, and they pay with one voice, either as a **single payer** or as coordinated payers
(e.g., White 2013).

Free Market Answers

For profit health care fails

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The American system of for-profit insurance and medicine is unique among affluent countries, and it clearly does not work well. Elsewhere, governments fund a much larger share of health expenditures than in the United States and regulate private insurance very closely. Everywhere else, most healthcare is paid for out of tax revenue and is provided either by government agencies (such as the British National Health Service) or by highly regulated private bodies.¹³ From this perspective, the United States has been conducting a social experiment in health policy, testing whether it is possible to provide quality healthcare efficiently and equitably when directed by private individuals and entities dedicated to profit making. If that was the intention, we can now drop the experiment because the answer is clearly “no”: for-profit medicine is not only inequitable but also inefficient. By virtually every metric, health-care in the United States is much more expensive than elsewhere and distributed with much greater disparities. In Bloomberg’s healthy country index, the United States ranked 35 in 2018, behind much poorer countries like Cuba, Slovenia, and Chile and one place below its rank of 34 in 2017.¹⁴ The World Health Organization similarly ranks the United States at 37 out of 191 countries, above Slovenia but behind Dominica and Costa Rica, not to mention France or Italy (rated 1 and 2 respectively).¹⁵ Furthermore, the US is sinking in the rankings, as its privatized healthcare system has been getting relatively worse. Note: This figure shows the relationship between female life expectancy and the logarithm of per capita healthcare expenditures for member states within the Organisation for Economic Co-operation and Development (OECD). The line shown is the average relationship between these two for member states other than the United States. The position of the United States well below and to the right of the line indicates that it is spending much more than other countries but has significantly shorter female life expectancy than would be expected given this level of spending. The point of healthcare spending is improved health and to extend life. On that basis, healthcare in the United States, while much better than it was in the past, has fallen behind other countries. We would expect affluence to bring greater longevity because of better nutrition and more comfortable lifestyles. For the same reason, we would expect life expectancy to increase over time as countries grow richer and are better able to provide quality nutrition, clean water, and improved healthcare. Growing affluence has been associated with longer average national life expectancy, but much less so for the United States (see Figure 2). Among the world’s wealthiest nations, we are less healthy than many poorer countries. Despite our affluence, our health outcomes were already below average in 1971; and, while we are living longer and healthier lives now, improvement has been much slower than elsewhere, slower than would be expected given our increasing wealth. While women in the US live 6.2 years longer now than in 1971, Canadian women live 7.5 years longer, British women 7.8 years longer, and French women 9.6 years longer.¹⁶ Since 1971, the United States has dropped from 19th to 34th place among members of the Organisation for Economic Co-operation and Development (OECD) in potential years of female life lost (see Table 1). One reason for our poor health performance is that we have a higher infant mortality rate than 30 of 35 OECD members. Indeed, having children in the United States is

particularly risky. At 14 deaths per 100,000 live births, the US maternal mortality rate is the worst in the affluent world, not only twice the rate in Canada and triple that in Japan, but twice the rate in the relatively poor countries of Croatia, Slovakia, and Slovenia.¹⁷ Note: This figure shows the relationship between female life expectancy and the logarithm of per capita income for member states within the OECD. The line shown is the average relationship between these two for member states other than the United States. The position of the United States well below and to the right of the line indicates that life expectancy in the US is about four years less than would be expected given its income level. Indeed, the US has shorter female life expectancy than most affluent countries. Table 1: US healthcare in comparative perspective Note: This table shows the standing of the United States compared to other member states of the OECD in 1971 and 2016 for various measures of healthcare performance. In every measure, the United States now performs worse relative to other affluent countries than it did in 1971. Since the United States has many of the world's best doctors and the most advanced medical technology, it is surprising that Americans die at such high rates. The problem is that our healthcare finance system blocks many from access to even basic healthcare, and forces doctors and nurses to waste excessive time and energy dealing with a recalcitrant financing system designed to maximize profit rather than health. Much of the discussion over the last decades has been about those like Alec Smith without any health insurance.¹⁸ A study of cancer treatments explains this in cold clinical terms: "In the absence of health insurance coverage, many forgo cancer screening and/or delay diagnosis and thus are likely to experience poor clinical outcomes."¹⁹ Health insurance, however, does not guarantee access to healthcare. Restrictions on access have become increasingly burdensome for many with insurance, like Shane Boyle. A recent survey found that while almost all diabetics had health insurance, 40% had rationed test strips and 26% had rationed insulin over the past year.²⁰ Private health insurers have made rationing worse with a range of tools designed to inflate profits by limiting access to healthcare services. Benefits are conditional on the use of doctors and services selected by insurance companies, with financial penalties for those who use services outside of narrow networks or without prior authorization. Almost 90% of Americans with private health insurance now face deductibles, the minimum spending required before benefits begin. Since 2008, the average deductible has more than doubled, reaching almost \$2000 in policies covering individuals and \$3400 in policies covering families. Virtually all insurance plans now cover expenses only after a co-pay, or payment by the patient before the insurance company pays anything. Co-payments for office visits average around \$25, and for hospital admissions over \$300 per day.²¹ Since many Americans do not have significant available cash to cover emergencies, with almost half not having even \$400 to hand, mounting cost-sharing forces them to choose between medical care and other essential bills.²² Doctors complain of patients who risk their health by not following recommended medication regimens or seeking follow-up care, but such "noncompliance" is a result of tragic financial constraints rather than an irresponsible act of defiance. The Federal Reserve finds that over 25% of Americans have skipped medical care because of cost. These noncompliant patients risk "adverse clinical outcomes" because they cannot afford the care they need.²³ Their financial situation is more toxic than their disease. Together, foregone treatment and medication nonadherence kill thousands, even hundreds of thousands, of Americans. This is demonstrated in a comparison of the share of a county's population who report that they could not afford to see a doctor when sick with that county's age-adjusted mortality rate (see Figure 3). No one should be surprised that the larger the share unable to afford a doctor, the higher the mortality rate; indeed, this alone accounts for nearly a third of the variation in county mortality rates in the United States. Much of the excess mortality in the United States compared with other affluent countries can be

associated with financial barriers to access, and most of these excess deaths are of people with health insurance.²⁴ Measured in crass economic terms, if we value human lives at \$9 million apiece, as is done by the Environmental Protection Agency, the annual economic cost of this excess mortality could be in the hundreds of billions of dollars.

Market based solutions ignore the elderly and raise costs

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

By treating healthcare as a commodity and promoting choice, the market turn in healthcare policy rewards the young and healthy at the expense of the sick and the old. At the same time, introducing market mechanisms and profit immediately raises costs. Before the 1970s, health insurance was highly regulated, often with a single Blue Cross/Blue Shield plan offering simple coverage to everyone at a uniform price without regard for pre-existing conditions. Economists joined with insurance companies to campaign for deregulation to allow for-profit companies to compete with Blue Cross/Blue Shield companies on the assumption that competition and the profit motive would lead to greater efficiency. The economists were wrong. The new for-profit private insurance companies were no more efficient than the old Blue Cross/Blue Shield plans. But by restricting sales to the young and healthy, the new entrants made quick work of the established companies, who were quickly forced to abandon open enrollment policies and community rating. The mistake here was that policymakers misunderstood the real advantage that the new entrants enjoyed. Far from increasing efficiency, administrative waste soared in for-profit companies, with increased spending on marketing, plan design, utilization review, managerial salaries, and, of course, profit. Rather than winning through efficiency, they profited by screening their subscribers. By offering plans attractive only to the healthiest, and cheapest, subscribers, they were able to make more money while driving the old Blues into bankruptcy with a pool of the sickest people. Thus, the market turn drove up healthcare costs even while reducing Americans' access to care. As a result, we have a for-profit healthcare system that is more expensive than that of any other country while providing less care. But it generates profits and makes some people very rich.

Medicare covers only 50% of healthcare spending by the elderly and Medicaid covers another 10%. The remaining 40% must be covered by private health insurance or out-of-pocket spending.

Consumers cannot make meaningful choices

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

The Problem of Healthcare Market Power Healthcare will often be provided by institutions with market power. Providers operate in large facilities, like hospitals. Hospitals, specialist practices with dedicated machinery, pharmaceutical companies with large research facilities: all operate at a large scale that

limits the number of competitors, giving each the power to influence prices.³ Even more important than scale, however, is the role of information. Few consumers can evaluate providers or treatment plans; even trained professionals do little better than amateurs in choosing providers.⁴ Every doctor is different, patients with identical diagnoses are different, each doctor-patient relationship is different. Feeling unwell, patients go to a doctor, not knowing what problems they may face, or even if they have a problem. They enter physician offices largely unaware of the proper treatment they require. Instead of comparing essentially equivalent bars of soap, where buyers can evaluate price and quality, healthcare "consumers" compare providers of unknown and unknowable quality. Facing such uncertainty, people rely on quality signals, brand names, reputation, the experience of others, advertising, even prices. Buying services that literally can be the difference between life and death, higher prices can increase demand because they are signals of quality. Signals steer patients to a small subset of providers who thus have real market power because people believe they provide better care and save lives. Massachusetts General Hospital, New York Presbyterian, Johns Hopkins, Yale New Haven, the Mayo Clinic, the Cleveland Clinic: these institutions do not compete on a level playing field with other hospitals and providers, and they advertise to further enhance their brands.⁵ Their reputation gives them the leverage to raise prices.⁶ The importance of reputation encourages providers to merge with marquee providers—hospitals with a reputation for extraordinary quality

Public Health Care Doesn't Destroy Free Trade

General patterns of compliance overwhelm individual violations

Grunfeld 7 – Michael Grunfeld, J.D. Candidate, Columbia University School of Law, “DON’T BET ON THE UNITED STATES’S INTERNET GAMBLING LAWS: THE TENSION BETWEEN INTERNET GAMBLING LEGISLATION AND WORLD TRADE ORGANIZATION COMMITMENTS”, Columbia Business Law Review, 2007 COLUM. BUS. L. REV. 439, Lexis

In response to this decision, the United States can still appeal to the AB. n174 If the final ruling is that the United States is not in compliance, then Antigua can request the imposition of countermeasures against the United States. Ultimately, even if Antigua chooses to pursue countermeasures, these countermeasures against the United States would have little effect on the U.S. economy. n175 However, the United States would face the indirect consequence of the reputational cost of not complying with its free trade commitments. But if this breach is seen as an insignificant exception to a general pattern of compliance, then it likely will not considerably affect the United States's overall reputation in this area. n176

Canada NHI and the ACA thump and disprove the DA – they committed health insurance to GATS and have had zero challenges

Trade doesn't solve war

Miller 14 – Charles Miller, Lecturer at the Strategic and Defence Studies Centre at the Australian National University, “Globalisation and War”, April, <http://www.aspistrategist.org.au/globalisation-and-war/>

John O’Neal and Bruce Russett’s work is perhaps the best known in this regard—and Steven Pinker cites them approvingly in his book The Better Angels of Our Nature. Analysing trade and conflict data from the nineteenth to the twenty-first centuries, they found that trade flows do have a significant impact in reducing the chances of conflict, even when taking a variety of other factors into account. But their conclusions have in turn been questioned by other scholars. For one thing, their model failed to take three things into account. First, it’s quite possible that peace causes trade rather than the other way around—no company wants to start an export business to another country if it anticipates that business linkages will be cut off by war further down the line. Second, conflict behaviour exhibits what’s called ‘network effects’—if France and Germany are at peace, chances are Belgium and Germany will be too. And third, both the likelihood of conflict and the level of trade are influenced by the number of years a pair of countries has already been at peace—because prolonged periods of peace increase mutual trust. Take any of these factors into account, and studies have shown (here and here) that the apparent relationship between trade flows and peace disappears. Perhaps, though, conceiving of globalisation solely in terms of trade flows is mistaken. Alternative indicators of globalisation include foreign direct investment, financial openness and the levels of government intervention in economic relations with the rest of the world. Data on those variables is less extensive than on trade flows, usually dating back only to the post World War II period. But some analysts, such as Patrick McDonald and Erik Gartzke, have argued that a significant correlation can be found between them and a reduction in the probability of conflict. Those findings, newer than O’Neal and Russett’s, haven’t yet been subjected to the same intense scrutiny, so may in turn be qualified by future research. What does all that mean for the policy-

maker? The statistical evidence certainly doesn't tell us that globalisation has made war in East Asia impossible. 'Cromwell's law' counsels us that a logically conceivable event should never be assigned a probability of zero. The most we could conclude is that globalisation has made such an occurrence much less likely. There's some hopeful numerical evidence that globalisation does indeed have that effect, but the evidence isn't so compelling that we can substitute an economic engagement policy for a security policy. By all means, let's continue to promote trade in the Asia-Pacific. But we should also continue to be prepared for scenarios which are unlikely but would be hugely damaging if they were to occur.

Gambling thumps – WTO's first case set the precedent of DSB failure to force compliance – outweighs any link to the aff

US can get HC out of or alter the rules of GATS easily – and dispute settlement costs would be minimal

Reeves 6 Terrie C., assistant professor in health care management at the University of Wisconsin-Milwaukee's School of Business Administration, "International Trade and Health Policy: Implications of the GATS for US Healthcare Reform," *Journal of Business Ethics*, Volume 63, 2006, pp. 313-332

This paper has argued that trade-offs between health policy and trade policy are being mediated within a political and institutional context that favors commercial interests over health priorities. In theory, it would be possible to take healthcare off the GATS negotiating table. In the near term, this could be accomplished in two ways. First, the US could withdraw existing 'specific commitments' in the health insurance and hospital sectors. Although the US would be required to compensate its trading partners for losses if commitments in health-related services are withdrawn, compensation would be relatively small until such time as foreign providers acquire a larger share of the US markets. Secondly, the US could oppose 'necessity testing' in all service sectors – including accountancy, engineering and architecture – during the current GATS negotiating round. A defeat for the first, precedent setting attempt to established WTO 'disciplines' over domestic regulation of professional licensing, regulation and standard setting would limit the WTO powers to intervene in the domestic affairs of member states. These actions, however, would require a major shift in US trade policy, a shift that is not likely to occur in the absence of political demands.

WTO and GATS not key to trade – globalization creates incentives for economic gain

Trade's resilient

Siles 14 – Gabriel Siles-Brügge, Lecturer in Politics at the University of Manchester, "Explaining the Resilience of Free Trade: The Smoot–Hawley Myth and the Crisis", *Review of International Political Economy*, 21(3), Taylor & Francis

Despite the onset of the current economic crisis there has been no significant move towards protectionism amongst most of the world's economies. Although rational institutionalist explanations point to the role played by the constraining rules of the World Trade Organisation, countries have largely remained open in areas where they have not legally bound their liberalisation. While accounts emphasising the increasing interdependence of global supply chains have some merit, I show that such explanations do not tell the full story, as integration into the global economy is not always associated with support for free trade during the crisis. In response, I develop a constructivist argument which highlights how particular ideas about the global trading system have become rooted in policy-making discourse, mediating the response of policy elites to protectionist pressures and temptations. Trade

policy-makers and a group of leading economists have constructed an ideational imperative for continued openness (and for concluding the Doha Round, albeit less successfully) by drawing on a questionable reading of economic history (the Smoot–Hawley myth); by continually stressing protectionism's role as one of the causes of the Great Depression non-liberal responses to the current crisis have been all but ruled out by all except those willing to question the received wisdom.

Libertarianism Answers

Health Care Specific Answers

Those with more limited talents will not be as financially successful, a just society requires ameliorating this inequality

Han Hennenberger, Connecticut College, 201, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

Individuals who in reality are best endowed will use their natural talents to flourish. Others, being less advantaged, will not have the same degree of success. As some prosper and others struggle social and economic inequality results. The first part of the difference principle holds that such disparity is morally permissible provided it results in compensating benefits for all members of society, especially those who are least advantaged. **Social cooperation requires the participation of everyone, the advantaged and disadvantaged alike.** Without those who are worse off in reality those with useful talents would not have the chance to flourish within the construct of social cooperation. The better advantaged provide compensating benefits to those who are less well situated in order to attract their participation. Disadvantaged persons in the framework of social cooperation should have little difficulty securing healthcare for themselves. If not born into wealth they could at least parlay their talents into the funds necessary for care. **Individuals poorly endowed in reality, however, have little hope of obtaining healthcare. Blinded by the veil of ignorance those in the original position would assent to principles of justice which ensure access to healthcare in the event that they are in actuality poorly endowed.** The difference principle provides the means to make this provision as it sets aside compensating benefits for these individuals. **One could imagine this coming in the form of taxes levied against those who have used their talents to create exceptional personal wealth.** Their opportunity to succeed is partially dependent upon the less well off and therefore they must offer compensation. **Individuals in the original position would agree to a stipulation that compensating benefits are put towards healthcare.**

Health care is not simply another commodity, it is something we have a moral obligation to provide

Frank G. Kirkpatrick Author, 'The Episcopal Church in Crisis: How Sex, the Bible and Authority are Dividing the Faithful, June 4, 2013, Huffington Post, The Missing Moral Dimension in the Health Care Debate,
http://www.huffingtonpost.com/frank-g-kirkpatrick/the-missing-moral-dimension-in-the-health-care-debate_b_3383194.html

This is good news for those concerned about the costs of providing all Americans with access to quality health care. But it also obscures an element that has been sadly and surprisingly missing from recent health care debates, especially among those vehemently opposed to the Affordable Care Act (Obamacare). That missing element is the moral basis for health care. The political debate has become focused almost entirely on costs rather than on the services those costs help to pay for. By concentrating on costs to the virtual exclusion of everything else, the opponents of providing universal health care want us to believe that health care is an optional consumer commodity, one that consumers can freely choose to obtain or not to obtain depending on their preferences. Among people committed to the libertarian principle that all choices are essentially economic and are to be made by individuals pursuing their own self-interests, it is almost inevitable that everything with a cost attached to it is a commodity, to be chosen or not chosen as one sees fit. But to treat health care as an optional commodity, which should compete in the market place alongside the option of choosing a large flat-screen TV, fundamentally misunderstands what health care is and why its provision is a moral imperative in a society that claims, however confusingly, to be a moral society. In a family, the health of the members is not normally treated as a commodity whose purchase is optional and whose importance is to be weighed alongside the purchase of a new car or a club membership. When a child is dying of a disease that can be treated, the family does not seriously ask whether it should seek the treatment and forgo the vacation. It places the health of the sick child above everything else. In a family context most people know that the health of those they love is an essential moral necessity not to be compared with truly discretionary options. (As a nation we used to think of national defense in the same way: It was a moral necessity and should be funded by taxes at whatever level was necessary to make it reliable.)

Government is already the largest health care provider

Leo Chan, Assistant Professor of Finance Department of Finance and Economics Woodbury School of Business, Utah Valley University, September 2010, It is the moral obligation of the state to provide basic health care for its citizens, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1578548 DOA: 6-26-16

Some of those opposing health care reform would argue that the government is not in the business of meddling with people's health care. But the government is already the largest health care and health care insurance provider in the US! If we don't do anything about the health care system now, the government's Medicare and Medicaid commitment will bankrupt the government in 20 years. If there is universal health care, Medicare and Medicaid will be part of it, and I can assure you that the cost for the government will be much, much less than 30% of tax revenue. The future Medicare and Medicaid unfunded liabilities of \$50 trillion will be off the books. So, the government's financial commitment will be smaller, not bigger with a universal health care system. Further people will actually make their own choice whether to have private insurance or not.

Government health care can't be dissolved

Leo Chan, Assistant Professor of Finance Department of Finance and Economics Woodbury School of Business, Utah Valley University, September 2010, It is the moral obligation of the state to provide basic health care for its citizens, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1578548 DOA: 6-26-16

The current system is so full of subsidies and loopholes that would be impossible to untangle. **It would be impossible to dissolve the current system when the government has already made commitments to millions of retirees. If you think deeply about the nature of health care, you can argue that the health of its citizens in any particular country is a public good. All public good should be provided, in some form, by the government under classical economic theory.**

Health care is a basic public good

Leo Chan, Assistant Professor of Finance Department of Finance and Economics Woodbury School of Business, Utah Valley University, September 2010, It is the moral obligation of the state to provide basic health care for its citizens, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1578548 DOA: 6-26-16

In economics, a public good is a good that is non-rivalrous and non-excludable. This means that consumption of the good by one individual does not reduce availability of the good for consumption by others; and that no one can be effectively excluded from using the good. Of course, no real world example can be classified a true public good. The two most common public goods are basic education and national defense. The similarities of basic education and basic health care are many. **For a nation to prosper, it must have a well educated and a healthy workforce.** One can argue that the benefits of education are largely captured by the person receiving the education. But a higher educated individual, with a high income, contributes far more tax revenue than a person with low level of education and who works for a low wage. Thus, the benefit of someone became highly educated is not fully excludable or rivalrous.

The same can be said about the health of the workforce of a nation. A country whose citizens have limited access to health care usually has low GDP per capita. The reason is that productivity will be limited as people get sick more often. Preventive medicines and early treatments are not easily obtainable in these countries. As a result, people usually wait until they get really sick before they get medical care (if they can get any). A healthy workforce (particularly for those who work for low income jobs) will ensure that basic services to those who are highly trained are uninterrupted. Imagine the economic loses if the baby sitter or nanny of a top executive of a Fortune 500 company got sick, and the executive has to take a day off to take care of the kids. Or imagine if the millions of college educated female members of the workforce were forced to do all the household tasks their grandmother's generation were expected to do because there were no healthy low-income workforce to shoulder those responsibilities (dinning out, lawn care, etc) for them? The economic consequence of these two examples is not a small sum.

Health care needs inconsistent with the free market

Leo Chan, Assistant Professor of Finance Department of Finance and Economics Woodbury School of Business, Utah Valley University, September 2010, It is the moral obligation of the state to provide basic health care for its citizens, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1578548 DOA: 6-26-16

A universal health care system is also fair and more efficient. An individual's income profile over the life time is a hump-shape. However, our need for medical care is a V-shape. So, there is a mismatch of income and the ability to afford medical care. Imagine if all babies had to come up the cost needed to get them delivered. Unless there is a market in which we can borrow our future income to get health care when we need it at a younger age, poor babies would suffer. Universal health care is the only way in which a person would be able to afford health care when born into a poor family. A person who is born into a poor family who gets good basic education and basic health care would be able to increase his/her income potential, and thus increase his/her ability to pay higher taxes in the future and repay the medical expenses the government lend them when they were young. In essence, this is how the free K-12 education supposes to work. The same can be applied to basic health care. If the government is benefitting from the hard work provided by low-income family, it has a moral obligation to provide basic health care to them to ensure a fair playing field for all.

Single payer not inconsistent with a free market in health care

Leo Chan, Assistant Professor of Finance Department of Finance and Economics Woodbury School of Business, Utah Valley University, September 2010, It is the moral obligation of the state to provide basic health care for its citizens, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1578548 DOA: 6-26-16

Finally, I must point out that I am not suggesting that the government is in the business of providing the best health care possible to everyone in the country. No government should. Best is a relative term that must be left at the discretion of the individual. Basic health care is just as the name implies. If an individual who wants to have access to whichever doctor he/she wants, or have the most options/protection from everything, that individual should pay for those. A basic health care system might result in long lines at the local government clinic. But no

one is suggesting that a person who makes \$100,000 a year is required to stay in that line. Such an individual could get a private health care insurance that could get him/her private medical attention at his/her schedule. In effect, a universal health care system will create a two-tier system: a free service provided by the government with no frills, and one that is paid for by individuals who can decide the level of medical care they need. In a market where there is universal health care, the free market will create more efficiency for medical care. That's the main reason why the system in Hong Kong is far more effective and produced far better outcomes.

Health care is a human right, not a commodity

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

The policy of universal health care has been justified by the principle that access to health care based on medical need is a human right, not a commodity to purchase commercially based on one's ability to pay, nor a privilege rationed according to level of income. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 3856-3857). AuthorHouse. Kindle Edition.

Market intervention necessary to obtain communitative justice

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Commutative Justice

People make contributions to their economy through their labor and capital investments. In a capitalist system, both are generally bought and sold in the market place. Commutative justice addresses the question of whether or not these exchanges are fair. Does the worker receive a decent living wage for his labor? Does the investor receive a fair return for his risk? Is the individual receiving benefits commensurate with his premiums paid for health insurance? Should the benefits of public insurance programs be available for everyone whose taxes support the public health care system? While some would argue that the free market should determine what is a fair price based on economic forces of supply and demand, others suggest that government regulation is necessary to ensure both fair competition and commutative justice. These different perspectives are evident in health care reforms based on private sector solutions (e.g., managed competition, medical savings accounts) versus public sector solutions (e.g., single-payer or all-payer proposals for a national health insurance system). "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 4685-4688). AuthorHouse. Kindle Edition.

Libertarian risk rating is inconsistent with justice

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

The consequence of this individualistic view of fairness is to actually discriminate against elderly, sick, or higher risk individuals by charging more, adding exclusions ("riders") or by denying insurance altogether, thereby exacerbating the problem of access to health care in the private sector. The practice is neither fair nor beneficent, however profitable for the insurance companies. Although this underwriting procedure of risk rating is consistent with libertarian ethics, it is unjustified by Rawls' principle of justice, and particularly his difference principle, which states that any social and economic inequalities [including access to health care] are justified only if the greatest benefit accrues to the least advantaged members of society (Rawls, 2001, p. 42). More consistent with Rawls' (and Daniels') views of health care justice is the concept of community rating, which ensures that everyone has a fair equality of opportunity " to access health care services. The reader is referred to Weiner (2006) for further discussion of community rating informed by communitarian ethics, which affirm the principles of solidarity and cross-subsidization. Stone (1993) has also contrasted the principles of solidarity versus actuarial fairness, and supports the former. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 5640-5642). AuthorHouse. Kindle Edition.

Market fails to provide adequate health care

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

Americans have a human and moral right to be protected from the above mentioned harms associated with the deficiencies and inefficiencies of a private health insurance system. The above shortcomings have led members of the European Union to reject market-driven health care as the dominant model for their health care systems. The five additional criticisms of a system of private health insurance noted by Thomson, Foubister, and Mossialos (2009) are relevant to reform of the American health care system (numbers added). Markets for private health insurance in EU health systems [1] generally serve richer and better educated groups and present barriers to access for older and unhealthier people, [2] they are also often fragmented, resulting in weak purchasing power. [3] Owing to the fact that many of them exist to increase consumer choice (or to reimburse cost sharing), insurers have limited incentives to engage in strategic purchasing and to link provider pay to performance. [4] Moreover, they may have strong incentives to select risks, to the detriment of equity and efficiency. [5] In general, private systems incur substantially higher transaction costs than public systems and may therefore be accused of lowering administrative efficiency. (p. xx) While a market-driven health care system is most pronounced in the United States, the system is basically a hybrid of both government government sponsored programs and private, for-profit health plans. Liberals favor more of the former; conservatives favor more of the latter. The arguments for both positions warrant an ethical analysis of the implicit values affirmed, and to evaluate the quality of their empirical and

normative reasoning. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 6348-6351). AuthorHouse. Kindle Edition.

We already have a massive public health care sector. The status quo just wrongly excludes people from it

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

The fair opportunity rule could be applied to argue for access to public (social) insurance, though Beauchamp and Childress do not make this argument. The argument is as follows: A large proportion of American citizens has the advantage of either publicly financed health insurance or government health services: Military personnel, veterans and their families through the Department of Defense and the Veterans Hospital Administration; Native Americans through Indian Health Services; the elderly through Medicare Part A (automatic), and both the elderly poor and the non-elderly poor through Medicaid (means tested); all government employees (including elected officials) at federal, state, county, and local levels. Participants in these programs receive the benefit of discounted premiums (or none) because the government subsidizes and negotiates prices with the power of enormous risk pools of enrollees. Collectively, tax-paid expenditures in this public sector account for about 45 percent of the total health expenditures, and for about 135 million Americans (45 percent of the total population). This means that the remaining majority of 165 million (55 percent) are excluded from this form of public health insurance. Though employee payments with pre-tax dollars for private group insurance purchased by employers is a form of subsidy, it is not necessarily equal to the cost and benefits of tax-based health insurance. In other words, equal opportunity is denied to more than half of the population to receive the benefits of public insurance based largely upon a reverse age discrimination against younger workers in the private sector. Even more discriminatory and unjust, these Americans who are denied fair opportunity to public insurance are paying taxes to support public health insurance for others without equal benefits. They are assuming burdens (costs) without the benefit of lower cost social health insurance. This violates that the remaining majority of 165 million (55 percent) are excluded from this form of public health insurance. Though employee payments with pre-tax dollars for private group insurance purchased by employers is a form of subsidy, it is not necessarily equal to the cost and benefits of tax-based health insurance. In other words, equal opportunity is denied to more than half of the population to receive the benefits of public insurance based largely upon a reverse age discrimination against younger workers in the private sector. Even more discriminatory and unjust, these Americans who are denied fair opportunity to public insurance are paying taxes to support public health insurance for others without equal benefits. They are assuming burdens (costs) without the benefit of lower cost social health insurance. This violates the moral principle of a fair exchange (commutative justice). One could also argue that this constitutes a denial of equal protection under the law, because the law stipulates eligibility requirements which are discriminatory and harmful to those excluded, who must bear the additional burden of paying for their own private insurance and health care services. The last statement alleges harmful effects. It suggests a teleological argument in support of the deontological principle of rights-based justice. What is the harm? First, higher out-of-pocket payments in the private sector (in the form of premiums, deductibles, co-payments, and co-insurance

charges), and second, citizens are forced to rely upon a more inefficient and expensive health care "system in the private sector. A third significant harm is that the present American health care system segments the population into different categories and groups. It is common to hear about America's fragmented system or non-system of health care. Our system is not merely fragmented; it is a segregated system based on discriminatory policies that make benefits and costs unequal. We know from the history of racial conflict in America that segregation reinforces prejudice and conflict. A policy of "separate but equal" maintained separation, but it did not lead to equality, not even after Jim Crow laws were finally struck down by the U. S. Supreme Court. Arbitrary divisions foster stereotypes and prejudices, jealousies and resentments, and destructive discrimination against "those people" in other groups who are blamed for the deficiencies and injustices experienced within one's own categorical group. A Hobbesian conflict among competing groups and a Darwinian struggle for dominance in the food chain of health benefits is inevitable under such a system. Hostile competition among self-interested groups is a predictable outcome because we are a divided country with a tribal health care system. Our health care system is a form of institutionalized segregation. We are an unjust society because we violate civil, natural, and moral rights to health care, even to a decent minimum for everyone. "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 6317-6322). AuthorHouse. Kindle Edition.

Answers to: Poor Are Lazy

Poor work hard, they just have low wages

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

The fact is that most of the uninsured are not unemployed, but employed in low wage jobs, and in many cases, more than one job in order for their families to survive.

General Answers

There must be fair equality of opportunity

Han Hennenberger, Connecticut College, 201, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

In her essay “Universal Access to Healthcare” Lesley Jacobs examines whether an egalitarian such as Daniels or myself can justify universal care. Specifically she deals with Daniels’ argument for universal healthcare which she refers to as “the minimalist egalitarian strategy” (Jacobs, 333). In this approach Daniels argues for universal access to care on the grounds that it is a requirement of fair equality of opportunity. Also known as the second part of the difference principle, fair equality of opportunity was introduced by John Rawls as an alternative to formal equality of opportunity. Rawls considered the former to be an improvement on the latter in one important sense. Formal equality of opportunity holds that individuals with equal talents and motivations must have equal legal access to advantaged social positions. Rawls recognizes that this view is incomplete without taking into account the different socioeconomic starting points which individuals come from. This uneven footing is the reason that people of similar merit do not reach the same advantaged positions even though everyone has equal legal access. Fair equality of opportunity seeks to remedy this problem as it holds that people of equal merit should have equal prospects of success regardless of socioeconomic position. To this end Rawls argues everyone must have access to a system of education that serves to minimize the effects of one's socioeconomic class on ambitions and natural talents. The desired effect is a flattening of the socioeconomic gradient.

A2: Nozick's Entitlement Theory

Han Hennenberger, Connecticut College, 201, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

We can't determine the legitimacy of the initial entitlement or how to distribute it. The critique of justice as fairness which Nozick advances begins with praise. His preface shows the deep impact of Rawls' work in the three years between the publication of *A Theory of Justice* and *Anarchy, State, and Utopia* saying, "Political philosophers now must work within Rawls' theory or explain why not" (Nozick, 183). Despite his laudatory remarks Nozick raises many strong objections to Rawls' account of justice. He argues that such a theory of distributive justice is unjustifiable and that a historical, non-patterned theory of justice would be superior. The alternative which he proposes is entitlement theory. It states that any distribution which comes about from a previously just distribution through the principles of justice in holdings is itself just. I have attempted to deflate Nozick's account by raising doubts about the legitimacy of one of his principles of justice in holdings, the principle of acquisition in holdings. Without a principle which dictates how and when resources may be initially appropriated no just distribution can arise. Without this principle Nozick's entitlement theory ultimately fails and cannot be suggested as a legitimate alternative to Rawls' account of justice. Nozick utilizes a similar strategy attacking Rawls' key principle of justice, the difference principle. In order to defend this principle I have argued that from behind the veil of ignorance individuals would still choose the difference principle even if they had knowledge of Nozick's objection. The chance that they could be badly endowed in reality is convincing enough to accept that if they are actually better endowed they will have taken an unfair deal. The objections which Nozick raises are formidable, however, I have shown that they generally ill founded and thus not harmful to Rawls' account.

Cap K Answers

Non-unique and turn – the ACA props up the neoliberal logic of healthcare – the plan's UNIVERSAL approach opens up space

Gaffney 14 – Physician – Blogs at the ProgressivePhysician

[Adam Gaffney, The Neoliberal Turn in American Health Care, <https://jacobinmag.com/2014/04/the-neoliberal-turn-in-american-health-care>]

Last year's three-ring Congressional shutdown circus — for many little more than a desperate rearguard action by an isolated right-wing fringe to undo the fait accompli of Barack Obama's health care reform – reinforced with each passing day the gaudy dysfunction of the American political system. But we miss something crucial if we construe the perseverance of Barack Obama's 2010 Affordable Care Act (ACA) as nothing more than the overdue victory of commonsense health care reform over an irrelevant and intransigent right, or, even more, as the glorious culmination of a progressive dream for American universal health care long deferred. For many commentators, though, this is precisely what the ACA represents. With the law's passage in March 2010 and its survival in the face of a constitutional review by the Supreme Court, they have concluded that the battle "over universal health coverage," as one writer for the Washington Post put it, "is basically over." Unfortunately, the evidence does not permit such a sanguine conclusion. Most plainly, when we consider the provisions and limitations of the law, it becomes clear that though it may help many, the ACA fails fundamentally to create what so many had hoped for: a system of universal health care. Leaving millions still uninsured and many more "underinsured" — a well-described and researched phenomenon in which the possession of health insurance still leaves individuals and families with dangerous financial liability when illness strikes — the ACA falls well short of the standard of universal health care as it is understood elsewhere in the social democratic world. But more broadly, when we consider the ACA through the lens of political economy, an even more concerning narrative emerges, one that says even less about the triumph of social democracy and more about the sharp shift of the political center and the disintegration of the New Deal left. For the law fundamentally leaves intact a system of health care predicated, as we shall see, on key neoliberal health care beliefs, for instance the "moral hazard" of free care, the primacy of health consumerism, and the essentiality of the private health insurance industry. This is not, however, an acute development: indeed, as we survey the last half-century, a long, slow, yet unambiguous neoliberal turn in the political economy of American health care becomes evident, during which the window for true universal health care — wide open as recently as the 1970s — has been slowly closed simultaneous to a historic rise in inequality and an unprecedented expansion of corporate power. These developments are, of course, manifestations of a single transformation. Yet the neoliberal revolution of the political economy of American health care remains inadequately contextualized, requiring much deeper analysis and demystification — particularly in light of parallel changes unfolding in other nations throughout the world — if it is to be understood.

Policies like single payer are crucial to reducing racial inequality EVEN IF they don't correct everything wrong with the medical industrial complex

Gaffney 16 (Adam, physician and fellow in pulmonary and critical care medicine at Massachusetts General Hospital, adviser to the board of PNHP and contributor to Jacobin, US News and World Report, and USA Today, "Is the Path to Racial Health Equity Paved with "Reparations"? The Politics of Health, Part II," March 7th, 2016, <https://lareviewofbooks.org/article/is-the-path-to-racial-health-equity-paved-with-reparations-the-politics-of-health-part-ii/#!>)

Martin Luther King Jr.'s statement on the evils of health inequality is frequently quoted, but not usually in its full form. In his 1966 speech at the annual meeting of the aforementioned Medical Committee for Human Rights, he said, "Of all the forms of inequality,

injustice in health is the most shocking and the most **inhuman** because it often results in physical death.”[21] Indeed, studies have shown a statistical association between lack of insurance and mortality. **Removing the boundaries between individuals and the health care system is a critical step in the movement toward health care equality.** Tweedy, for instance, sees firsthand the harm inflicted on the uninsured when he works at the rural health clinic described earlier. But, even so, like Matthew, he gives insufficient attention in his book to the fact that, even with the reforms of the Affordable Care Act, we will continue to lack universal health care.[22] For instance, **under current reforms, 27 million are expected to remain uninsured 10 years from now, according to an approximation of the Congressional Budget Office.** We know that **Hispanics and blacks** are disproportionately represented among the uninsured.[23] **Covering these excluded millions seems critical.** Moreover, neither author discusses the fact that **the US health care system imposes substantial financial burdens at the “point of use,” in the form of copayments, deductibles, and co-insurance for medical care, which may deter care for those who need it.** Some have legitimately suggested that **these forms of cost-sharing disproportionately harm minorities, who have lower median income and net wealth.**[24] In other words, **the potential harm of, say, a \$2,000 medical deductible is dependent on your income and assets: those with fewer resources may lose out on important health care.** And finally, though Tweedy refers to the shortcomings of Medicaid, neither he nor Matthew emphasizes that **a health care system with a separate tier of access for the poor may be inherently unequal.** But would “true” **universal health care** do much to **combat racial health inequalities,** if it were, say, a **single-payer** system that eliminated out-of-pocket expenses and was equally accessible by all, without tiers or walls?[25] Or would it replicate current biases and inequalities? To some extent, **the answer is yes** to both questions. But even so, a body of research has suggested that, **even if these biases persist, a fully universal system might nonetheless be a powerful tool in reducing racial health care inequalities.** That evidence comes from what is arguably a quasi-single-payer system located in the US: the Veterans’ Administration (VA). Notwithstanding recent scandals that are indeed of great concern, the modern-era VA has justifiably earned praise for delivering a high — indeed, comparatively superior — quality of health care.[26] **There is also evidence that it may indeed effectively reduce, even potentially eliminate, some racial health inequalities.** Last fall, a study published in Circulation, the premier journal of the American Heart Association, received wide coverage in the media for some provocative findings. **The US Veterans Health Administration (VHA),** as the study notes in its introductory section, “**is a healthcare system that does not impose the typical access barriers of the US healthcare system that may disproportionately impede enrollment of blacks.**” The investigators therefore hypothesized that racial inequalities in cardiovascular outcomes and mortality found in the general population might be reduced in the VA, a “healthcare system that allows enrollment independent of race or socioeconomic status.”[27] **Consistent with previous studies, in their analysis of data from the general (non-VA) population, they found racial inequalities much as they expected to find them: blacks had a much higher mortality (after adjusting for various other factors) as compared to whites** (indeed, approximately 40 percent to 50 percent higher).[28] In striking contrast, in the VA population, even though the risk of stroke was either higher or similar among blacks as compared to whites depending on which statistical adjustments were used, the risk of coronary heart disease as well as overall death was actually lower among blacks. This is, of course, only a single study, albeit a rather large one with more than three million subjects. An accompanying editorial concedes that a number of factors may be at play. Nonetheless, the fact is that, as described by the investigators, these findings build on an existing literature consisting of multiple studies that together point to a reduction of racial health inequalities within the VA for critically important outcomes like mortality.[29] No doubt, there are still discriminatory practices in some or all of these facilities, and we can assume that there are conscious or unconscious biases at work in the minds of some of its clinicians, as there are elsewhere. Indeed, other studies clearly show that, even after the significant reorganization and reform of the VA in the late 1990s, there are still racial disparities in the VA.[30] **If we moved to a single-payer system on a national level, such biases would still need to be addressed along the lines Matthew argues. But the point is that a more egalitarian structure of the health care system itself might go even further in reducing them.** Indeed, in light of this research, **it seems fair to say that health care universalism could be a very powerful tool in combatting ubiquitous racial health inequities.** Attaining health care equality, in other words, requires **true equality of access.** And yet this simple notion is all too often ignored entirely in any discussion of health “disparities.”

Single Payer

Single Payer Critical to Fulfill Moral Obligation

The single payer system is critical to fulfill the moral obligation – the current system drives-up health care costs, threatening health care

Leo Chan, Assistant Professor of Finance Department of Finance and Economics Woodbury School of Business, Utah Valley University, September 2010, It is the moral obligation of the state to provide basic health care for its citizens, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1578548 DOA: 6-26-16

The title of this paper sets an almost impossible bar to clear. I must layout the reasons why universal health care is the moral obligation of the government, and why it is good for society. The health care reform plan presented by the Obama administration, while noble in its intention, will not solve the health care problem faced by many low-income families. To address the lack of health care for the low-income families, we must have a universal health care system. The problem is not just an issue for low-income families. If nothing is done to address the structural problem of the health care system in this country, the rapid cost increases will make it difficult for the middle class to obtain quality care at a reasonable price in the near future. Insurance is, in fact, not the solution, but it is the problem. The current system of subsidized health care insurance for those who have relatively high paying jobs is the main contributing factor for the lack of health care provided to low income families because it drives up the price of health care beyond the level low-income families can afford. Regardless how big the government's insurance plan gets, the root cause of the rapid increase in health care costs will not go away unless there is a national health care system. In this article, I will outline the problems with health care insurance and present a case for a nationalized health care system that is fair to all citizens.

Single payer models such as the plan recognize health care as a human right and use rights based discourse to advocate in favor of increased access to care.

Nichols, National Affairs Correspondent for The Nation, July 27, 2017 (John, "Jimmy Carter Calls for Single Payer", The Nation, <https://www.thenation.com/article/jimmy-carter-calls-for-single-payer/>, DOA 8/19/2017,

Democrats should listen to Carter, as they should **to the great mass of Americans who have made it clear that they want to maintain the access to health care that came with the Affordable Care Act and extend that access with an absolute guarantees of health care as a human right.** That old **argument for single payer, in combination for the new realities of scorching income inequality** and an increasingly unstable gig economy, **has made Carter and others recognize that the reform that was once morally necessary is now becoming an economic and social inevitability.** “I think eventually we’ll have a single-payer system,” Carter told a crowd of well-wishers before teaching his usual Sunday school class at Maranatha Baptist Church in his hometown of Plains, Georgia. Noting his own recent experience with Canada’s national health-care system—the 92-year-old former president was treated at a Winnipeg hospital, after he showed signs of becoming dehydrated while working on a Habitat for Humanity project—**Carter spoke in Plains about the logic of a universal single-payer system at a time when a growing number of prominent Democrats are joining Sanders making the “Medicare for All” argument.** Senator Elizabeth Warren, D-Massachusetts, has signaled that Democrats should campaign on the issue, arguing that: *President Obama tried to move us forward with health-care coverage by using a conservative model that came from one of the conservative think tanks that had been advanced by a Republican governor in Massachusetts. Now it's time for the next step. And the next step is single payer.* New York **Senator Kirsten Gillibrand has expressed similar sentiments in recent weeks, saying: “Health care should be a right, it should never be a privilege. We should have Medicare for all in this country.”** That’s smart policy and smart politics. The June Kaiser Health Tracking poll found that a majority of Americans (53 percent) now favor a single-payer health plan, while just 43 percent oppose such a plan. What’s especially notable is that not just progressive Democrats but independents are turning toward a “Medicare for All” system. “Not surprisingly,” note the Kaiser analysts, *There are partisan divisions in how the public feels about single-payer health care, with a majority of Democrats (64 percent) and just over half independents (55 percent) in favor and a majority of Republicans (67 percent) opposed. However, the recent increase in support for single-payer has largely been driven by an increase among independents. Among this group, on average in 2008-2009, 42 percent said they would favor a single-payer plan, a share that has increased to a majority (55 percent) in the most recent tracking poll.* **The Pew Research Center notes that support for the argument that government has a responsibility to provide health-care coverage is especially pronounced among young people under the age of 20—precisely the potential voters that Democrats will need to motivate in 2018 and in 2020.** Jimmy Carter finished his presidency before Americans who are under the age of 30 were born. But he recognizes what they recognize. **This is not complicated. It is what other countries have done. It is what the United States has done for older Americans with Medicare. Now, says Carter, the next step can be taken with “the expansion of Medicare to include all ages.”** Republicans have made their opposition to that expansion clear. They seek to constrain access to health care, not just by repealing the Affordable Care Act but also by undermining programs such as Medicare and Medicaid.

Single Payer Generally Works and Improves the Economy

Single Payer reduces costs by reducing billing/compliance

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The economic case for single-payer reform is compelling. **Private insurers' overhead currently averages 12.4% versus 2.2% in traditional Medicare (2). Reducing overhead to Medicare's level would save approximately \$220 billion** this year (Table) (3). **Single-payer reform could also sharply reduce billing and paperwork costs for physicians, hospitals, and other providers.** For example, by paying hospitals lump-sum operating budgets rather than forcing them to bill per patient, **Scotland and Canada have held hospital administrative costs to approximately 12% of their revenue versus 25.3% in the United States** (4). Simplified, uniform billing procedures could reduce the money and time that physicians spend on billing-related documentation. All told, we estimate that **single-payer reform could save approximately \$504 billion annually on bureaucracy** (Table). Any such estimate is imprecise; however, this figure is in line with Pozen and Cutler's estimate (\$383 billion, updated to reflect health care inflation) (5), which excludes potential savings for providers other than physicians and hospitals. Additional savings could come from adopting the negotiating strategies that most nations with national health insurance use, which pay approximately one half what we do for prescription drugs. Of course, **single-payer reform would bring added costs as well as savings. Full coverage would (and should) boost use for the 26 million** persons in the United States who remain uninsured despite the ACA. And plugging the gaps in existing coverage (abolishing copayments and deductibles, covering such services as dental and long-term care that many policies exclude, and bringing Medicaid fees up to par) would further increase clinical expenditures.

System wide expansion prevents any patient pile up

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Studies provide imperfect guidance on the probable magnitude of changes in use under single-payer reform. Microlevel experiments indicate that when a few persons in a community gain full coverage, their use surges (6). But when many persons gain coverage, the fixed supply of physicians and hospitals constrains community-wide increases in use. For example, when Canada rolled out its single-payer program, the total number of physician visits changed little; increased visits for poorer, sicker patients were offset by small declines in visits for healthier, more affluent persons (7). Despite dire predictions of patient pileups, Medicare and Medicaid's start-up in 1966 similarly shifted care toward the poor but caused no net increase in use (8). Despite some uncertainties, analysts from government agencies and prominent consulting firms have concluded that administrative and drug savings would fully offset increased use, allowing universal, comprehensive coverage within the current health care budgetary envelope (9). International experience with single-payer reform provides further reassurance. It has been thoroughly vetted in Canada and other nations where access is better, costs are lower, and quality is similar to that in the United States.

Racial Inequality

Single payer, with its recognition that health care is a human right, is key to address persistent structural racism in health care.

Caruso, Himmelstein, and Woolhandler, writing for the Harvard Public Health Review, 2015 (Dominic, David, and Steffie, MDs, July, "Single-Payer Health Reform: A Step Toward Reducing Structural Racism in Health Care", <http://harvardpublichealthreview.org/single-payer-health-reform-a-step-toward-reducing-structural-racism-in-health-care/>,

Racial and income equality are too often absent from conversations about health care financing. Research continually exposes alarming health disparities in the United States, particularly impacting African Americans and Native Americans. These groups have lower life expectancies than non-Hispanic white Americans, and experience higher rates of most major causes of death including infant mortality, trauma, heart disease, and diabetes.¹²³⁴⁵⁶⁷ Yet despite their greater need, **access to care is worse for minority populations by most measures.**⁸ **Unequal medical care is often viewed as a consequence of broader social inequalities, but the current health financing system also reinforces and institutionalizes inequality; unequal care may be viewed as a form of structural racism. While most Americans rely on private insurance, rates of private coverage are much lower for minorities** and the poor.⁹ **The Patient Protection and Affordable Care Act (ACA) offered subsidies to expand private coverage, making insurance more affordable for many families. However, many of these new private plans carry high deductibles and co-payments.** Deductibles for the ACA's bronze and silver plans average over \$5000 and \$2900, respectively, for single coverage, and over \$10,000 and \$6,000, for family coverage.¹⁰ Deductibles have also soared in employer-sponsored plans; in 2014, more than 40% of such plans carried a deductible of more than \$999, up from just 10% in 2006.¹¹ Moreover, while Medicaid traditionally imposed virtually no cost-sharing, several conservative state governors have extracted waivers from the Centers for Medicare and Medicaid Services allowing the imposition of cost-sharing on recipients as a condition for implementing the ACA's Medicaid expansion.¹²¹³ **High cost-sharing particularly impacts minority families, whose average incomes are far lower than those of non-Hispanic whites. Yet even figures on income disparities understate minorities' disadvantage when confronted with high out-of-pocket costs. With medical bills often reaching into the thousands for even routine care such as childbirth and appendectomy, many families must tap savings or other assets like housing equity, and racial/ethnic disparities in assets dwarf the differences in income.**¹⁴ African American and Hispanic median household income was 58 percent and 70 percent, respectively, that of non-Hispanic whites in 2011.¹⁵ In contrast, the median net worth of black and Hispanic households was \$6,314 and \$7,683, respectively, vs. \$110,500 for non-Hispanic whites, a 15-fold difference.¹⁶ Hence, the average family deductibles for bronze and silver plans would bring financial ruin to most African American and Hispanic households. **Even the lower cost-sharing now increasingly common under Medicaid may be prohibitive for poor families**, many of whom have zero or negative net worth. **The ACA's drafters erred in relying on private, for-profit insurers to fund health care. Health insurance's social purpose is to pay for care in order to promote access to health services and prevent financial hardship. For-profit insurers' purpose is to maximize shareholders' profits**, a goal that provides strong incentives to maximize premiums and minimize the health care they pay for.

Historically, this incentive led to such practices as denying coverage for pre-existing conditions and canceling policies for expensive enrollees. **Although the ACA prohibits these tactics, recent evidence indicates that insurers are finding ways to subvert these regulations**, e.g. through tiered pharmacy benefits that discriminate against enrollees with potentially expensive illnesses such as HIV, Parkinson's, seizures, psychosis and diabetes.¹⁷¹⁸ The persistence of our corrupt and irrational insurance system may stem in part from the way Americans (and particularly health professional students) are taught to think about health care. In a recent conversation with a Canadian student at Harvard's school of public health, he expressed surprise that many of his U.S. classmates perceive health care interactions as business transactions, and reflected that Canadians, who have a publicly-funded universal coverage system, view health care as a fundamental right to be provided for all. **Should we in the U.S. continue to treat health care as a commodity distributed according to financial ability, or shift to a financing system that assures it as a right equally available to all without regard to income, health status, race or ethnicity? While market theorists might claim that a commodity-based approach to care breeds efficiency, facts on the ground argue otherwise. At present, we have the**

world's highest per-capita health care expenditures, yet tens of millions remain un- and under-insured, and our health outcomes trail most other wealthy nations.^{[9]192021} This isn't just an indication of failed policy, it's a national embarrassment. We have the resources to provide everyone in the U.S. with access to health care. And Canada provides a working model for how to put those resources to good use: a public, single-payer, national health insurance program, similar to an expanded and improved Medicare for all. In our view a national single-payer health insurance program offers the best possibility for equitable financing of U.S. health care. It would eliminate the motive to deny needed care or discriminate against the expensively ill for the sake of profit. A national public insurance system would provide coverage based on residence in the U.S., not employment status, income level or ability to pay, as in the current regime. A program that abolished co-payments and deductibles would level the playing field for minorities and the poor who generally lack the assets to surmount these barriers.²² A single-payer system would also offer economic benefits. A federally-run financing system would have far lower administrative costs than private insurance, as the Medicare program consistently demonstrates. A universal public model would lift a significant financial burden from businesses that currently fund health insurance for their employees. Finally, a single-payer program would largely eliminate the financial burden of illness, a leading cause of bankruptcy and debts sent to collection.^{[19][23]} Perhaps most importantly, a single-payer system would make a clear statement that health care is a human right. This framework recognizes health care as a universal necessity, not a commodity reserved for those lucky enough to have won the economic lottery, and most definitely not a scheme for denial and discrimination. While implementing a single-payer insurance program will not solve all of our nation's health, racial or social inequities, it is clearly a step in that direction.

Healthcare is characterized by massive inequalities that create gaps in treatment quality AND outcomes---BUT, policy interventions can make gaps measurably smaller

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Health equity is a choice. Worldwide, humanity is consciously choosing to make progress toward health equity. The World Health Organization has reported more than a 50% reduction in under-five child mortality since the year 2000. The Lancet Commission's Global Health 2035 report asserted that, with strategic investments, nearly all countries could achieve "a grand convergence in health within a generation," reducing maternal-child deaths in high-mortality countries to the levels of the best-performing middleincome nations by 2035.1 The World Health Organization has similarly endorsed the Sustainable Development Goal of eliminating preventable deaths of infants and children under age five years. **WHAT IS A STRATEGIC INVESTMENT?** Spending money does not automatically buy better health outcomes. In an American Journal of Public Health report published in 2014, Barthold et al. found "robust differences" among Organization for Economic Cooperation and Development (OECD) nations from 1991 to 2007 in the efficiency of their health spending, as measured by life-expectancy improvements achieved for each one percent increase in annual health care expenditures.2 The United States ranked poorly in these international comparisons, ranking number one in per capita health expenditures, but 19th among OECD nations in the translation of spending into increased OECD life expectancy. The human return on US health dollars invested was only one fifth to one sixth that of Germany and Switzerland. A most basic choice is total spending. Budhdeo et al. showed that a one percent decrease in health care spending in European Union countries was associated with short- and long-term increases in mortality across a wide range of age–gender groups.3 How the money is spent also matters. Among nations, greater public-sector spending had far greater impact on survival than total spending, and up to a certain level, publicsector government spending was significantly more efficient.4 The United States continues to be the outlier in these international comparisons. **The moral choice to favor health care provider autonomy and free market economics over the collective good provides an ongoing demonstration of the US capacity to achieve market fragmentation and collective inefficiency in spending.** A related outcome is the persistence of gaping inequalities in health care access and health outcomes, which exact not only a human cost, but also a significant and avoidable economic burden. **ELIMINATING HEALTH DISPARITIES** Eliminating health disparities and making progress toward health equity comes down to a series of choices. **Expanding Medicaid and providing health insurance subsidies in the Affordable Care Act were small steps toward the progressive**

universalism that is necessary but not sufficient for ensuring population health. Repealing only those portions of the Affordable Care Act preferentially supporting the poor while maintaining only the provisions supported by families already able to purchase health insurance for themselves and their families will be a decision to move away from health equity, a choice violating the moral principles of justice and nonmaleficence. Even so, we can choose to make progress on racial/ethnic disparities in health outcomes. Fuchs recently documented mounting evidence of Black gains in life expectancy, and even greater gains among lower-income segments of the Black population.⁵ More than a decade ago, under the intellectual and moral leadership of David Satcher and Robert Levine, our team at the National Center for Primary Care at Morehouse School of Medicine dared to imagine, “What if we were equal?”⁶ We demonstrated that although Black–White disparity rate ratios had changed little over the decades from 1960 to 2000, the 40-year flatline was actually the average of significant reductions in Black–White disparities for women and increasing disparities for men. The choices we made as a nation mattered. Black women’s income as a percentage of White women’s increased significantly, even as antipoverty programs explicitly favoring women and children (the Special Supplemental Nutrition Program for Women, Infants, and Children; Medicaid; family planning; etc.) were being implemented. Black–White disparities for women declined. At the same time, our nation chose to systematically exclude men from these same programs, and to disproportionately incarcerate Black men, exacerbating male Black–White mortality disparities. Research on local-area variation in disparities shows that some communities are moving toward more optimal and equitable health outcomes without necessarily making conscious choices to pursue health equity or even being aware of their own progress. We have documented US counties that have moved from high levels of racial disparity to near equality in measures ranging from infant mortality to breast and colorectal cancer mortality across the entire population, as well as significant county-level variation in racial disparities in the low-income Medicaid population for conditions ranging from asthma to HIV. At the root of health disparities are social determinants. When policy decisions and systems combine to increase inequalities in equity. Behavioral health. Resiliency. Social cohesiveness. All of the above. Many income, wealth, and opportunity, they represent an explicit choice to move away from health equity. Even so, social determinants are not entirely deterministic, and demographics are not destiny. Levine et al. found 66 counties in the United States [have] with lower Black male mortality rates than the US average White male mortality rate, with no significant difference in Black–White poverty rate ratio or residential segregation index.⁷ Perhaps we can find replicable paths to health equity by learning from these positive outlier communities that have succeeded in making a way out of no way. The road out may not be the same as the road in. PROMOTING INTEGRATION It will not be easy. There are highly complex, bidirectional associations among upstream, midstream, and downstream factors driving disparities. No single intervention will produce health equity. We must consciously connect our efforts across sectors to achieve collective impact. We must become a cohesive and effective movement, promoting integration and managing the in-betweens of all sectors. Medical care. Public health. Community leadership development. Income equality. Economic development. Wealth equality. Educational communities have individuals or agencies working in each of these areas, but let us ask—whose full-time job is it to build the coalitions, to maximize collaboration, to deepen partnerships, to measure collective impact, and to create structures for mutual accountability on the specific objective of health equity? Who is actively measuring and reporting explicitly on progress toward equality of health outcomes and social determinants repeatedly in real time, to energize rapid cycle improvement across entire communities and nations? Global health research and US health equity research alike suggest that population health and economic efficiency are not incompatible. They are mutually reinforcing. We can choose both health equity and economic efficiency by demanding the most effective human return on investment (whether measured as improved survival, or decreased suffering, or best possible health) for the greatest number of people—in other words, committing to spend every dollar efficiently to achieve optimal and equitable health outcomes for all.

Other nations are achieving much higher economic efficiencies and much better health outcomes by using public-sector investments for the collective good. So let us choose to spend our money wisely. Let us demand the greatest human return on investment for every dollar we

spend. Let us pursue optimal and equitable health outcomes for all with precise economic efficiency. We can achieve health equity—if we choose to.

Single payer remedies inequalities from resource allocation and treatment bias by increasing government influence over providers and eliminating the profit motive for disparate treatment

David A. Ansell 17. Senior Vice President for Community Health Equity, Rush University Medical Center, Associate Provost for Community Affairs, Rush University, social epidemiologist and author. 2017. The Death Gap: How Inequality Kills. University of Chicago Press. CrossRef, doi:10.7208/chicago/9780226428291.001.0001.

The US healthcare system provides unequal care. Just as life expectancy is determined by which neighborhood you live in, for many Americans what hospital or doctor you can see is influenced by neighborhood, insurance, race, and ethnicity. And if you live in a high-mortality neighborhood, a trip to the local hospital might just be a matter of life and death. There are three major reasons why health care delivery in the United States is not equitable. The first is that health care is treated as commodity, not a right. The poor (with or without insurance) living in neighborhoods of concentrated disadvantage often have more limited access to quality health care.² Those who are uninsured and underinsured experience great difficulty accessing needed care.³ Minorities and the poor are less likely to have private health insurance than white middleclass Americans.⁴ When minorities and the poor do have insurance, it is more likely to be one of the publicly funded insurance policies that not all hospitals and doctors accept. The second reason is that minorities sometimes get different treatment for the same illness from what whites get, regardless of insurance. Health care providers' implicit racial bias and patients' mistrust may be the causes of this differential treatment.⁵ The third reason why health care delivery is unequal is that the health care institutions that serve the poor in general suffer from cash and capital shortages. Neighborhoods of concentrated advantage where people with better insurance live have better-resourced hospitals and clinics than poor neighborhoods do. This is how structural violence works within the fabric of the health care system. It is not as if great care cannot be delivered in underserved settings. It is, every day. But it is inconsistent or constrained by a lack of resources. Thus minorities and poor people die disproportionately as a result of an unfairly structured American health care system. The Deadly Divide Take breast cancer care. It is a gruesome fact that in the United States, black women are 40 percent more likely to die from breast cancer than white women. While black and white American women now develop breast cancer at the same rates (something that was not always the case), more black women will die of the disease.⁶ Why does this particular death gap exist? An oncologist will tell you that black women first seek treatment with larger, more deadly, laterstage breast cancers.⁷ But the truth is that the breast cancer death gap is not just a biological phenomenon but a consequence of structural violence. A woman's neighborhood can determine whether she will survive breast cancer or die from it. It would be grisly enough if breast cancer were the only disease that discriminated. It is not. From heart disease to hepatitis C, depression to diabetes, blacks throughout the United States suffer higher rates of illness and death than whites. It is tough to name many diseases that do not discriminate by race, place, and poverty. But breast cancer is a disease that demonstrates vividly how structural violence is woven into neighborhood fabric, especially in black communities. The Missed Breast Cancer The key to unlocking the inequity in breast cancer mortality came from a radiology reading room on the top floor of Mercy Hospital on Martin Luther King Jr. Drive on Chicago's South Side. The room was dark except for the projected image of a mammogram. Amid the cool gray background of fatty breast tissue was an unmistakable irregular-shaped mass, its speculated white tentacles invading

the surrounding tissue—a telltale sign of advanced breast cancer. It was as obvious as a ticking bomb. Dr. Paula Grabler, a radiologist specializing in reading mammograms and diagnosing breast cancer, was then the director of breast imaging services. At most of the other small hospitals that served South Side African American communities, mammograms were read not by specialists but by general radiologists. Too often cancers were evident but missed. This case was no different. “She was a middle-aged African American woman,” Dr. Grabler recalled.⁸ “The patient had been seen in the past at a small South Side hospital and had a screening mammogram that was reported to be normal. Months later she came to me with a lump in her breast. I asked to get a copy of the prior mammogram and there it was: a large, very obvious breast cancer.” Grabler typically removes mammograms from the view box when she meets with patients. She does not want the image of the cancer to shock the patient. “But on this particular day, I forgot to,” she said. The patient gasped when she saw the large white mass that exploded from the gray background of the x-ray. “How did they miss it?” she asked. It was a glaring mistake that could cost her her life. “I honestly don’t know,” Grabler replied. But she did know. The doctor who read her mammogram was not an expert. He was an itinerant radiologist who read all types of x-rays. Detecting breast cancer early requires meticulous attention to detail. Trained experts who read mammograms find six times more breast cancers than general radiologists do.⁹ In Chicago, most of the breast centers that are near or in the black wards do not have such specialists. Cancers are missed. Women die. An obvious breast cancer on a mammogram. The patient presented with a lump in her breast; the prior mammogram had been read as normal. Sometimes the cause of racial disparities in health care can be as banal as an inexperienced or busy doctor missing cancer. Source: authors personal collection. That missed breast cancer held the key to understanding an aspect of premature mortality: access to screening is important for finding breast cancer early—but the quality of that screening is even more critical. We found a screening facility serving Chicago’s black community that found two breast cancers for every thousand women screened, when the correct number should have been at least six.¹⁰ More than half were missed. Add to this injury the insult a black woman feels later when she goes to see a doctor with a bad cancer and is told that her genetics are at fault. Institutional racism as a structural cause of increased mortality can sometimes be as banal as a poorly qualified doctor missing a cancer in a poorly run mammography center. In a Chicago study of missed breast cancers, poor women, minority women, and publicly insured women were significantly more likely than well-insured white women to have their cancers missed (they were there on the mammogram on a lookback.)¹¹ Socially disadvantaged women (poor, minority, and uninsured) are significantly more likely to have a cancer missed on mammography because they are more likely to receive care at substandard facilities, in segregated neighborhoods, than advantaged women are.¹² Even if women of color do everything right—get screened, schedule follow-up appointments—they can still fare worse than white women simply by virtue of where they live. This is not just a product of poverty, though poverty itself is a big predictor of inequity. There are plenty of poor white women in Chicago, but there is not one poor white Chicago neighborhood.¹³ Poor white women can get their breast care in the same neighborhood hospitals as the more wealthy women in their neighborhoods. This is structural violence and institutionalized racism at work. Women living in Chicago’s neighborhoods of concentrated advantage are 37 times more likely have ready access to a “breast center of excellence” than women living in high-poverty neighborhoods.¹⁴ This maldistribution of resources did not occur by chance. The Spread of Racial Disparity None of this mattered when there were no effective treatments for breast cancer. From the mid-i930S, when breast cancer mortality was first measured in the United States, until the early 1980s, when screening mammography and new chemotherapy agents were shown to be effective at

reducing mortality, there were no black-to-white or rich-to-poor gaps in breast cancer mortality.¹⁵ But in the early 1990s, as breast cancer became more amenable to new treatments, the breast cancer death rate for white women across the United States began to plummet.¹⁶ The death rate for black women in Chicago did not budge.¹⁷ The improvement for white women was easy to comprehend. Years of effort to raise awareness about the importance of regular mammography screenings coupled with improvements in technology and the emergence of specialists like Grabler meant that more cancers were detected early. Meanwhile, advances in treatment further increased survival rates. But it was here that a new racial death divide emerged. It grew from a sliver to a chasm over the next twenty years. Poor women, and specifically poor black women, were not getting the same quality of breast cancer care as wealthier and white women. Researchers have described this growing racial gap in cancer mortality as the “amenability factor.”¹⁸ As cancers such as breast cancer become more amenable to treatment interventions, racial cancer survival disparities widen because poor minority women do not have easy access to the lifesaving cures.¹⁹ Inequality in Quality In 2007, 160-plus doctors, researchers, and community activists in Chicago convened the Metropolitan Chicago Breast Cancer Task Force to investigate the gap and decide how to close it. We analyzed the data. We drilled into the deaths. We held focus groups of black and Latina women on the South and West Sides. We heard their stories of fragmented and disrespectful health care in their communities. We released a report.²⁰ It confirmed that access to quality of care was responsible for the wide racial gaps in breast cancer mortality. The report also made thirty-seven recommendations for closing the gap. Yet breast cancer researchers scoffed. They clung to the usual genetic and biological explanations. We fought back, pointing out the structural components of the death gap, both in Chicago and nationwide. Chicago’s gap was twice as large as the national gap and seven times larger than the gap in New York City, suggesting that geography is a significant variable.²¹ Cities like Memphis and every major Texas city had even larger breast cancer death gaps than Chicago’s.²² In Detroit, black and white women had the same terrible mortality rates. The cities with the greatest breast cancer death gaps were also the ones with the largest dissimilarity index scores, denoting advanced degrees of racial segregation.²³ Moreover, biology cannot explain the variability in the racial death rates in cities within the same state. For example, in Los Angeles black women are 71 percent more likely to die from breast cancer than whites. In Sacramento and San Francisco this gap does not exist.²⁴ A Map and a Story The task force published a map of Chicago showing the communities with the highest breast cancer mortality. Twenty-three were black communities and one was white. All were located on the West and South Sides. All the black communities were neighborhoods of concentrated US Health Care: Separate and Unequal * 119 Years Disparity ratios in breast cancer mortality between white and black women across New York City, the United States, and Chicago from 1990 to 2010 show that geography, more than biological and genetic factors, influences women’s mortality. Source: Metropolitan Chicago Breast Cancer Task Force. poverty and disadvantage.²⁵ In mostly black neighborhoods, not one hospital has earned the American College of Radiology’s seal of approval for breast imaging centers. Only one hospital in a high-mortality black neighborhood has been certified by the American College of Surgeons’ Commission on Cancer as a cancer treatment center. In contrast, in the white wards there are fourteen cancer accredited hospitals. This was a bleak picture of the structural nature of racial inequality. It’s one thing to look at disparity on a map. It’s another to hear from the women who try to navigate the fractured system of care. Chicago and other cities have a hodgepodge of public and private hospitals and clinics, with little communication between them and poor coordination of care. Barbara Akpan is a retired nurse in Chicago. After her breast cancer diagnosis and treatment at an academic medical center, she began serving as a volunteer

community advocate for other African American women on the South Side. Her observations reinforce the notion that inequality in the quality of breast cancer care was failing women. "Many of the women I work with are afraid," she said. "They do not trust the health care system. Many of the clinics and hospitals they go to do not provide the best care, or they simply give them the wrong Hospitals with American College o f Surgeons Approved Cancer Programs African American Community Areas with Elevated Breast Cancer Mortality In Chicago's African American neighborhoods with high mortality for female breast cancer, there are few hospitals with American College of Surgeons-approved cancer programs. Consequently, black women with breast cancer concerns have to either travel for care or receive care at nonapproved cancer treatment sites. This map depicts how health inequality is structured into the geography of a region. Source: <http://link.springer.com/article/10.1007/s10552-009-9419-7>. information. It's hard to overcome the mistrust. For women in the southland—Ford Heights, Chicago Heights, Harvey, poor areas on the South Side—access to mammography screening sites is really poor," says Akpan. "Women are falling through the gap—they don't know where to go."²⁶ When we traveled around Chicago and other cities, showed audiences of black women the mortality curves illustrating the black breast cancer death gap, and gave our explanations, they cried. We had validated something they knew to be true: the systems that served them were often inadequate. They cried because our data told them that the breast cancer death gap was a system problem and not a problem within black women. Their reactions galvanized us to focus on fixing the system. Because the mortality gap was structural, we needed hospitals to work together to improve care for black women. We identified hospitals with undertrained mammography technicians and radiologists and arranged free continuing-education courses. We met with CEOs to share their hospital's quality data and make recommendations for improvement. But this was not going to improve care fast enough. If a small inner-city hospital lacked the expertise to provide comprehensive breast cancer care, no amount of quality improvement would remedy it. But what if we could move women from poor institutions to good ones? Navigating to Quality We hired health "navigators." These were community health workers and nurses who could direct women to high-quality hospitals for screening and treatment. We solicited breast cancer services from all the region's top hospitals. Most obliged. The navigators guide their clients into care at the city's highest-quality medical centers even when they are two hours and two bus transfers away. Sometimes the navigators battle with the local doctors to wrest the patient into better care. Gerri Murrah is typical of the patients navigated. She was 60 and developed a sore lump in her breast in 2015. Not having a primary-care physician, she had gone to her local emergency room. The doctor didn't even consider cancer; Gerri was given antibiotics and sent home. Luckily, Murrah knew something was wrong and went to a different clinic and requested a mammogram. The results were suspicious. Murrah was assigned to a surgeon at a neighborhood hospital. This surgeon, not a breast specialist, made two bungles: Instead of doing a needle biopsy, he surgically removed the lump—a painful and unnecessary procedure. Then, without informing Murrah of the stage of her breast cancer (stage III), he recommended an unneeded mastectomy. When DeShauna Dickens, one of the task force navigators, finally connected with Murrah, she referred Murrah to the University of Chicago Hospital for a second opinion. There, Murrah learned she had other options that would preserve her breast. "DeShauna came in just in time to stop me from having my breast cut off," she says, in an O, the Oprah Magazine interview.²⁷ There are setbacks. Not all women respond. Not all institutions have the will to better their conditions. Some facilities were deplorable, such as the mammography facility in the Washington Park neighborhood's Provident Hospital, which the task force staff visited in 2014. The room that was used to develop mammography films had a sewer manhole cover in the middle of the floor and was suffused

with noxious sewer fumes. The path to improve quality and reduce mortality can be slow and painful. The Breast Cancer Quality Consortium Yet progress has been made. The grassroots team persuaded 160 health care providers across the state, including every Chicago hospital, to share their data, such as tumor detection rates and follow-up rates. Slow improvements in quality were made even in the poorly performing hospitals. In 2013, after seven years of work, the black-white breast cancer death gap in Chicago had narrowed by 35 percent.²⁸ While the exact reasons for the improvement in the mortality gap are not easy to tease out, in no other metropolitan area of the United States has that death gap been reduced. The reduction in black breast-cancer deaths in Chicago shows that mortality inequities caused by structural violence are fixable. Focused and deliberate work directed at equalizing the health care system can save lives. Racial disparity can be reduced—and possibly eliminated. “We don’t need a magic bullet to fix this,” says Dr. Patricia Ganz, a member of the Breast Cancer Research Foundation Scientific Advisory Board and professor of medicine and public health at UCLA. “We just need to give black women the same standard of care.”²⁹ Implicit Bias Contributes to Unequal Care While the story of the Chicago breast cancer death gap has had early success, in too many areas and on too many levels we are still dealing with the most basic inequities and prejudices. Bias, even if unconscious, affects individual physicians and their treatment decisions. This is unsettling but true. While most doctors do not exhibit explicit racial bias, such as refusing to treat certain patients because of their race, on tests of implicit bias they, too, show unconscious preferences for whites over dark-skinned faces. The Implicit Association Test is a widely used test of social cognition. More than 70 percent of the millions of Americans who have taken it exhibit a subconscious preference for whites over blacks.³⁰ Physicians score similarly. An ingenious 1999 experiment showed how unconscious bias affects clinical decision making. Thousands of doctors were asked to test their clinical acumen by reviewing the medical history given by a performer who acted out the symptoms of a potential cardiac syndrome on film.³¹ There were eight elderly patients. Four were men: two white and two black. Four were women: two white and two black. Physicians were asked to recommend a cardiac workup based on the clinical information the patients relayed. In addition, physicians were told whether the patient was insured or uninsured. The results were not surprising. Based on the gender, race, and insurance status of the patient, doctors recommended entirely different medical workups. Men of both races were more likely to be referred for angiograms to evaluate symptoms of chest pain. But blacks of both genders were less likely than the whites to be referred for the full cardiac workup. Those who were noted to be insured were more likely to be referred for a full workup as well. While this was an experiment and not real clinical care, unconscious bias in health care delivery seems to be a real phenomenon. In an eye-opening 2002 report on health care disparities, the Institute of Medicine found “strong but circumstantial evidence for the role of bias, stereotyping, and prejudice” in perpetuating racial health disparities.³² Some research suggests that there is a direct relationship among physicians’ implicit bias, mistrust on the part of black patients, and clinical outcomes.³³ In a prospective study of older adults, patients who experienced discrimination in health care more than once yearly were twice as likely to have a disability four years later than cohort members who suffered no discrimination.³⁴ What needs to be done to address implicit bias in medicine? Awareness is a start. Mandatory bias testing and cultural intelligence training have been proposed. But it requires day-to-day interactions between people of different backgrounds to break the implicit boundaries that prevent deeper understanding.³⁵ And that’s necessary, but fair. But bias is only a piece of the story. Having No Insurance Is Bad for Your Health Another major factor driving inequitable care is lack of health insurance. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether. Twenty-five percent of adults without coverage

say that they went without care in the past year because of its cost, compared to 4 percent of adults with private insurance coverage. Moreover, 55 percent of uninsured adults do not have a regular place to go when they are sick or need medical advice.³⁶ When uninsured patients get injured or develop a chronic disease that requires follow up, they are less likely than those with coverage to actually obtain all the services that are recommended.³⁷ Blacks and Latinos are more likely to be uninsured than whites, which only increases the burdens of health care inequity borne in neighborhoods of concentrated poverty. Prior to the Affordable Care Act, an estimated 45,000 residents died each year due to a lack of insurance, or one person every twelve minutes. If being uninsured was a cause of death, it would be the tenth most common one in the United States.³⁸ The next chapter will deal further with the issue of health insurance. Apartheid Hospitals Once people do get insurance, there is no guarantee they will get good treatment. As Nobel Prize winner Angus Deaton has noted, "Hospitals in the United States are run on something close to an apartheid basis with few white patients in the hospitals that treat mostly African Americans and vice versa."³⁹ Hospitals in which the majority of patients served are minorities have higher mortality rates across the board, whether from trauma, cardiac surgery, or general surgery procedures. In fact, as the percentage of minority patients served increases at an institution, so do the mortality rates across many conditions. There seems to be a direct correlation between the proportion of minority patients served by a hospital and death rates.⁴⁰ Take trauma care as an example. Trauma centers that serve mostly minority patients have higher mortality rates than those that serve mostly white patients. There is a gradation of trauma mortality based on the percentage of minority patients served by the trauma center. Those trauma hospitals with fewer than 25 percent minority patients have 60 percent better trauma survival rates than trauma hospitals with more than 50 percent minority patients. Hospitals with 25-50 percent minority patients have trauma mortalities in between the two.⁴¹ Why would this be? Trauma centers require specific levels of physician and other staff coverage, and they require periodic rigorous certification. Shouldn't this attention and regulation lead to better care, regardless of race and ethnicity? There are only two possibilities. One is that trauma severity or high-risk conditions are more prevalent among patients in institutions that serve mostly minorities. However, even when severity of illness is controlled for, minority trauma centers have 37 percent higher mortality rates than those serving mostly whites. The other possibility is that the care is actually unequal. I have shown how this is true for breast cancer care. It seems to be true for many conditions. What hospital you attend is literally a matter of life and death. In general, hospitals and clinics where many minority patients receive care are lower quality than those that serve white populations, whether for medical or surgical conditions.⁴² Further, hospitals treating a higher proportion of black patients have higher mortality rates for many surgical procedures. In addition, these hospitals have higher mortality rates independent of race: both black patients and white patients have higher mortality in hospitals with mostly black patients than their racial counterparts in other centers.⁴³ The federal Center for Medicare and Medicaid Services recently created a national star ranking system for hospitals, to allow consumers a means to assess hospital quality. A hospital can be ranked from five stars to one star, with five stars denoting a very high quality hospital with lower mortality and one star being a low-quality hospital with high mortality.⁴⁴ In practice, star rankings vary by the whiteness of the hospital's clientele. Five- and four-star hospitals in America serve patient populations that are predominantly white. One- and two-star hospitals in America serve predominantly minority patients and very few whites. This is true for care at clinics as well as hospitals. The doctors who work at clinics that care for predominantly black and other minority populations are less likely to be board certified, have less access to specialty consultation, and work in more chaotic conditions. It is not

a matter of the patients' race or ethnicity. Hospitals and clinics in poor neighborhoods, those that serve uninsured populations or those on Medicaid, often do not have enough resources to provide the very best care.⁴⁵ What seems at first blush to be a racial disparity is actually a consequence of structural violence and institutionalized racism. Just follow the money. Let's compare the cash situations at two Chicago hospitals, both trauma centers. During my decade at Mount Sinai Hospital, located in a low-income black neighborhood, 20 percent of the patients had no insurance. Another 60 percent had Medicaid. The patient population served is virtually 100 percent black and Latino. If a white person happens to be hit by a car down the street from Sinai, then they might be brought there. Otherwise a white patient, or anyone who is well insured, would rarely set foot inside Sinai. Then there's Northwestern Memorial Hospital. One of the top hospitals in the United States, on the US News and World Report Honor Roll, it towers over Lake Michigan about five miles from Sinai, in Chicago's predominantly white Streeterville neighborhood. It has an A bond rating, and about 500 days of cash brimming in its accounts. This translates to \$2 billion in bank reserves. Most of Northwestern's largely white patient population has private insurance. A small number are uninsured. During my time at Sinai, there were often only a few days of cash on hand. Sinai had no bond rating—meaning no bank would lend it money for capital investments. Just as Lawndale had been redlined seventy years prior, Sinai and other hospitals that serve poor communities are redlined by the banking industry today, limited in their ability to borrow. Sinai has been an anchor in the Lawndale neighborhood since 1919, and it takes care of everyone who comes to its doors, regardless of ability to pay. The price of this noble mission is a hospital's equivalent to a vow of poverty. From a banker's perspective Sinai is a bad investment. Compare Northwestern and Mount Sinai's spending on capital in 2012. Capital dollars reflect the amount of money that a hospital has to spend on patients, doctors, equipment, and upgrades. Northwestern spent \$273 million on buildings and equipment. Sinai spent just \$6 million.⁴⁶ The failure of capital markets to support Sinai contributed to its chronic struggles to maintain service quality. If we really want to achieve equity in health care outcomes, then we have to invest more into the institutions serving those who need care the most, like Sinai. This means redistributing capital dollars based on need from Northwestern and its neighborhoods to invest in Sinai and its Lawndale neighborhood. This is just the opposite of how the American health care system works. In America we have arranged it so those who need it the most (often black people and other minorities) get less, while those with the most (white and affluent people) get the best care and facilities available in the world. It is no surprise that life expectancy in Northwestern's neighborhood is 85 years. In Sinai's neighborhood it is 72 years.⁴⁷ Failure to Rescue When it comes to providing the highest quality of care, volume matters. The doctors and the nursing staff who are exposed to high volumes of particular kinds of cases have more time to hone their skills, and this leads to better outcomes. A surgeon who does liver transplants every week is better at them than one who does one per year. As for complex surgical conditions where high volumes of cases are crucial to achieve the best outcomes, nonwhite patients are more likely than whites to receive them at low-volume institutions. These patients are also less likely to be rescued if they deteriorate postoperatively. Procedural complication rates are exactly the same at high-mortality and low-mortality hospitals. So what is the reason for the death gap? The answer is culled failure to rescue. When a sick patient gets a complication, the doctors and nurses have to recognize and treat it—that is, rescue the patient from dying. Hospitals with well-developed systems to recognize complications and rescue patients have lower mortality.⁴⁸ While all the components of rescue have not been identified, adequate nurse staffing and training is critical. The hospitals with the least capability to rescue—due to nursing shortages, lack of training opportunities for staff, or other factors—serve significantly more minority

patients and suffer higher mortality rates.⁴⁹ Truth or Consequences Cardiac surgery at Mount Sinai Hospital is an example of a low-volume and high-mortality program. Its struggles are instructive for understanding the day-to-day decisions in a poor hospital and how they lead to health inequities. When I worked there, the heart surgery program was small—about fifty cases each year. Programs this small have trouble maintaining quality because there is not enough repetition for all the staff who need to be in top form. In addition, because the capital investments required to maintain the service were so high, Sinai managers thought the limited capital we had should be invested elsewhere. So we closed the program and partnered with a nearby, higher-volume academic medical center (University of Illinois) to take our patients. It made sense. The neighborhood did not need a small, poorly functioning heart-surgery program. Then one day we had a patient in the cardiac-care unit with three blocked coronary arteries. He needed emergency bypass surgery. Our cardiologists inserted a special pump into his aorta to boost to his failing heart until lifesaving cardiac surgery could be performed. Time was critical. But the patient was uninsured, and the University of Illinois refused the patient. In desperation I phoned the chief of cardiology there. He recommended that the patient be discharged from Sinai and instructed to walk into the University of Illinois emergency room. Then, he said they would be required to treat him. I was shocked. Not only was this immoral, but it was medical malpractice. The patient was hooked to life support, teetering on the edge of death with an artificial heart pump attached to a blood vessel in his groin. Without surgery soon he would surely die. It took a call from our CEO to U of I's CEO to get this patient transferred. After this event, against their better judgment, our cardiologists urged our CEO to restart cardiac surgery at Mount Sinai. Despite the low volumes, inability to guarantee quality, and high capital costs, it became a necessary investment. These are the choices faced by safety-net hospitals in communities of concentrated disadvantage. Provide nothing and let patients die from neglect; or provide the best care you can, at risk of higher than desired mortality, and hope to pull most patients through. More broadly, a 2014 study evaluated cardiac-surgery mortality in patients insured by Medicare. Nonwhite patients succumbed at a 33 percent higher rate than whites (after risk factors were controlled for). Thirty-five percent of the death gap was due to deficiencies in hospital quality. The highest-mortality hospitals were those that served predominantly minority populations. Both white and black patients who received their heart surgery at predominantly minority hospitals had higher mortality rates, suggesting structural factors were responsible. When we speak of institutionalized racism as a structural cause of premature death, it is not the virulent type of racism that we associate with opposition to the civil rights movement of the 1960s. It's a more banal but deadly form of brutality woven into the tapestries of our institutions and thus harder to eradicate. I was not shocked by the study's findings.⁵⁰ I knew that race itself—as a social marker—was not the reason for the cardiac mortality gap at predominantly minority hospitals; it was our tolerance for inequality in quality across our health care system. This becomes even more obvious when we contrast these findings with the outcomes in the Veterans Administration system, where care is structured the same way nationwide. In the VA system there is no equivalent racial heart-disease death gap.⁵¹ Inequality in Quality and Unequal Treatment It is not only in majority minority hospitals that black health-care inequities exist. When black and brown patients receive medical care in any setting, they are more likely than white patients to receive unequal care. This was documented in the Institute of Medicine's shocking Unequal Treatment report, which synthesized hundreds of studies of age, sex, and racial differences in medical diagnoses, treatments, and health care outcomes. The report concluded that for almost every disease studied, black Americans received less effective care than white Americans. These disparities prevailed even among groups with identical socioeconomic or insurance status. Minority patients received fewer

recommended treatments for diseases ranging from AIDS to cancer to heart disease.⁵² How much of the treatment gap is related to implicit bias, patient mistrust, physician practice style, or systematic organizational dysfunction is not known, but these gaps have persisted over the decade and more since the Institute of Medicine report.⁵³ Each year since 2003, the Agency for Health Care Quality and Research has tracked progress on health care inequity across America, analyzing more than 250 quality measures across a broad array of settings and services. In the 2014 report, the agency reported no overall improvement in racial health disparities from prior years. Not one iota. The American Hospital Association Pledge In 2015, in response to years of intractable health care inequities, the American Hospital Association called upon CEOs of hospitals across America to sign a pledge to measure health inequities within their own institutions and to fix them. The Equity of Care Campaign to End Healthcare Disparities focus is on four areas. First, hospitals are to choose a quality measure that is important to their community. Next, they are to develop a plan to address a disparity, whether by race, ethnicity, or language preference. Third, hospitals are asked to provide cultural competency training for all staff or finalize a plan to do so. Finally, hospital operations teams are asked to initiate a dialogue with the board and leadership team about this disparity work.⁵⁴ After over a century of documented health-care disparities, this step is important. But it is hardly enough. The nation's hospitals have been organized for the most part to make money by attracting the best clientele with the best insurance policies. For most hospitals this means avoiding poor and minority neighborhoods. Those frayed and capital-poor hospitals that have made it their mission to care for poor and uninsured often struggle in poverty like their clients. Just as the neighborhoods of concentrated disadvantage were created by white and industrial flight and the expansion of neighborhoods of concentrated advantage, a similar phenomenon has occurred in health care. The nation's wealthiest health care systems for the most part have avoided serving the residents of concentrated disadvantage by placing offices and hospitals only in white communities of advantage. So pledges are well and good, but without larger structural changes that level the insurance and capital decisions that underpin the health care system, health care equity will continue to be elusive. Only with national health insurance reform that begins with the idea of health as a human right could these structural issues be resolved. The Affordable Care Act, the most recent response to the need for health care reform, has tried to address these issues. However, as we will see, it has been an inadequate solution so far.

HEALTH INSURANCE IN AMERICA

You guys are evil. Canada's the best country in the world. We go to the doctor and we don't have to worry about paying him, but here your whole life you're broke because of medical bills.¹ JUSTIN BIEBER It will not do to note that under the Affordable Care Act almost 90 percent of Americans currently have some form of health insurance, any more than it would do for a hotel to note that 90 percent of the time the roof over your bed does not leak when it rains.² Of all possible ways to remedy structural violence in America, the creation of an equitable universal health-care system based on the idea that health care is a right, not a commodity, ranks high. While the health care law was a reform of the old system that saw fifty million Americans uninsured, the Affordable Care Act perpetuates health care inequity and fragmentation by its very design. Yet if Republican calls to repeal the law are heeded, we will be back to square one. And bad will revert to worse. I was not surprised that the solution for universal health care in the United States would be to prop up the existing costly, inequitable, and inefficient insurance system. In 2003 my wife and I cosponsored a fundraiser in Chicago for the then little-known Illinois state senator Barack Obama, who was running for the US Senate. In the living room of a modest single-family home in the neatly manicured South Shore neighborhood of Chicago, I asked the future president his position on national health-care reform. His words presaged what came to be known as "Obamacare." "I'm a proponent of a

single-payer system," he responded. But he explained that the political power held by the health insurance companies was so formidable that opposing them would be political suicide. He noted that the insurance industry had over 250,000 employees across the country and a lobbying apparatus that had to be reckoned with in any drive for universal health care. "Single payer will never get passed in the United States," he concluded. He was correct. Single payer did not even get a hearing. The Affordable Care Act was a modest reform of the existing tiered healthinsurance system, which treats health care as a commodity, not a human right. The coverage provisions in the Affordable Care Act built on and attempted to fill in the gaps in a piecemeal system that had left many without affordable coverage. There have not been impressive gains since the passage of health reform.³ A net of twenty million more people gained health insurance coverage between 2013 and 2015. Medicaid has expanded in thirty-two states and the District of Columbia, providing new access to coverage to millions of previously uninsurable Americans.⁴ The Affordable Care Act has been successful in reducing the number of uninsured, but about 30 million Americans remain uninsured.⁵ Most important, the Affordable Care Act fails two critical parameters of health justice: it is neither universal nor equitable. Elegant, Equitable, and Not to Be The most elegant, comprehensive, fairest, and lowest-cost solution to the health care crisis would have been to expand and improve the Medicare insurance plan to cover all Americans.⁶ Medicare, enacted in 1965 as a single governmental payer system to provide health insurance for Americans 65 and older, has been well liked since its inception. Before Medicare, 48 percent of such Americans had no insurance; now only 2 percent are uninsured. In addition, before Medicare 56 percent of senior Americans paid out-of-pocket health care expenses, compared to 13 percent now.⁷ Satisfaction with coverage is substantially higher among Medicare recipients than for those who have private insurance. Only 8 percent of Medicare enrollees report their experience as fair or poor, compared to 20 percent of those with typical employer-based health insurance coverage and 33 percent of those who purchased private insurance directly.⁸ Moreover, the costs of administering the program are substantially lower than those of private insurance companies—only about 2 percent of the total cost for Medicare, compared to 12 percent for the least expensive insurance company's overhead charges.⁹ Most important, experts estimate that since its inception Medicare has added five years to the life expectancy of older Americans.¹⁰ Polls have shown that universal government-sponsored health coverage is preferred by half of Americans.¹¹ And an improved Medicare would be an entitlement available to all Americans, with the exact same benefits for the wealthy and the poor. Medicare for all would achieve the goal of universal access to health care. As an entitlement for all US citizens (and extended to noncitizen residents), access to health care would be a right. This would contribute to the improvement of the life expectancy gap between rich and poor. Plus it would save an estimated \$400 billion yearly by eliminating administrative waste.¹² So if one wanted to solve the problem of the uninsured and reduce the death gaps between rich and poor, expansion of Medicare with other enhancements would have been the most logical approach. This is not a radical idea. Thirty advanced industrialized nations have forms of universal health care.¹³ Canada has a "Medicare for All" health insurance with easier access to care, lower costs, and better health outcomes (including life expectancy) than those of the United States. The evidence is compelling. While health inequity has not been eliminated in Canada, the differences between poor and rich are not as striking as they are in the United States.¹⁴ In Canada, men in the poorest urban neighborhoods experienced the biggest declines in mortality from heart disease from 1971 to 1996.¹⁵ Life expectancy gaps between income groups declined during that period as well. Poor Canadians with cancer had better survival than poor people from Detroit, an outcome The Poison Pill: Health Insurance in America * 135 136 * CHAPTER TEN

attributed to the Canadian system.¹⁶ Of all the major Western economic powers, the United States is the only one without a universal health care system in which health care is considered a human right.¹⁷ Rather than treating access to health insurance as a universal right, the language of the Affordable Care Act endorsed the idea that health care is a mandate.¹⁸ The difference between health care as a right and health care as a mandate is critical, as these conceptions lead to very divergent solutions. If health care is a right, universal health care is an entitlement that should be the same for all citizens. If health care is a mandate, however, then there is no such entitlement, and health care is a commodity to be bought and sold. The Affordable Care Act established the mandate as a core component of health care coverage, perpetuating the complex system of multiple payers, limited access, variability in quality of care, high costs, and large rich-poor life expectancy gaps. Obamacare and Beyond The 2010 Affordable Care Act remains the most significant overhaul of the American health care system since the passage of Medicare in 1965, expanding insurance coverage to millions. The law survived multiple attempts by Congress and two Supreme Court challenges that aimed to gut its major provisions.¹⁹ As a reform of the current for-profit insurance marketplace, the Affordable Care Act addressed two major gaps in the existing system. First, it allowed young adults to stay on their parents' health insurance until the age of twenty-six—a popular provision that benefits almost eight million Americans.²⁰ The second major reform prevented insurers from denying coverage to people with preexisting medical conditions. Medicaid was expanded to include millions of previously uninsurable individuals who had been excluded from the health care system. Uninsured rates among whites, blacks, and Hispanics dropped, narrowing though not eliminating racial and ethnic insurance coverage gaps.²¹ At the same time, the Affordable Care Act incorporated the worst aspects of our fragmented for-profit health insurance system. The tiered system of insurance—where the coverage options for the poor are markedly different from those for the rich—has further hardwired inequity into the law. In 2004 there were fifty million people without health insurance in the United States. That year the Institute of Medicine published a report, “Insuring America’s Health,” that outlined the principles against which any health reform legislation would have to be measured.²² The institute identified the ideal system as having “universal, continuous insurance coverage that is affordable and sustainable for individuals, families, and society, and should enhance well-being through care that is effective, efficient, safe, timely, patient-centered, and equitable.” Eleven years later, none of these standards was being met. Even after the passage of the Affordable Care Act, there are around thirty million Americans without insurance and an equal number of underinsured who have health insurance policies but with deductibles and copayments that are high enough to deter care.²³ How did the United States end up with a more fragmented, more costly, and more confusing health care system? Simply stated, collusion between members of Congress and entrenched corporate health insurance and Big Pharma interests precluded a more equitable and lower-cost solution. What Americans got with the Affordable Care Act was complicated insurance marketplaces in every state with a complex array of confusing private insurance products. The health reform process exposed, in the words of the British medical journal *The Lancet*, “how corporate influence renders the US Government incapable of making policy on the basis of evidence and the public interest.”²⁴ When the moment arrived to consider having a Medicare-like “public option” on the state exchanges to compete with private insurance companies, Senator Joseph Lieberman of Connecticut, the deciding Senate vote, deep-sixed the idea by threatening a filibuster.²⁵ The capital of Connecticut is Hartford, the home of Aetna, one of the big five health insurance companies. Skin in the Game There are three major structural flaws in the Affordable Care Act, all of which could be solved by a single-payer system. The first flaw is The Poison Pill: Health Insurance in America * 137 138 * CHAPTER TEN that the insurance expansion is

neither universal nor equitable. For example, because mandatory Medicaid expansion was blocked by the Supreme Court, nineteen states have left millions of poor people uninsured.²⁶ These states account for over half of poor uninsured blacks, single mothers, and the country's uninsured working poor. For poor people in these states, it is as if Obamacare was never enacted. Note that for the most part these states that have refused to expand Medicaid are the former Confederate slaveholding states, accentuating the legacy of structural racism. Access to specialty care for those who receive Medicaid coverage is limited compared to access for patients with private insurance.²⁷ More than one-third of US doctors refuse to take Medicaid—another structural barrier.²⁸ The second flaw is that premiums, copays, and deductibles for private health insurance and products on the marketplaces are prohibitively high for many people, especially the working poor. In 2015 average annual premiums for employer-sponsored health insurance were \$6,251 for single coverage and \$17,545 for family coverage. Between 2014 and 2015, premiums increased by 4 percent, while during the same period workers' wages increased 1.9 percent. Premiums for family coverage increased 27 percent during the last five years, while cost sharing has skyrocketed.²⁹ The average individual deductible across the marketplace plans in 2016 was \$5,765 for bronze plans. After the deductible is paid, an individual with such a plan will face 40 percent copays for services.³⁰ Insurance companies have reacted to their rising costs by creating narrow networks of providers and hospitals.³¹ This limits choice of patients by restricting the doctors and hospitals whose services they can use. At the heart of the Affordable Care Act are subsidies for the working poor to pay for health insurance premiums.³² The goal was to keep these premiums within reach of most Americans. It was a sweet deal for the insurance companies. The insurance companies are guaranteed to get their premiums; the federal government poured billions of dollars into their coffers. In exchange, an individual gets an insurance card. But with that card came unprecedented out-of-pocket expenses that kicked in before the insurance company paid one cent.³³ The belief is that without "skin in the game," the newly insured will overuse the system. As a result, coinsurance and deductibles that many Americans now are forced to pay have skyrocketed across the insurance markets. Yet every study ever done on the impact of copays and deductibles (even for middle-class people) is that they cause individuals to delay medical care.³⁴ Under a single-payer health care system there would be no copays or deductibles. Obamacare Bullshit The third flaw of the Affordable Care Act was that long-term doctorpatient relationships have been disrupted by insurance restrictions. President Obama said, "No matter how we reform health care, I intend to keep this promise: If you like your doctor, you'll be able to keep your doctor; if you like your health care plan, you'll be able to keep your health care plan."³⁵ This turned out to be untrue. Windora Bradley, a year before her stroke, struggled to pay her health insurance premiums. Faced with the dilemma to buy food or go without medications, she chose to go without medications. At one of her office visits, she let loose. "I'm tired about this Obamacare bullshit," she shook her head, frowning as her jowls quivered. "I worked for thirty-five years. Those people on welfare who never worked are getting free health care. I am paying \$700 each month and there is not enough left for medicines and food. That's not right. That's why I call it Obamacare bullshit." Windora lived on a pension of about \$1,000 per month. Most went for the premiums on her health insurance, which she still received through the Chicago Board of Education. She scrimped and saved to pay for her medications for her diabetes, hypertension, asthma, and vascular disease. Her situation is common among the working poor. Windora was ultimately able to get insurance on the marketplace that reduced her premium costs but not her out-of-pocket expenses. At first she purchased a Blue Cross insurance plan that she was told my hospital accepted, but this proved incorrect. She then had to purchase a more expensive plan to stay with me. Meanwhile her two sisters, who The Poison Pill: Health

Insurance in America * 139 140 * CHAPTER TEN had also been my patients for over thirty years, had to switch doctors because my group did not accept the insurance they enrolled in. A number of my long-term patients found themselves in this dilemma. In 2015, after her stroke, Blue Cross dropped my hospital and many others from the plan Windora had just purchased. There was only one plan, from United Health Care, in all of Cook County that included my hospital and me in the network. The week after Windora signed up for it, United Health Care let it be known that it was considering withdrawing from all the exchanges in 2017.³⁶ In three years of the Affordable Care Act, Windora had purchased three different insurance policies just to retain me as her physician. In the fall of 2016, United Health Care announced it would drop my hospital from its network, and Windora, now wheelchair bound and speechless, is forced to find another doctor (to say nothing of her many specialists) after thirty-six years. For someone like Windora with complex medical and social obstacles, keeping a team of providers who are familiar with her medical travails is essential to getting good care. For me, her longtime doctor, it is a gut-wrenching experience. The fact is that Obamacare, despite its modest benefits, does not remedy American health care inequity. It will never achieve universal coverage. Eleven million noncitizen residents will never be eligible for its benefits. Thirty million people will remain uninsured. While insurance coverage has increased for all races, there is still a large racial and ethnic gap in insurance coverage, which will perpetuate health disparities. For those with health insurance, spiraling copays and deductibles have made access to care more difficult. Finally, by allowing a dizzying array of for-profit insurance carriers with high administrative overhead expenses, the Affordable Care Act as currently configured will not control costs. In 2016, the third year of Obamacare, insurance companies asked for double-digit increases in premium prices, as they claimed costs of delivery had outstripped the revenues. Meanwhile, health insurance stocks are trading at all-time highs, while patients like Windora Bradley face rocketing expenses and uncertainty about the future.³⁷ The Poison Pill: Health Insurance in America * 141 A Call for Single Payer I speak for many of my health care colleagues across the nation when I say that the Affordable Care Act is a disappointment. In contrast, an improved and expanded Medicare for All would achieve truly universal care, affordability, equity, and effective cost control. It would put the interests of our patients—and our nation's health—first. By replacing multiple private insurers with a single nonprofit agency like Medicare that pays all medical bills, the United States would save approximately \$400 billion annually. Administrative bloat in our current private-insurance-based system would be slashed. That waste would be redirected to clinical care. Copays, coinsurance, and deductibles would be eliminated. A single streamlined system would be able to rein in costs for medications and other supplies through the system's strong bargaining clout—clout directed to benefit health, not profits. Finally, it would create an equitable system of care that would provide equal access to rich, poor, black, and white. As a result, life expectancy gaps between rich and poor would narrow. Hospitals that serve poor communities would have access to capital investment based on need. It has been done in other countries, and it can be done in the United States. Single-payer health care stands in stark contrast to the ACA's incremental reform. Yet it is important to remember that enactment of a single-payer system requires the defeat of deeply vested, deep-pocketed ideological opponents, health insurance conglomerates, and a thick alliance of health care constituencies along with other interest groups. The Affordable Care Act, passed by a Democratic majority and signed by a Democratic president, was a weak compromise that left the foundations of our flawed \$2.9 trillion health care system intact. It will be some time before political conditions are again right to tackle an improved Medicare for All. So why, given these hurdles, do I (and many other health care providers) persist? I persist because I have watched too many patients suffer and die because they lacked health

insurance or had the wrong insurance card. I persist because I have witnessed the racial and ethnic death gaps enabled by our current health insurance arrangements. I persist because simple fairness dictates that health care is a fundamental human right. I persist because of patients like Win142 * CHAPTER TEN dora and Sarai, who deserve better. For those who counter that single payer is too expensive or politically unfeasible, we persist because the American ideal of “life and liberty” cannot be achieved without an equitable and universal health care system. Winston Churchill reportedly said, “You can always count on the Americans to do the right thing... after they have tried everything else.”³⁸ We have tried everything else. I look forward to being part of a single-payer health care system that values the health of individuals, families, and communities as a common good—where health care is valued as a human right. Someday.

Stats prove---even assuming backsliding

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But would “true” universal health care do much to combat racial health inequalities, if it were, say, a single-payer system that eliminated out-of-pocket expenses and was equally accessible by all, without tiers or walls?[25] Or would it replicate current biases and inequalities? To some extent, the answer is yes to both questions. But even so, a body of research has suggested that, even if these biases persist, a fully universal system might nonetheless be a powerful tool in reducing racial health care inequalities. That evidence comes from what is arguably a quasi-single-payer system located in the US: the Veterans’ Administration (VA). Notwithstanding recent scandals that are indeed of great concern, the modern-era VA has justifiably earned praise for delivering a high — indeed, comparatively superior — quality of health care.[26] There is also evidence that it may indeed effectively reduce, even potentially eliminate, some racial health inequalities. Last fall, a study published in Circulation, the premier journal of the American Heart Association, received wide coverage in the media for some provocative findings. “The US Veterans Health Administration (VHA),” as the study notes in its introductory section, “is a healthcare system that does not impose the typical access barriers of the US healthcare system that may disproportionately impede enrollment of blacks.” The investigators therefore hypothesized that racial inequalities in cardiovascular outcomes and mortality found in the general population might be reduced in the VA, a “healthcare system that allows enrollment independent of race or socioeconomic status.”[27] Consistent with previous studies, in their analysis of data from the general (non-VA) population, they found racial inequalities much as they expected to find them: blacks had a much higher mortality (after adjusting for various other factors) as compared to whites (indeed, approximately 40 percent to 50 percent higher).[28] In striking contrast, in the VA population, even though the risk of stroke was either higher or similar among blacks as compared to whites depending on which statistical adjustments were used, the risk of coronary heart disease as well as overall death was actually lower among blacks. This is, of course, only a single study, albeit a rather large one with more than three million subjects. An accompanying editorial concedes that a number of factors may be at play. Nonetheless, the fact is that, as described by the investigators, these findings build on an existing literature consisting of multiple studies that together point to a reduction of racial health inequalities within the VA for critically important outcomes like mortality.[29] No doubt, there are still

discriminatory practices in some or all of these facilities, and we can assume that there are conscious or unconscious biases at work in the minds of some of its clinicians, as there are elsewhere. Indeed, other studies clearly show that, even after the significant reorganization and reform of the VA in the late 1990s, there are still racial disparities in the VA.[30] If we moved to a single-payer system on a national level, such biases would still need to be addressed along the lines Matthew argues. But the point is that a more egalitarian structure of the health care system itself might go even further in reducing them. Indeed, in light of this research, it seems fair to say that **health care universalism could be a very powerful tool in combatting ubiquitous racial health inequities.** Attaining health care equality, in other words, requires true equality of access. And yet this simple notion is all too often ignored entirely in any discussion of health “disparities.” 5.

Medical research reforms improve access and distribution of treatments while preventing racist malpractice.

Harriet A. Washington 7, Writer, Washington was Health and Science editor of the Rochester Democrat and Chronicle. In 1990, she was awarded the New Horizons Traveling Fellowship by the Council for the Advancement of Science Writing.[4] She subsequently worked as a Page One editor at USA Today newspaper, before winning a fellowship from the Harvard School of Public Health.[5] In 1997, she won a John S. Knight Fellowship at Stanford University, and in 2002 was named a Research Fellow in Medical Ethics at Harvard Medical School.[6], “Medical Apartheid, A dark History of Medical Experimentation on Black Americans from Colonial Times to the Present,” Epilogue, pp 423-442.

EPILOGUE Medical Research with Blacks Today The voluntary consent of the human subject is absolutely essential. —THE NUREMBERG CODE In this book, I have traced the long, unhappy history of medical research with black Americans. I have detailed how **blacks have been convenient, powerless, maligned, and abused subjects of profitable medical research** and also how their treatment has changed over the years. Slaves were physically forced into painful medical bondage, their bodies were forced onto the stage of medical experiments to lend credence to claims of black inferiority and difference, and black bodies were even conscripted for anatomical dissection after death. Blacks were made subjects of experimentation that served to denigrate their intelligence or to provide distorted justifications for their enslavement. The reproductive rights of blacks also have been subjugated via fraudulent research up to the present day. Groups of vulnerable blacks, including children, soldiers and prisoners, have been consistently targeted. Both the federal government and private corporations have devised large-scale research abuses that range from radiation experiments to biological-weapons development. This medical ill-use has not strictly paralleled scientific knowledge: Rather, it has mirrored the larger American cultural beliefs as well as politics and economic trends. Once, black Americans enjoyed the sparsest of legal and social protections, nearly universal abject poverty, and few health-care options. But this social and legal landscape has changed dramatically, and so have research practices. Where We Are Today **Today, the worst abuses are mostly memories**, although some forms of abusive research persist, and a few new issues have arisen. However, today’s offenses pale beside those our forebears survived. Today, much medical **research is more than safe for African Americans; it is necessary.** This may seem a strange message for a book that has described so many racial research abuses, but this volume’s frankness is an essential prerequisite for asking African Americans to consider participating in medical research. No one can dismiss blacks’ historically grounded fear of research and retain any credibility. **We must acknowledge the past** in order **to regain trust and to seize the future.** But medical abuse is more than historical fact. Although less rife, it remains a contemporary reality, and an ever-present possibility.

The challenge is to prepare the way for a new openness to medical research on the part of African Americans while maximizing their protections from abuse. I do not see how this can be accomplished without candor, because the traditional strategy of ostrichlike denial merely heightens mistrust. To gain trust, we must first acknowledge the flagrant abuses of the past and the subtler ones of the present, yet much of the popular argument around medical experimentation and African Americans is dictated by culture and politics, not historical fact. The scientific camp includes most physicians, medical researchers, and others of all racial groups who pride themselves upon their educational sophistication. They tend to deny all present research dangers and most past ones, dismissing fears as emanating from those who are uneducated about the legal protections governing research or so credulous as to believe unsubstantiated rumors about the medical targeting of blacks. Mainstream medical scientists, journals, and even some news media fail to evaluate these fears in the light of historical and scientific fact and tend instead to dismiss all such doubts and fears as antiscience. The potentially damping effects on medical research, not the facts, become the focus of most discussions of troubled experiments. Like the medical school professor whose horror at my choice of topics I described in the introduction, many claim that any acknowledgment of abuse will drive African Americans from sorely needed medical care. However, a steady course of lies and exploitation has already done this. A 2002 American Journal of Law and Medicine article estimated that as many as twenty million Americans have enrolled in formal biomedical studies—but fewer than 1 percent are African American.¹ Yet the focus on African American fears is misplaced. A January 2006 Public Library of Science study entitled “Are Racial and Ethnic Minorities Less Willing to Participate in Health Research?” examined the consent rates of twenty research studies that reported consent rates by race or ethnicity for more than 70,000 individuals. It found only slightly lower consent rates for blacks compared to (non-Hispanic) whites. The investigations ranged from interviews to drug treatment to surgical trials. Yet blacks are significantly less likely to be included in clinical trials, which suggests that some factor other than consent is implicated. Studies such as those mentioned in chapter 11 already show that black children are more likely to be used in nontherapeutic, harmful studies than in therapeutic investigations. Future research may document that this is true for black adults as well. In short, many scholars such as Tuskegee Bioethics Center director Dr. Vanessa Northington Gamble aver that the true focus should not be on the aversion of black subjects but rather on the untrustworthiness of American medical research when it comes to studies involving blacks. This book certainly documents this ethical deficiency. Although the focus of this book is clearly on experimental abuses of a vulnerable population, I do not want to leave the impression that I am advising people to avoid potentially beneficial medical experimentation. Quite the contrary. African Americans desperately need the medical advantages and revelations that only ethical, essentially therapeutic research initiatives can give them. The reticence of African Americans is the reasonable and understandable result of a horrendous history, but it lags behind progress. African American absence from research reflects the realities of yesterday, not today. More to the point, this aversion is a reaction black Americans can ill afford. For this book to have the most value, I ask readers to hold two seemingly contradictory but actually complementary facts in mind. The first is that African Americans must welcome and embark upon medical research as a bridge to fording the gulf that yawns between the health profiles of sickly enfranchised blacks and those of healthy, long-lived whites. The second fact is that African Americans must remain wary of research abuses. They are rarer, but the potential for exploitation and abuse still looms. Physicians, patients, and ethicists must also understand that acknowledging abuse and encouraging African Americans to participate in medical research are compatible goals. History and today’s deplorable African American health profile tell us clearly that black

Americans need both more research and more vigilance. The worst abuses no longer occur and others are becoming far rarer, in part because the media exposure of racial research scandals has led to public condemnation. This, in turn, has helped to support the enactment of stiffer laws carrying real penalties rather than yesterday's toothless codes, such as that written at Nuremberg. This matrix of legislation is not perfect, but it reduces the unabashed use of African Americans as duped or unwitting research subjects. Sociopolitical changes have also helped in this regard. There are no more "separate but equal" hospitals to provide powerless research fodder. There are no more nakedly vulnerable black people without the protection of the law; there are no more hospitals devoid of those black physicians who can protest racial dichotomies in patient treatment. Black physicians, researchers, and journalists now join the white professionals of conscience who have brought such abuses to attention and to a stop. The news media may not always discern and detail the patterns underlying problems with new therapies, but they do regularly expose research abuses. Government has shown itself more likely to close down entire university research programs under the aegis of the FDA when embarrassed by federally sponsored abuse. Closure is a fate that has been suffered by even premier universities, from Duke to Johns Hopkins. Most universities have heeded the message. All this amounts to a limited but real success story. African Americans are no longer the primary targets of research, exploitation, and abuse. Research ethics and policies have evolved to the point where the worst abuses of blacks are but a bad memory. That's the good news. Africa: Continent of Subjects The bad news is that the racial mythology, the medical exploitation of black bodies for profit, and even the instances of medical sadism that threatened African Americans in the past have been exported to Africa. The recent history of medical research in Africa parallels closely that of African Americans in the United States a century ago. Colonialism and its residual racial and class separations have isolated blacks in hospitals or hospital wards away from whites, just as segregated hospitals once provided exclusively black subjects for white doctors. Laws that offered few or no protections for abused blacks have emboldened unscrupulous physicians and researchers who put curiosity and profits above the rights and welfare of their black patients. Western physicians, scientists, and pharmaceutical companies need large pools of people for Phase I trials, and they have swarmed Africa as they once flocked to prisons. U.S. researchers who can no longer conduct trials at home without intense scrutiny from the FDA and the news media have moved their operations to sub-Saharan Africa to exploit the public-health vacuum that once condemned black Americans. "To get around consent forms and a skeptical public, many researchers are turning their attention to African and other developing countries," Robert F. Murray, Jr., M.D., chief of the Division of Medical Genetics at Howard University, has observed. "I would say the greatest chance for injury is in the Third World, where people don't even know research is going on and don't have a clue." The long history of how Western investigators have taken their more questionable research initiatives to Africa is well documented in works such as Dr. Wolfgang U. Eckart's *Medizin und Kolonialimperialismus*. In it, Eckart details how, in a ghastly dress rehearsal for Dachau, nineteenth-century German scientists conducted genocidal experiments on Africans, especially the Herero of Namibia.² The United States, like Europe, has long used its nonwhite colonies and territories as its laboratories. For example, Richard Strong, M.D., used prisoners in the Philippines to conduct deadly malarial experiments, and chapter 8 relates how Brazilian, Mexican, and Puerto Rican women have more recently been used for birth-control trials that maimed and killed many.³ Warwick Anderson, M.D., documents how colonizing nations, including the United States, have used often-mythical racial differences, including the purported infectious-disease immunities of Africans, to further colonial aims and to justify the use of natives as workers in dangerous environments—just as U.S. slave owners once

did. In much of Africa, Asia, and South America, a wide understanding has reigned that ethical rules governing medical experimentation were not “for natives.” Henry Louis Gates, chairman of African American Studies at Harvard University, recalls encountering such persistent racial myths during his undergraduate studies. “I was premed at Yale and took a year off to work at a mission hospital in Tanzania, where the doctors were all Australians. I was only twenty-one years old and I gave anesthesia to patients. I was shocked by the fact that when patients were writhing in pain, the doctors would say, ‘They don’t experience pain the same way we do.’ I was totally disgusted. I complained loudly and called them all racists, of course. But this illustrates how it is always easier to distance oneself from the pain of ‘the other.’” The use of poor people of color abroad by American scientists today enables researchers to escape both the strictest scrutiny of institutional review boards and the gaze of the FDA, says Murray, who issued a prescient warning in 1994: “People are going overseas trying to do research in Africa. They are saying, ‘We don’t have to go through all that IRB stuff to study AIDS, sickle cell and other diseases. This sort of questionable research is now going on in Africa and Third World countries because there are plentiful patients and the scientists are not subject to the same restrictions they are now subjected to here.’” The Third World has become the laboratory of the West, and Africans have become the subjects of novel dangerous therapeutics. In 2002, the hormones of “Bushmen” were mined for potential weight-loss therapies;⁴ human growth factor was tested on Pygmies before being used on Western children;⁵ and Depo-Provera, although a carcinogen, was tested on Zimbabwean women before it was introduced into the United States as a reproductive injection. American firms tested artificial blood on unsuspecting black South African hospital patients, at the cost of at least twenty deaths. Harvard tested HIV therapies through research that would have violated ethical requirements for Americans. Some of the research on Africans by Western scientists has been more subtle but equally troubling from an ethical perspective. For example, trypanosomiasis, or sleeping sickness, kills as many as half those it infects in the central African regions of Uganda, the Democratic Republic of Congo, Sudan, Ethiopia, Malawi, and Tanzania. Melarsoprol, the only effective treatment, is a very toxic compound of arsenic and antifreeze that kills one in five people who take it. By 1995, the pharmaceutical firm Aventis had completed research demonstrating that its drug eflornithine was effective against sleeping sickness, although not against cancer, as the firm had hoped. But the company decided to abandon its use against trypanosomiasis, due to high production costs and low profits. It began seeking other profitable uses for the drug, and U.S. researchers soon found one: Eflornithine effectively banished facial hirsutism in women. Aventis and later Bristol-Myers Squibb began marketing the drug as Vaniqa, because many American women were able to part with fifty dollars a month to keep their faces free of hair, while few Africans were able to pay fifty dollars monthly to save their lives. It is completely understandable that the firm should focus its resources upon the profitable depilatory use of their medication, but it is disappointing that it chose not to make the drug available cheaply to Africans in order to vanquish sleeping sickness. Doctors Without Borders forged a coalition, which included Bristol-Myers Squibb, Bayer, and the Bill and Melinda Gates Foundation, to provide drugs to Africans through 2006, but although sleeping sickness threatens sixty million people, only 7 percent of these have access to adequate medical treatment.⁶ Medications considered far too dangerous or too hopelessly tainted for testing in the West have been introduced into clinical trials with unsuspecting African patients. Within the past decade, even the infamously teratogenic drug thalidomide has been tried on Africans as a treatment for leprosy—forty years after it produced twelve thousand horribly deformed babies around the world. FDA researcher Frances O. Kelsey, M.D., refused to approve thalidomide as a treatment for morning sickness in the 1950s because she determined that clinical trials did not demonstrate its safety; her caution saved most

American infants the fate suffered by English and Europeans whose mothers took the drug. (Only those U.S. babies whose mothers received thalidomide samples from their physicians were affected.)⁷ But Third World women subjects of thalidomide trials for leprosy and AIDS were not warned of the horrible birth defects the drug can cause. African experimental subjects, like the slaves of antebellum America, are legally vulnerable, relatively powerless, and racially distinct. Like black Americans after the Civil War, Africans' poorer health and vanished healthcare infrastructure make it easier to pass off nontherapeutic research as medical therapy or to impose participation in research as a condition for therapy. The U.S. physician-researchers who descend upon Africa in search of subjects frequently characterize their work as therapy, offering experimental solutions for medical disasters. When physicians offer Africans the same therapeutics they offer Westerners, they can lay claim to unalloyed beneficence. But the Western standard of care is not being offered; usually poor black Africans with no access to medical attention are offered treatments that are new or untried. Sometimes U.S. researchers appear in the midst of an epidemic against which the stricken Africans have no medication and offer experimental treatment.

During the height of a 1996 meningococcal meningitis epidemic, for example, scientists offered Pfizer's experimental drug Trovan (floxacin) to terrified parents in Kano, Nigeria. Nigerians desperate for medical attention grasped at Trovan's straw. By the time the experiment ended, two hundred children were left severely disabled and eleven were dead. In 2001, at least 211 Nigerian parents sued New York-based Pfizer, Inc., alleging that non-FDAapproved experiments had killed or injured their children; that Pfizer failed to obtain the requisite approval from local leaders; and that the pharmaceutical giant failed to administer standard therapies with proven efficacy, such as Pfizer's own ceftriaxone to those children who continued to deteriorate after being given Trovan. Peter Ebigbo of Childrights Africa told Inter Press Service, "Our leaders must not allow Nigerians to be used as guinea pigs by any company to make money." Pfizer counters that it treated ninety children with Trovan and ninety-seven with ceftriaxone, and that it obtained all the necessary approvals. However, Dr. Sadiq Wali, chief medical director of the Aminu Kano Teaching Hospital, says the hospital's medical ethics committee never gave Pfizer the required approval to use the drug at the infectious-disease hospital in Kano. "Pfizer did not do that. I am not sure if they had the consent of the people used as guinea pigs, because that means informed consent in medical parlance. Such consent has to do with the patients being told the good as well as the side effects of the drugs to be administered," said Dr. Wali. But documenting Trovan's effects on these patients for the lawsuit would prove tricky: The medical records of 350 meningitis patients treated between April and June 1996 have disappeared from the hospital.⁸ The dearth of health care in much of Africa and the Third World makes its peoples vulnerable to experimental abuse. One cannot generalize about a continent as large and diverse as Africa. There are wealthy countries as well as poor ones, and a few health-savvy nations, such as Cameroon, could teach us a thing or two about providing health care to all our citizens. But much of sub-Saharan Africa has been devastated by colonial rape and depletion. These have left poor health, a ravaged health-care infrastructure, and few physicians in their wake. A mere 750,000 health workers care for the continent's 682 million people. The Organisation for Economic Co-operation and Development estimates that this represents a health-care force that is as much as fifteen times lower than in OECD countries. Only 1.3 percent of the world's health workers practice in sub-Saharan Africa, but the region harbors fully 25 percent of the world's disease.⁹ A bare minimum of 2.5 health workers is needed for every one thousand people, but only six African countries meet this standard. Instead, the average in sub-Saharan Africa is 0.8 health workers per one thousand people—less than onethird the minimal standard. To achieve the minimum health-care staffing level will require an infusion of one million health workers into the continent. Safe devices are as scarce as

doctors. Reused SUDs (single-use devices) and unsterilized needles help to spread AIDS and other infectious illnesses throughout Africa. The medically damaging injection practices and use of ethically suspect research has fomented a loss of trust in vaccines in Nigeria. Much of the news coverage focuses upon the contentions by suspicious Africans that the administration of Western vaccines spreads HIV and causes sterility.¹⁰ But no matter whether these fears are correct or imaginary, the practical result is unambiguous: suspicious patients avoid care, and this iatrophobia means that “conquered” diseases such as polio are seeing a resurgence on the continent. A burgeoning research culture is thriving in the midst of this desultory public-health activity and therapeutic vacuum. While the continent’s wounds go unbound, research is big business in Africa. Seventy billion dollars is spent each year on medical research, but only 10 percent is devoted to diseases that cause 90 percent of the global health burden.¹¹ This dichotomy provides an incubator for research abuses. Surrounded by pain, death, and infection, desperate, medically ignored Africans are confronted with a Hobson’s choice: experimental medicine or no medicine at all. Western researchers who conduct investigations in the Third World are supposed to elicit the approval of their home medical institutions. For example, most university policies align with FDA regulations that require treatments given to the control-group members must be the standard of care for the treatment of the illness. Thus if one wanted to test Trovan in Connecticut, the protocol or research plan would stipulate that researchers must give the control group the best drugs known to treat meningitis, a drug such as ceftriaxone. Under some conditions, generally when no effective treatment for a condition exists, control-group members receive a placebo, an inert substance or a sham technique that does not offer any intrinsic therapeutic value but allows scientists to compare results between a treated and an untreated group. But placebo studies, which are falling out of favor in the West, are completely inappropriate for serious diseases for which effective treatment exists. You cannot ethically justify withholding, for example, an efficacious drug such as AZT from HIV-positive people or people at high risk of contracting HIV just to determine whether protease inhibitors work better than nothing. You must give the tested group protease inhibitors and the control group either AZT or the best-known standard therapy. Tossing the people in the control group placebos, vitamins, or antibiotics would doom the control group and so would be an unacceptable ethical breach—at least in the West. However, American IRBs treat Africans as second-class subjects and employ different standards for evaluating study designs in Africa than those used in the United States. Requiring evidence that the drug being administered meets or exceeds the standard of medical care is de rigueur for Western trials, but university IRBs now employ an ethical sleight of hand to stipulate that the tested drug must meet or exceed the standard of care in the country where the study is being evaluated. In impoverished, medically underserved sub-Saharan African countries, that standard of care has historically tended to be nothing. Americans who conduct research in African venues are supposed to seek the consent of their subjects. But this has never been a popular move, as the exasperated 1964 complaint of Dr. Francis D. Moore, a Harvard surgeon whose photograph had graced the cover of Time a year earlier, illustrates. Several years ago an individual from this country went to Nigeria to try out a new measles vaccine on a lot of small children. Now how exactly are you going to explain to a black African jungle mother the fact that measles vaccine occasionally produces encephalitis but that more important than that it might sensitize the child for the rest of his life to some other protein in the vaccine? We now know that any sort of immune response excites cross reactions. For example, if a person develops a heightened immune reaction to some specific antigen such as typhoid he will be found to have other high titers against non specific antigens at the same time. In fact, there is a suspicion [sic] that some of the so-called auto-immune diseases are aroused by exposure of the

reticuloendothelial system to completely different antigens. The possibility therefore arises that measles vaccines applied to thousands and thousands of children might excite in some of them such diseases as thyroiditis and ulcerative colitis. Can you imagine trying to explain that to a jungle mother? ...One of the greatest assets of a good doctor is the ability to look a patient in the eye and have the patient go along with him on a hazardous course of treatment.... The same quality is exhibited by a medical experimenter when he looks at [a] patient and says that he thinks everything is all right.¹² Moore avoided the troublesome task of individual disclosure and consent, and so do many researchers in Africa today, who do not want to take the time to translate their proposal into the local language and culture. They do not want to explain to hundreds or thousands of subjects such risks as iatrogenic encephalitis and sensitization—concepts that would have been as murky to a Connecticut homemaker in 1964 as they were to Moore's "jungle mother." These scientists do not want to risk having the subjects reject the experiment once they understand the possible health costs. Neither do they especially want to explain why they are testing a new therapeutic approach to HIV thousands of miles away from the millions of cases in their own country. Moore doesn't mention this sort of question in his tirade against informed consent, but I suspect that it is the more difficult of the questions his jungle mother might put to him today.

The Erosion of Consent Unlike the disastrous Third World research trends, medical research with black Americans has lost so much of its historically abusive nature that black Americans should embrace new medical research—after judicious inquiries of their own into any study they are considering. But there are still issues that must be addressed, and until these problems are rectified, black Americans must embrace medical research warily. These issues include the recent erosion of informed consent; the need for better-quality research into black health issues; the overemphasis upon genetic research in nongenetic issues; and the government's distortion of research with black Americans to further political and ideological ends. "It is the most fundamental tenet of medical ethics and human decency that the subjects volunteer for the experiment after being informed of its nature and hazards. This is the clear dividing line between criminal and what may be noncriminal. If the experimental subjects cannot be said to have volunteered, then the inquiry need proceed no further." So testified Andrew Ivy, M.D., chief witness for the prosecution in the Nuremberg doctors' trial. The Nuremberg Code was instituted in August 1947, by Americans judging twenty-three physicians and scientists, to ensure that the horrors of abusive medical experimentation never again be visited upon the world. Its very first line is unambiguous: "The consent of the subject is absolutely essential." But American research culture increasingly disagrees. In October 1996,¹³ the Department of Health and Human Services passed 21CFR50.24, a regulation that robbed seriously ill emergency room patients of the right to informed consent. This allows researchers to legally enroll such patients in medical-research studies and test experimental therapies on them without their consent.¹⁴ The emergency room deaths began the very next year. On April 1, 1997, when the Occupational Health and Hygiene Plan (OHHP) suspended a U.S. clinical trial that had enrolled unwitting patients in a clinical trial of diaspirin cross-linked hemoglobin (DCLHb) for treating shock. So many more people who received the experimental treatment died than those receiving standard care that the trial had to be stopped early. These people had never given their consent to participate in the study that killed them. Yet today the practice of experimenting with nonconsenting emergency room patients continues. For example, when they need a blood transfusion, unconscious patients brought into some emergency rooms are as likely to be given an artificial substitute as blood—without their knowledge. Also, the AbioCor company proposes to implant their complication-ridden model of a self-contained artificial heart into a wide variety of heart-attack patients who are brought into emergency rooms if they meet certain (rather wide) research criteria—again

without their permission or knowledge. And informed consent is also being attacked more insidiously—in assaults upon existing laws.¹⁵ Various ethicists who are experts in human medical experimentation, such as Jay Katz, M.D., and George Annas, J.D., worry that the vague language of federal regulations governing human medical experimentation is being interpreted in a manner that minimizes protections. At the same time, they point out addenda to these regulations that further curtail patient protection and patient autonomy while expanding the types and number of people who can become subjects. The erosion of consent is often presented as a partial surrender or a compromise between the needs of researchers for subjects and a small loss to a patient autonomy. Or it is presented behind the mask of futility—in such scenarios, it is argued, the patient is unconscious and cannot agree or disagree to partaking of a possibly lifesaving experimental treatment, so his doctors should decide for him. In such cases, “research” is conflated with “treatment” to justify removing informed consent from the equation. But these scenarios are false and misleading. It is not necessary to waive informed consent in order to provide the unconscious with treatment: Laws already exist that permit doctors to offer the best-available treatment to patients who are comatose, unconscious, underage, or in other ways unable to consent to treatment. But these laws do not extend to experimentation, and rightly so. Treatment focuses upon the patient’s needs; experimentation focuses upon the researchers’ needs, no matter how much those researchers may invoke possible or future benefits for patients. In fact, these studies are typically randomized, which means that the computer, not the doctor, determines what experimental therapy will be administered. This may not be the best treatment for the patient, nor the therapy the patient would choose. Once one loses the right to be told what one is about to undergo, to agree or to refuse participation, research policy gains momentum on a very slippery slope. This book documents the depths to which researchers have stooped to bypass the consent of the subject. In fact, African Americans first became favored subjects because during the antebellum period they did not enjoy legal protections and researchers did not need their consent. This vulnerability also persists today in other settings where blacks are overrepresented, such as military ground troops. In 1990, the Department of Defense (DOD) sought and obtained from the Food and Drug Administration a waiver of the informed-consent requirements for human medical experimentation. Under Rule 21 CFR 50.23(d), soldiers suddenly lost the protection of the informed-consent provisions that give other Americans the right to say no to experimental medications. The DOD forced them to accept experimental drugs, including pyridostigmine bromide, a putative prophylactic against nerve gas attack; and the pentavalent botulinum toxoid vaccine for botulism. In 1998, with FDA permission, the DOD Anthrax Vaccination Immunization Program (AVIP) also began immunizing 2.4 million soldiers against the potential threat of airborne anthrax: At least 900,000 troops have been immunized to date. But, citing devastating side effects and deaths that have been validated by amendments to the medication warning labels, hundreds of soldiers have refused to comply, at least one hundred of whom have been court martialed, and many have been forced to leave the military. One of these was Jemekia Barber, who while stationed in Colorado was ordered to accept an anthrax vaccination in preparation for a transfer to Korea. She disobeyed that order on the grounds that the vaccination may not be safe for females of childbearing age. Black soldiers such as Barber are twice as common in ground troops as in American society, and so are especially vulnerable to measures such as forced vaccinations.¹⁶ In late 2003, Judge Emmet G. Sullivan of the United States District Court in Washington, D.C., noted that the Supreme Court had ruled that U.S. combat troops could no longer be compelled to take the experimental anthrax vaccinations. The FDA responded by rapidly elevating the anthrax vaccine from a questionable investigational drug to an approved therapeutic, allowing the DOD to sidestep the intent of the law and restoring the soldiers

to a state of investigative servitude—"investigative" because the data collection and evaluation of the anthrax vaccine risks, including death, will continue among soldiers. Fortunately, in 2004, Judge Sullivan ordered the DOD to stop forcing anthrax vaccines on U.S. military personnel. Barber's lawsuit against the army continues. Today, African American are at greater risks than whites of being conscripted into such research without giving their consent, because blacks are more likely than whites to receive their health care from emergency rooms. However, this coin of research vulnerability has an obverse: We also need more and better research into black health care. Such high-quality research has begun to emerge but, as chapter 14 points out, it has also taken some wrong turns. For example, research into black ailments and medications, such as that conducted in support of the black heart-failure drug BiDil, is sometimes sloppy and illogical, and in other cases it is based on the thinnest of premises. The long history of flawed science in the service of preconceived notions is being supplemented by new, insufficiently questioned racial theories of disease. Adopting these unquestioningly while ignoring important environmental disease factors not only imperils black health; it also reinforces the idea of blacks as possessing dramatic physiologic differences. The inclusion of blacks in quality American medical research is also important for everyone. Why? Many arguments cite the dollar savings or the reduction in disease exposure to the larger society that will emanate from better health among African Americans. However, I am often uncomfortable with arguments that focus solely on utility, especially when it comes to medicine and health. Such benefits can be elusive or hard to quantify. I believe that caring for people and maximizing their chances at health and happiness are goals that we should pursue for their own sake, because they are the right thing to do. They elevate us spiritually and socially, and reaffirm our cohesion and our humanity. But that said, there's no denying that increasing the ethical, reasonably safe research available to African Americans will benefit everyone else. This book has repeatedly demonstrated how the poor health profile spawned by experimental abuse has not only harmed blacks but has spilled over to harm their white compatriots. Pathogens, for instance, are notoriously democratic. Had African Americans not been excluded from early AZT therapy on the basis of flawed HIV treatment clinical trials (that largely excluded them), would the number of HIV-infected African Americans be lower today? Would the number of all domestic AIDS cases be lower, considering that black Americans today constitute half of all the HIV-infected? It's too late to know now, but not too late to do better racial recruitment for the next HIV clinical trials. The fallout extends beyond infectious disease. For example, Donna Christian-Christensen, M.D., who represents the U.S. Virgin Islands in Congress, has observed that the percentage of black Americans who are insured is lower than that of white Americans, and the cost of caring for these uninsured people raises the rates and health-care costs of all Americans. She said, "We're getting to the hospital late, using much more expensive care: We're really driving up the costs of health care." In fact, a decade ago, research by Harvard School of Public Health professors Ichiro Kawachi, M.D., and Deborah Prothrow-Stith, M.D., explained this public-health phenomenon in detail and even quantified it, emerging with what was popularly referred to as the "Robin Hood Index." The shorthand is that public health suffers more in the nations with the greatest inequities in wealth, and that the middle class suffers nearly as much as the poor from inequities. In the United States, which has, for example, one of the world's greatest disparities in income between the haves and have-nots, we have not only the greatest health disparities but the greatest health-cost burdens for the mostly white middle class. In short, whites should care about quality medical research for African Americans because its dearth has generated needless pain, suffering, anger, and costs that continue to permeate the fabric of our entire nation: It is not only a racial tragedy but also an American tragedy. For their part, African Americans cannot afford passivity. Seneca said, "It is part of the

cure to wish to be cured." When it comes to medical research, that wish must be awakened in African Americans. African Americans should not shun lifesaving research; indeed, they cannot afford to do so. Instead, they must carefully scrutinize research initiatives before becoming subjects. But we must do more: We must also address the dearth of therapeutic research in areas that affect the health of African American most dramatically. What changes are necessary to achieve this? REPAIR THE SYSTEM OF INSTITUTIONAL REVIEW BOARDS (IRBS) IRBs judge the scientific and ethical acceptability of proposed studies on human subjects. However, a string of abusive experiments have revealed that the nation's five thousand IRBs have failed to perform their role of protecting the public, and African Americans in particular. In June 1998, a Department of Health and Human Services (HHS) report concluded that IRB staff are inadequately trained, subject to conflicts of interest, and overwhelmed by too many cases.¹⁷ The Office of Protection from Research Risks (OPRR) requires IRBs to have a minimum of five members, at least one of whom must have primarily scientific interests, another of whom must have primarily nonscientific interests, and another of whom must be otherwise unaffiliated with the IRB's institution. But most IRB members are scientists affiliated with the organization in question, and even the lay members tend to have loyalties to the home institution. I propose that each IRB be composed of equal numbers of scientists and of peers of the group who will be asked to participate as subjects. Some may object that laypeople will be unable to understand enough about scientific experiments to judge their suitability and value, but as a medical communicator, I doubt this: I know many skilled and motivated scientists who routinely convey complex information to many people, although to do so may require some preparation and effort. Moreover, if a project cannot be explained to laypersons in an IRB meeting, how does a researcher propose to explain it to the potential subjects, as he [they] must do by law? I also propose that each IRB include a medical ethicist and, if possible, a medical historian. STOP THE EROSION OF CONSENT Ban exceptions to informed consent. Recognize the right of every patient to say yes or no as an absolute value and cease designating groups such as soldiers, unconscious emergency room patients, and Third World experimental subjects as appropriate subjects without their input. When physicians are faced with a patient who is unable to consent because of his or her medical condition, and whose condition requires treatment before a family member or other proxy can be consulted, I propose that the patient be treated as if the physician had no research protocol to worry about. Treat him or her, but don't enroll that patient in a study. Instead, use the best-known treatment for that particular individual. INSTITUTE A COORDINATED SYSTEM OF MANDATORY SUBJECT EDUCATION The NIH and the Office of Research Integrity require that every practicing medical researcher receive education in the ethical and practical conduct of biomedical research. I took such a course at Harvard Medical School in 2004 and found it factually invaluable and culturally revealing. I propose that prospective research subjects be given the same advantage. Every institution that receives government funds to perform research should be required to hold approximately three classes that equip subjects with information about how research is conducted, what risks and benefits are inherent in different types of research, what their legal rights and moral responsibilities are, what sort of questions they should ask, and how they can maximize their chances of getting the desired result from the clinical trial they enter. Except for seriously ill or otherwise-incapacitated patients, only people who have completed this course should be eligible to participate in governmentfunded clinical trials, and only they should be permitted to serve on IRBs. EMBRACE A SINGLE STANDARD OF RESEARCH ETHICS We cannot retain moral credibility if we champion human rights in medical research at home and ignore them abroad. Researchers should be made to follow informed-consent strictures abroad that are as restrictive as those governing their research on American shores. Pharmaceutical companies should be forced to

make lifesaving drugs available to people in poor countries, even when this means sacrificing their obese profits for the benefit of human welfare. Because the federal government sponsors much of the research that enables pharmaceutical companies to develop vital medications, the federal government should take advantage of its legal right either to force manufacturers to lower their prices or to suspend patent enforcement in poor countries. However, more important than any of the above recommendations is the need for African Americans to set their own research agendas. Black patients must take ownership of medical-research issues, as they have done with so many other complex health issues, from AIDS to environmental racism. Already, expert medical organizations have taken leadership roles. The National Center for Bioethics in Research and Health Care at Tuskegee University provides not only a center for scholars but also a venue for muchneeded lay education on medical research. The National Medical Association has also spearheaded patient education through its Project IMPACT, which has helped black Americans to navigate clinical trials safely by providing brochures, Web sites, and access to experts. African American and other health organizations must continue and expand the work of these pivotal groups, and much of this can be done close to home, through church health fairs, social organizations, and community activism. I challenge African Americans to bring medical-research education to the fore of the American health agenda. I challenge you, the reader, to familiarize yourself with the informational documents on this book's Web site and elsewhere, to join an IRB, to ask the hard questions of physicians who are recruiting in your community, and to join appropriate clinical trials once you have satisfied yourself that they are worthwhile and relatively safe. I challenge African Americans to effect a transformation of our attitudes toward medical research and to demand our place at the table to enjoy the rich bounty of the American medical system in the form of longer, healthier lives.

Workforce representation enables culturally conscious policy design at the micro level

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Racial/ethnic disparities in health have been well described, with data showing that members of minority groups suffer disproportionately from cardiovascular disease, diabetes, asthma, and cancer, among other conditions.¹ The causes of these disparities are multi-factorial, and perhaps the largest contributors are those related to social determinants of health external to the health care delivery system. For example, members of minority communities tend to be more socio- economically disadvantaged, to have lower levels of education, to work in jobs with higher rates of occupational hazards, and to live in areas with greater environmental hazards (such as air pollution) than members of the majority population.²⁻⁶ Furthermore, minorities are overrepresented among the rolls of the uninsured, with Latinos, for example, representing 13% of the U.S. population but 25% of those Americans without health insurance.⁷ Lack of insurance takes a significant toll on these populations, with health effects including less access to preventive care than among people with insurance, high rates of emergency department use and avoidable hospitalizations, later-stage diagnosis of cancer, and the

inability to obtain prescription medications.^{8,9} Even the prolonged impact of racism has been studied and linked to poor health outcomes among African Americans.¹⁰⁻¹¹ Racial/ethnic disparities in quality of care for those with access to the health care system are equally concerning. These disparities have been shown to exist in the utilization of cardiac diagnostic and therapeutic procedures,¹²⁻¹⁶ prescription of analgesia for pain control,¹⁷⁻¹⁹ surgical treatment of lung cancer,²⁰ referral to renal transplantation,²¹ treatment of pneumonia and congestive heart failure,²² and the utilization of specific services covered by Medicare (e.g., immunizations and mammograms).²³ The recent Institute of Medicine report *Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care* identified well over 175 studies documenting racial/ethnic disparities in the diagnosis and treatment of various conditions, even when analyses were controlled for socioeconomic status, insurance status, site of care, stage of disease, comorbidity, and age, among other potential confounders.²⁴ Among the many root causes of disparities that have been presented and explored, variations in patients' health beliefs, values, preferences, and behaviors have recently garnered attention.^{29,27} These include variations in patient recognition of symptoms; thresholds for seeking care; the ability to communicate symptoms to a provider who understands their meaning; the ability to understand the prescribed management strategy; expectations of care (including preferences for or against diagnostic and therapeutic procedures); and adherence to preventive measures and medications.²⁸ These factors are thought to influence patient and physician decision-making and the interactions between patients and the health care delivery system, thus contributing to health disparities.²⁹⁻³² As a result of these observations, the field of "cultural competence" in health care has emerged. A "culturally competent" health care system has been defined as one that acknowledges and incorporates-at all levels-the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs. A culturally competent system is also built on an awareness of the integration and interaction of health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes for different patient populations.³³ Furthermore, the field of cultural competence has recognized the inherent challenges in attempting to disentangle "social" factors (e.g., socioeconomic status, supports/stressors, environmental hazards) from "cultural" factors vis-a-vis their influence on the individual patient. As a result, understanding and addressing the "social context" has emerged as a critical component of cultural competence.³⁴ We will therefore refer to sociocultural barriers throughout this article to emphasize this connection, and will integrate this idea into our working definition of cultural competence. The movement toward cultural competence in health care has gained national attention and is now recognized by health policy makers, managed care administrators, academicians, providers, and consumers as a strategy to eliminate racial/ethnic disparities in health and health care.³⁻³⁹ There is, however, an ongoing debate as to how to better define and operationalize this critical yet broad construct. A number of different terms have been proposed to better articulate and encapsulate its meaning. Cultural sensitivity, responsiveness, effectiveness, and humility each emphasizes certain aspects and together reveal a lack of consensus, as each has a unique definition. Models for operationalizing cultural competence have emphasized particular aspects of the health care delivery system, especially the provider-patient interaction. No one has yet reviewed the literature and developed a more comprehensive approach to thinking about and implementing cultural competence in health care at multiple levels and from multiple perspectives. We surveyed the medical and public health literature to seek answers to two questions: (1) What are the major components of cultural competence? and (2) How do we incorporate culturally competent interventions into the delivery of

health care? METHODS We set out to practically define cultural competence and develop a framework that links interventions to an overall approach to eliminating racial/ethnic disparities in health and health care. Our goals were to: * Identify sociocultural barriers to care for various racial/ethnic groups. We focused on specific social and cultural factors that form the basis for individual health beliefs, behaviors, values, and preferences and how they potentially mitigate a patient's ability to obtain quality care. (Limited English proficiency as a barrier is a simple example.) It should be noted that our goal is not to look at sociocultural factors from a deficit model, as there are many cultural factors that have been found to be "protective" for health, and the "healthy immigrant" effect, or "epidemiologic paradox" has been well established. Instead, our goal was to identify situations in which sociocultural factors are not incorporated into the U.S. health care delivery system and how that leads to poorer quality care-as these are points for intervention. * Explore at what level in the process of obtaining care these barriers occurred (health systems level, clinical encounter level, and so on). * Identify cultural competence interventions that address these specifically identified sociocultural barriers. * Link these interventions to a framework that can be applied to the elimination of racial/ethnic disparities in health and health care. We reviewed: * Academic literature: We searched the PubMed database (MEDLINE, PreMEDLINE, HealthSTAR) for 1977-2002 using the following keywords: sociocultural barriers, cultural competence, cross-cultural care, health disparities, racial/ethnic disparities, minority health, and multicultural health, both alone and in combination. From the original set of articles that we identified, we set up criteria for relevance to our project. We included in our review only those publications that specifically addressed sociocultural barriers to health care (and provided details about the level of the health care system at which they occurred); cultural competence interventions; and/or racial/ethnic disparities in health and health care. We defined a sociocultural barrier to care as a social or cultural quality, characteristic, or experience of a racial/ethnic group or individual that led to differential treatment and varying quality of care. * Government and foundation publications: We searched major government and foundation reports relevant to our work by reviewing websites of the Commonwealth Fund, the Kaiser Family Foundation, the Kellogg Foundation, the Robert Wood Johnson Foundation, the California Endowment, the Office of Minority Health, the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institutes of Health, the Agency for Healthcare Research and Quality, and other Department of Health and Human Services agencies. We collected data and references, for example, from Minority Health: A Chartbook, published by the Commonwealth Fund,⁴⁰ the Kaiser Family Foundation's report on Race, Ethnicity and Medical Care,⁴¹ the CDC's Diabetes Today project handbook,⁴² and the American Medical Association's Cultural Competence Compendium RESULTS Sociocultural barriers to health care: a multilevel analysis We identified three major levels of health care at which sociocultural barriers occur that contribute to racial/ethnic disparities in health and health care. While these are not perfectly distinct categories and there may be some overlap between them, they help to build a framework on which to understand the complex and important issue of cultural competence in health care. Organizational barriers. Health care systems and structural processes of care are shaped by the leadership that designs them and the workforce that carries them out. From this organizational standpoint, one factor that impinges on both the availability and acceptability of health care for members of minority racial/ethnic groups is the degree to which the nation's health care leadership and workforce reflect the racial/ethnic composition of the general population. Institutional leadership. Despite representing almost 28% of this nation's population,⁴⁴ African Americans, Latinos, and Native Americans make up only 3% of medical school faculty, fewer than 16% of public health school faculty, and only 17% of all city and county health

officers.⁴⁰ Furthermore, fewer than 2% of individuals with senior leadership roles in health care management are non-white.⁴⁵ In the absence of strong quantitative data, a plethora of anecdotal evidence suggests that lack of diversity in the leadership and workforce of health care organizations results in structural policies, procedures, and delivery systems inappropriately designed or poorly suited to serve diverse patient populations.⁴¹ Given their social and cultural understanding of the communities they serve, minority professionals are more likely than their white counterparts to organize health care delivery systems to meet the needs of minority populations.⁴⁷ Examples of barriers to care in the way systems are currently organized include: limited clinical hours of service that don't account for community work patterns, bureaucratic intake processes that create fear of deportation among the undocumented, and long waiting times to make appointments and/or at the time of visit.⁴⁸ In addition, under-representation of minorities on faculty at medical schools and schools of public health prevents a nuanced understanding of community needs from being shared through the critical avenues of role modeling and teaching. Ultimately, inadequate minority representation in governance, administrative, and clinical leadership roles causes health care systems to be disconnected from the minority communities they serve.⁴⁵ Health care workforce. Racial/ethnic diversity in the health care workforce has been well correlated with the delivery of quality care to diverse patient populations. For example, research has shown that, for minority patients, racial concordance between patient and physician is associated with greater patient satisfaction and higher self-rated quality of care.⁴⁹ Other work has established the preference of minority patients for minority physicians, independent of practice location or other geographic issues.⁵⁰ Spanish-speaking patients, for example, report more satisfaction with care from Spanish-speaking providers than from non-Spanish-speaking providers,⁵³ and African American patients report more satisfaction with care when their physician employs a participatory and inclusive style of decision making.⁵⁴ Although there are no head-to-head quality of care comparisons between patients of minority and non-minority physicians, in general, self-rated quality of care and patient satisfaction have been closely linked to certain health outcomes, such as blood pressure control.⁵⁵ Given this logical link, it is feasible to hypothesize that there are quality of care differences for minority patients dependent on the race/ ethnicity or culture of their providers. Other practical issues that link service delivery to diversity arise. Komaromy et al. showed that approximately 45% of African American physicians and 24% of Hispanic physicians in office-based practices in California care for patients with Medicaid as the primary insurer, compared with 18% of white physicians.⁵¹ Furthermore, in a national consumer survey, Saha et al. found that 25% of African American respondents and 23% of Hispanic respondents were cared for by either African American or Hispanic physicians, despite African American physicians making up 4% and Hispanic physicians 5% of the nation's physician pool.⁵² These studies demonstrate that minority physicians are more likely than their white counterparts to provide care to poor and minority patients and may provide more effective care to patients of their own ethnicity. However, African Americans, Hispanics, and Native Americans are drastically underrepresented in the health professions.⁵⁸ The prognosis for the future is not much brighter. From 1996 to 1997, Mexican American medical school enrollment dropped by 8.7% (451 to 412) and enrollment of mainland Puerto Ricans dropped by 31% (141 to 97), while the enrollment of African Americans dropped by 3.7% (1,189 to 1,134), compared to a 1% drop in whites from 10,556 to 10,450. In that same year, only 11% of all graduates were from underrepresented minority groups.⁵⁹ It is both impossible and inappropriate to try to match minority patients to concordant minority providers. Still, these data suggest that there is justification for bolstering the ranks of minorities in the health care professions. Structural barriers. In a complicated health care system in

which the rules are many and economic forces drive both structure and function, the needs of vulnerable populations inevitably suffer. Structural barriers arise when patients are faced with the challenge of obtaining health care from systems that are complex, underfunded, bureaucratic, or archaic in design. Whereas many structural barriers to care may equally impact people of low socioeconomic status, regardless of race/ethnicity, several barriers are especially pertinent to minority populations: * Lack of interpreter services or culturally/linguistically appropriate health education materials is associated with patient dissatisfaction, poor comprehension and compliance, and ineffective or lower quality care.^{6>8} Doctor-patient communication without an interpreter when there is even a minimal language barrier is recognized as a major challenge to effective health care delivery.⁶⁰⁶² Research in this area has shown that: + Spanish-speaking patients discharged from emergency rooms are less likely than their English-speaking counterparts to understand their diagnosis, prescribed medications, special instructions, and plans for follow-up care⁶³; less likely to be satisfied with their care or willing to return if they have a problem; more likely to report problems with their care⁶⁴; and less satisfied with the patient-provider relationship.⁶⁴ * Physicians who have access to trained interpreters report a significantly higher quality of patient-physician communication than physicians who use other methods, such as untrained staff or family members.⁶⁵ + Hispanic patients with language-discordant physicians are more likely to omit medication, miss office appointments, and visit the emergency room for care than those with Spanish-speaking physicians.⁶⁶ * Bureaucratic intake processes and long waiting times for appointments have both been cited disproportionately by minority patients as major barriers to access to health care.⁴⁶⁴⁸ When patients have insurance but must undergo difficult intake processes to see a provider or when patients must wait exceedingly long to receive medical care, quality of care is compromised.⁷⁰* Members of minority groups also face structural barriers with regard to referral to specialists and continuity of care. A large survey by the Commonwealth Fund found that 22% of Hispanics and 16% of African Americans, as compared to 8% of whites, reported a "major" problem accessing specialty care.⁴ Another study revealed that 46% of Hispanic and 39% of African American adults, compared with 26% of white adults, do not have a regular doctor.⁴ Clinical barriers. Clinical barriers have to do with the interaction between the health care provider and the patient or family. They occur when sociocultural differences between patient and provider are not fully accepted, appreciated, explored, or understood. Patients may have very different socioculturally based health beliefs; medical practices, including use of home remedies; attitudes toward medical care; and levels of trust in doctors and the health care system.⁷² As the country becomes more culturally diverse, health care providers of all ethnic backgrounds are dealing with a greater proportion of patients whose perspectives are different from those taught in the mainstream health care system. Research has shown that provider-patient communication is directly linked to patient satisfaction, adherence, and subsequently, health outcomes⁵⁵⁻⁵⁷⁷³(see Figure). Thus, when cultural and linguistic barriers in the clinical encounter negatively affect communication and trust, this leads to patient dissatisfaction, poor adherence (to both medications and health promotion/disease prevention interventions), and poorer health outcomes.^{38,53,63,67,69,75,76} Moreover, when providers fail to take social and cultural factors into account, they may resort to stereotyping, which affects their behavior and decision-making.³² In the worst cases, this may lead to biased or discriminatory treatment of patients based on their race/ethnicity, culture, language proficiency, or social status.³² Defining cultural competence: a practical framework "Cultural competence" in health care entails: understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of

care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations. Given the evidence of sociocultural barriers to care and the levels of health care delivery in which they occur, a new framework for cultural competence would include organizational, structural, and clinical interventions: * Organizational cultural competence interventions are efforts to ensure that the leadership and workforce of a health care delivery system is diverse and representative of its patient population- e.g., leadership and workforce diversity initiatives.⁷ * Structural cultural competence interventions are initiatives to ensure that the structural processes of care within a health care delivery system guarantee full access to quality health care for all of its patients-e.g., interpreter services, culturally and linguistically appropriate health education materials.³³ * Clinical cultural competence interventions are efforts to enhance provider knowledge of the relationship between sociocultural factors and health beliefs and behaviors and to equip providers with the tools and skills to manage these factors appropriately with quality health care delivery as the gold standard-e.g., cross-cultural training.^{31,8082} To date, there have been various cultural competence interventions at the organizational, structural, and clinical levels: Organizational cultural competence interventions. Organizational cultural competence interventions include "diversity" and "minority recruitment" initiatives within the Department of Health and Human Services, academic health centers, hospitals, and medical schools. As a result of minority under-representation in medicine, the Physician-Population Parity Model of the Association of American Medical Colleges (AAMC) was set forth in 1970. Its goal was that the percentage of minorities in our physician workforce would approximate the percentage of minorities within the general population of the U.S. Although progress was made, efforts fell short. In the 1990s, the AAMC initiated Project 3000 by 2000 with the stated goal of having 3,000 minority students enrolled in the entering medical school class by 2000. Despite strategies to achieve these goals, the AAMC fell quite short of its target, perhaps as a result of anti-affirmative action legislation in states such as California and Texas in the mid-1990s.⁵² Given our growing diversity, minority recruitment efforts in health care have been seen as critical to meeting the needs of our population.⁵²⁸³ There are successful models at many levels of the health care delivery system, including those sponsored by foundations (the Commonwealth Fund, the Robert Wood Johnson Foundation), professional organizations (including the AAMC), and government (HRSA). Describing these in more detail is outside the scope of this article. Ultimately, it is obvious that the organizational component of cultural competence is an important part of efforts to improve quality of care for all Americans. Structural cultural competence interventions. These initiatives have been the most studied, with research focusing, for example, on the impact of reducing language barriers on quality of care.⁸⁴ Some studies have also been done on culturally appropriate health education materials and their impact on patient knowledge and understanding of certain medical interventions.⁸⁵ There is an obvious and direct link between these structural barriers and quality of care, and this remains a fertile area for intervention. The federal government and managed care organizations, through various initiatives, have attempted to develop policy and regulatory efforts to ameliorate these barriers.³³⁸⁶

Cultural safety training demilitarizes clinical encounters---focus groups prove it's an effective framework for contesting hegemonic care practices

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"Rethinking Cultural Competence." *Transcultural Psychiatry*, vol. 49, no. 2, pp. 149–164.

In actual practice, cultural competence in the US has been largely approached through sensitization of clinicians to the social predicaments of these ethnoracial blocs or through efforts at ethnic matching of

patient and practitioner (Good, Willen, Hannah, Vickery, & Park, 2011). The cultural competence literature tends to treat culture as a matter of group membership (whether self-assigned or ascribed). This assumes that members of a group share certain cultural “traits,” values, beliefs and attitudes that strongly influence or determine clinically relevant behaviour. Unfortunately, this approach tends to reify and essentialize cultures as consisting of more or less fixed sets of characteristics that can be described independently of any individual’s life history or social context – hence the plethora of textbooks with chapters on specific ethnocultural groups. This is an old-fashioned view, now largely abandoned by anthropology. Contemporary anthropology emphasizes that culture is not a fixed, homogeneous, intrinsic characteristic of individuals or groups (Guarnaccia & Rodriguez, 1996). Instead, culture involves a flexible, ongoing process of transmitting and using knowledge that depends on dynamics both within communities and at the interface between ethnocultural communities and institutions of the larger society, like the health care system, as well as global networks (Modood, 2007; Phillips, 2007). As a result, cultures are often hybrid, mixed, and undergoing constant flux and change (Burke, 2009; Kraidy, 2005). Nevertheless, because culture provides the concepts through which individuals and communities interpret the world and construct their hierarchies of goals and values, cultural processes remain central to the ethics and pragmatics of health promotion and health delivery. An approach to cultural competence based on this more contemporary view of culture must consider how to meld recognition of, and respect for, the identity of individuals and communities with attention to the dynamic, contested, and often highly politicized nature of individuals’ interactions with collectivities, both local and global. The cultural identity of an individual must be understood in terms of ongoing interactions within multiple networks or communities; similarly, the culture of an ethnic community can only be understood in terms of its interaction with the larger society. Each struggles to define, position, constrain and exploit the other. This view of culture foregrounds issues of power and the politics of identity and otherness (Modood, 2007). Recognition of cultural diversity coupled with analysis of the structural sources of inequality offers us the best way to understand and redress the inequities and injustices that are ignored, or even aggravated, by culturally-blind [culturally-ignorant] health care (Fraser & Honneth, 2003). Competence and epistemic communities “Competence” is the latest iteration of the emphasis on technical expertise in a scientifically-based medicine that was central to the professionalization of biomedicine and the reform of medical training following Flexner in the 1920s (Carraccio, Wolfsthal, Englander, Ferentz, & Martin, 2002). Science remains the touchstone of technically competent practice in current efforts to develop evidenced-based practice in the health professions (Whitley, Rousseau, Carpenter-Song, & Kirmayer, 2011). This has close parallels in the development of clinical psychology, with the notion of the scientist-practitioner. Far from criticizing this central role for science, we should recognize it as an essential though unfinished project, but distinguish the unique value of scientific research and reasoning from “scientism” — the invocation of science as an article of faith or rhetorical flourish to foreclose critical analysis and debate. Certainly, clinical and professional competence are highly desirable qualities. Indeed, some version of competence (the ability to do things well, to achieve desired goals, and to act appropriately for the context) is widely desired and respected across very different traditions, professions and domains. Judgements of competence may not only reflect evidence on outcomes (which, of course, are hard for individuals to judge and prone to bias), but on the ability to act in ways that are viewed as (culturally) appropriate for the case in context. Emphasis on this attention to protocol, appropriateness and other forms of cultural authority is sometimes viewed as an alternative to the epistemology of science. Thus, traditional healing is said to work because “it has stood the test of time,” it fits with deeply held ontologies that explain illness and

healing, it is authorized by social institutions that are among the pillars of collective identity, or simply because it is sacred and ineffable and, hence, beyond any critique. Whatever the merits of arguments that traditional medicine lies outside the epistemological frame of biomedicine, practitioners must still meet some shared criteria of safety and competence. There are inept practitioners and ineffective or inappropriate practices in every health care system or healing practice. Appeals to tradition do not vouchsafe the clinical efficacy or ethical integrity of any health practice or practitioner. Traditionally, healers were members of local communities so that their ethical conduct and effectiveness could be monitored by others close at hand. However, the modes of regulating practice that worked in small-scale societies will not suffice in the global agora, where every form of knowledge and medicine is commodified, and superficial appeals to cultural tradition are used to market treatments. Pluralistic health care systems raise complex ethical and pragmatic issues and simply decrying the hegemony of biomedicine does not take us very far toward resolving the problems created by a naïve embrace of anything labelled “non-Western” or “traditional” as being inherently good and beyond critical appraisal. Despite this caution, it is important to recognize that the institutionalization of competence within the mental health professions also serves political and economic processes of boundary marking, domination and legitimization. Professionals who are competent arrogate the right to designate others as less competent (or frankly incompetent) and to regulate and control the delivery of health services. The ingredients of competence, in terms of knowledge, skills and attitudes, may be quite distinct from the mechanisms by which competence is certified and maintained – and both the content and the process of defining competence in different medical systems deserve critical analysis. We need to diversify our notion of competence itself, not to encourage the indiscriminate embrace of any treatment that is labelled traditional but to broaden our notions of efficacy and outcome to assess practitioners and treatments in diverse systems of healing and intervention. Alternatives to cultural competence While it is essential that professionals be technically competent and, in the case of clinicians, this competence includes interpersonal skills, ethical commitments, and the ability to effectively refine and use one's empathic capacity, an emphasis on professional competence in the domain of culture risks reifying appropriating rather than respecting and engaging the other's lifeworld. For this reason, some have advocated alternative concepts through metaphors such as “cultural responsiveness” (Sue et al., 1991), “cultural humility” (Tervalon & Murray-Garcia, 1998), or “cultural safety” (Papps & Ramsden, 1996). The notion of cultural safety was developed in the 1980s in New Zealand in response to Maori discontent with medical care (Papps & Ramsden, 1996; Koptie, 2009). In contrast to the emphasis in cultural competence on practitioners' skills, cultural safety “moves beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health care” (National Aboriginal Health Organization, 2008, p. 3). In Canada, cultural safety has been recognized by the National Aboriginal Health Organization (NAHO), other Aboriginal organizations and the Mental Health Commission of Canada, as a preferred approach to guide efforts to improve the cultural responsiveness and appropriateness of health care. Nursing educators and practitioners have led the development of the concept of cultural safety in New Zealand and in Canada (Aboriginal Nurses Association of Canada, 2009; Smye, Josewski, & Kendall, 2010; Stout & Downey, 2006). Cultural safety is a powerful means of conveying the idea that cultural factors critically influence the relationship between carer and patient. Cultural safety focuses on the potential differences between health providers and patients that have an impact on care and aims to minimize any assault on the patient's cultural identity. Specifically, the objectives of cultural safety in nursing and midwifery training are to educate students to examine their own realities and attitudes they bring to

clinical care, to educate them to be open-minded towards people who are different from themselves, to educate them not to blame the victims of historical and social processes for their current plight, and to produce a workforce of well-educated and self-aware health professionals who are culturally safe to practice as defined by the people they serve. (Crampton, Dowell, Parkin, & Thompson, 2003, p. 596) Cultural safety in indigenous contexts means that professionals and institutions, whether indigenous or not, work to create a safe space for an encounter with patients that is sensitive and responsive to their social, political, linguistic, economic, and spiritual realities. Culturally unsafe practices involve “any actions that diminish, demean or disempower the cultural identity and well-being of an individual” (Nursing Council of New Zealand, 2002, p. 7, cited in Polaschek, 1998). In Canada, the National Aboriginal Health Organization (NAHO, 2008; Brascoupe' & Waters, 2009) has advocated principles of cultural safety that are grounded in recognizing the historical context of Aboriginal experience. This includes recognizing the diversity of populations, understanding power issues in health care worker-patient relationships, and raising awareness of cultural, social and historical issues in organizations and institutions. In the training of health care providers and professionals, cultural safety involves attention to issues of communication, power sharing and decision making, working toward understanding and addressing misunderstandings, and recognizing and respecting fundamental cultural beliefs. Although there is overlap between concepts of cultural safety and cultural competence, the metaphors have different connotations and the constructs emphasize distinct approaches to social and cultural dimensions of care. Cultural safety does not emphasize developing “competence” through knowledge about the cultures with which professionals are working. Instead, cultural safety emphasizes recognizing the social, historical, political and economic circumstances that create power differences and inequalities in health and the clinical encounter (Anderson, Perry, et al., 2003; Anderson, Scrimshaw, et al., 2003). Cultural safety has some overlap with concepts such as “cultural sensitivity,” cultural responsiveness and “cultural humility” – that is, with a willingness and ability to listen and learn from patients. Openness, respect and attentiveness are pre-requisites for cultural safety but, by themselves, are not sufficient. “Sensitivity can be thought of as the first step towards learning about oneself within the context of one’s interaction or relationship with people of a different culture” (NAHO, 2008a, p. 27). The self-reflexivity of practitioners and systems opens the door to reorganizing the delivery of services and the conduct of clinical work in ways that share power and control over health care but the details of how this is achieved must be worked out for specific contexts. The concept of cultural safety has also received some criticism, both for its ambiguities and its narrow readings of the social determinants of health and the politics of the clinical encounter. Johnstone and Kanitsaki (2007) provide a critique from an Australian perspective. They note that cultural safety developed in the bicultural political context of New Zealand and it is not clear how well the construct applies to the multicultural context of Australia. There has been relatively little research on cultural safety and, in particular, the links between cultural safety and positive outcomes (in training or practice) have not been clearly demonstrated. As metaphor or model, cultural safety is not a transparent concept but, like cultural competence, requires unpacking and further specification in terms of its implications for training, health systems and clinical practice. Discussions of cultural safety tend to frame the clinical encounter as a situation fraught with risk and vulnerability, and locate all the power and potential for aggression and harm on the side of the clinician. As a result, cultural safety tends to approach culture in terms of vulnerabilities rather than strengths. By implying that the cultural “other” is vulnerable, cultural safety may also contribute to essentializing and stereotyping ethnocultural groups. To explore the significance of some of these criticisms, Johnstone and Kanitsaki (2007) conducted a focus group and key informant study of how practitioners, patients,

consumers and ethnic minority organizations in Australia understand cultural safety. Providers interpreted cultural safety as not imposing their own cultural values on patients in areas that were of vital importance, or as exhibiting "racial respect" and explicitly anti-racist perspectives. The key threats to cultural safety identified by patients included: inability to communicate with service providers; poor attitudes by staff resulting in not being treated with respect (for example, patients being treated as if they were stupid, subjected to stereotypes and prejudice); not being able to have their families present; not being listened to; not being given clear explanations; being forced to comply with unfamiliar forms of care or treatment; being powerless or unable to take action to help themselves or their loved ones; overall inflexibility of the system; feeling isolated because no one around them shared their culture or language); not having access to appropriate interpreter services. It is these sorts of violations of clinical trust and power imbalances that attention to cultural safety is meant to remedy. A wide range of strategies have been proposed to counteract these barriers to work toward an open, collaborative and safe space in clinical services and systems (Brascoupe' & Waters, 2009). The framework of cultural safety can be used to critique health policy and practice (Josewksi, 2011).

Specifically resolves subconscious racial bias among medical professionals by counteracting anti-black facets of the libidinal economy.

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"Breaking the Cycle of Unequal Treatment with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias." Conn. L. Rev., vol. 44, p. 1281.

I. INTRODUCTION The election of President Obama prompted many Americans to declare that the United States had entered into a "post-racial" era in which racial bias no longer existed and African-Americans are treated equally. However, racial bias did not cease before or after the election of an African-American president. In fact, empirical evidence shows that African-Americans continue to be treated unequally because of racial bias in decisions regarding bankruptcy, residential zoning, mortgage lending, apartment rental, and housing rental.¹ One of the most poignant examples of the continuation of racial bias in a "post-racial" era was a Cincinnati landlord's posting of a "White Only" sign by a pool in the summer of 2011.² The persistence of racial bias in a "post-racial" era is also evident in the health care system, where the unequal treatment of African-Americans because of their race is the main cause of the continuation of racial disparities in health care.³ However, unequal treatment of African-Americans in health care is nothing new. In 2002, the groundbreaking Institute of Medicine Study, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare ("IOM study"), noted that some health care providers, such as physicians, were influenced by a patient's race, which, in turn, created a barrier to African-Americans' access to health care.⁴ Not only did this racial bias prevent African-Americans from accessing health care services, it caused African-Americans to have poor health outcomes.⁵ The IOM study also found evidence of poorer quality of care for minority patients in studies of cancer treatment, treatment of cardiovascular disease, and rates of referral for clinical tests, diabetes management, pain management, and other areas of care.⁶ Ten years after the publication of this sweeping study, racial bias continues to drive racial disparities in health care, and as a result, access to health care remains unequal.⁷ Racial bias in health care operates on three different levels: interpersonal, institutional, and structural.⁸ Interpersonal bias is the conscious (explicit) and/or unconscious (implicit) use of prejudice in interactions between individuals.⁹ Interpersonal bias is best illustrated by physicians' treatment decisions based on racial prejudice, which results in the unequal treatment of African-Americans. According to René Bowser's seminal article, Racial Profiling in Health

Care: An Institutional Analysis of Medical Treatment Disparities, these racial disparities in treatment often lead to racial disparities in mortality rates between African-Americans and Caucasians.¹⁰ Institutional bias operates through organizational structures within institutions, which "establish separate and independent barriers"¹¹ to health care services.¹² According to Brietta Clark, institutional bias is best demonstrated by hospital closures in African-American communities.¹³ Finally, operating at a societal level, structural bias exists in the organizational structure of society, which "privile[ges] some groups ... [while] denying others access to the resources of society," including health care.¹⁴ An example of structural bias is the provision of health care based primarily on ability to pay, rather than on the needs of the patient. Unfortunately, the government often ignores the significance of racial bias in causing racial disparities in health care, and by extension, overall health, even though such biases are among the causes identified in numerous government reports, initiatives, and empirical research studies conducted over the past decade.¹⁵ The Patient Protection and Affordable Care Act ("ACA") exemplifies the government's failure to acknowledge the interconnectedness of racial bias and racial disparities.¹⁶ Although the Patient Protection Act explicitly mentions disparities in health care and provides several mandates to address these disparities, it fails to acknowledge or target the root causes of racial disparities-racial bias. Therefore, this Article argues that the ACA will not fully equalize access to health care for minorities. In fact, the Act may exacerbate the existing problem of racial disparities because it proposes individual and community based solutions that will not put an end to interpersonal, institutional, and structural racial bias, which cause racial disparities in health care. The debate surrounding the ACA has rarely focused on issues related to racial disparities. This Article begins to fill this void.¹⁷ Part II provides a brief historical context for the ACA by discussing previous legislation that addressed racial disparities in health care and governmental action to measure and eradicate racial disparities. Part III then reviews the root cause of racial disparities-racial bias-as evidenced by empirical data. Next, Part IV examines specific sections of the ACA, which address racial disparities, and discusses the strengths and weakness of the Act. Finally, Part V suggests some solutions.

II. BRIEF HISTORICAL CONTEXT

The U.S. Department of Health and Human Services ("HHS") defines health disparities as the differences in health between groups of people who have systematically experienced greater obstacles to health care services based on their racial group, socioeconomic status, or other characteristics historically linked to discrimination or exclusion.¹⁸ The largest disparity in accessing quality health care and health status in the United States remains between African-Americans and Caucasians.¹⁹ With the enactment of Title VI of the Civil Rights Act of 1964 ("Title VI"), the right to equal enjoyment and access to health care became the subject of federal government regulation.²⁰ Title VI prohibits health care entities receiving government funding from using racial bias to determine who receives quality health care.²¹ Using its spending power, Congress made compliance with Title VI mandatory before a health care provider, such as a hospital or nursing home, could become eligible to receive Medicare²² or Medicaid²³ funding.²⁴ Decades of government reports and research studies have shown that forty-seven years after the enactment of Title VI, access to health care still remains unequal and as a result racial disparities in health care persist.²⁵

A. The Civil Rights Era: The Promise of Equal Treatment

Throughout the 1960s, African-Americans waged national and international battles to obtain the rights of full citizenship in the United States.²⁶ The civil rights movement focused on equality of rights in every area of life, including the right to quality health care. The disenfranchisement of African-Americans seeking health care did not change until African-Americans forced the government to comply with the Constitutional mandates of the Equal Protection Clause of the Fourteenth Amendment.²⁷ In 1962, a group of African American physicians, dentists and patients filed a lawsuit against two hospitals in North

Carolina receiving federal funding because the hospitals denied admission to African-Americans because of race.⁸ Not only did the federal government intervene on behalf of the plaintiffs, but it also enacted Title VI of the Civil Rights Act of 1964 to put an end to 'separate, but equal' access to health care.²⁹ Title VI provides both a private right of action and mandates for government enforcement. The private right of action is found in section 601,³⁰ which reads: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of or be subjected to discrimination under any program or activity receiving Federal financial assistance."¹ The mandates of enforcement for the government are found in section 602, which states: Each Federal department and agency which is empowered to extend Federal financial assistance to any program or activity, by way of grant, loan, or contract other than a contract of insurance or guaranty, is authorized and directed to effectuate the provisions of section 2000d [Section 601] of this title with respect to such program or activity by issuing rules, regulations, or orders of general applicability which shall be consistent with achievement of the objectives of the statute authorizing the financial assistance in connection with which the action is taken.³² Under Section 601, private parties have a right to sue health care facilities for disparate treatment, i.e., race conscious actions that prevent participation or the access of benefits under federally funded health care programs.³³ Section 602 requires the U.S. Department of Health and Human Services, Office for Civil Rights ("OCR") to undertake measures to ensure that health care entities receiving federal funding do not discriminate either through disparate treatment or disparate impact, i.e. race-neutral actions that have a disproportionate effect on minorities.³⁴ When Title VI was enacted federal funding to health care entities was limited. However, the enactment of Medicare and Medicaid in 1965 significantly increased federal funding to all health care entities, including hospitals and nursing homes.³⁵ In fact, Congress made compliance with Title VI "mandatory" before health care entities could receive any Medicare and Medicaid funding.³⁶ OCR focused its initial efforts on hospitals.³⁷ Because hospitals relied on federal funding, the federal government was able to force hospitals to integrate without much resistance from the hospital industry.³⁸ Faced with the loss of a substantial source of revenue stream, most hospitals integrated overnight, putting an end to "separate but equal" hospital care.³⁹ Unfortunately, this was the main victory of Title VI. Physicians were not required to comply with Title VI⁴⁰ and other health care entities, such as nursing homes, were allowed to ignore the requirements of Title VI.⁴¹ Specifically, physicians receiving payments under Medicare were exempted from compliance with Title VI because these payments were not defined as federal financial assistance.⁴² Moreover, nursing homes were not interested in participating in Medicare and Medicaid initially, and the government was not dedicated to forcing racial integration in nursing homes.⁴³ In fact, David Barton Smith's research has shown that nursing homes never fully racially integrated or actively sought African American patients.⁴⁴ The only change in nursing homes after Title VI was the removal of blatant discriminatory advertising.⁴⁵ Thus, because the promise of equal health care never became a reality, it comes as no surprise that government reports and research studies conducted after the passage of Title VI show that there are racial disparities in health care access and health status between African-Americans and Caucasians. B. After Title VI. Evidence of Racial Disparities Twenty-one years after the passage of Title VI, the government issued the first report on African-American health outcomes. In 1985, the Secretary of HHS issued a landmark report—the Heckler Report—exposing and detailing the existence of racial disparities between African-Americans and Caucasians in the U.S. health care system.⁴⁶ Seventeen years later, in the IOM study, the government acknowledged the continuation of racial disparities in health status and in access to health care because of racial bias, and provided suggestions for the elimination of these

disparities.⁴⁷ Finally, in 2007 the National Healthcare Disparities Report ("NHDR") noted that racial disparities in health status and in access to quality health care between African-Americans and Caucasians were not decreasing; instead the gaps persisted.⁴⁸ In response to these reports, the federal government issued several initiatives to put an end to racial disparities in access to health care and health status. In 1990, HHS issued the first national health initiative, which provides ten years of science-based national objectives for improving the health of all Americans. In the first national health initiative, called Healthy People 2000, one of the main objectives was to reduce health disparities among all Americans, and particularly among racial and ethnic minority populations.⁵⁰ To wit, "[i]n 1998, President Bill Clinton announced the Initiative to Eliminate Racial and Ethnic Disparities in Health Care[, which] was supposed to eliminate racial and ethnic health disparities in six key areas of health status, including infant mortality, by the year 2010."⁵¹ In 2000, the Healthy People 2010 initiative was issued with an objective of eliminating racial disparities in health care.⁵² In 2010, the Healthy People 2020 initiative expanded these goals of eliminating racial disparities in health care to include achieving health equity and improving the health of all groups.⁵³ These disparities are also illustrated by empirical evidence. Research studies have shown that in 1950, before the end of legalized racial segregation, the life expectancy rates of 65-year-old male African-Americans and Caucasians were the same.⁵⁴ By 1995, African-American mortality rates—when compared to Caucasians for cancer, diabetes, suicide, cirrhosis of the liver and homicide—were higher than they were in 1950.⁵⁵ As of 1985, 60,000 excess deaths were occurring annually in African-American and minority populations.⁵⁶ By 2002, an estimated 83,570 African-Americans had died each year that would not have died if African-American death rates were equivalent to those of Caucasians.⁵⁷ "In fact, 'there has been no sustained decrease in black-white disparities in age-adjusted mortality (death) or life expectancy at birth at the national level since 1945.'⁵⁸ These disparities in mortality are a result of disparities in medical treatment. In 1996, the New England Journal of Medicine published a study regarding racial disparities in the provision of Medicare services.⁵⁹ Even after controlling for income, the study showed that physicians treated African-American Medicare patients less aggressively than Caucasians, who were more likely to be hospitalized for ischemic heart disease, have a mammography, and undergo coronary-artery bypass surgery, coronary angioplasty, and hip-fracture repair.⁶⁰ Likewise, a 1998 study found that African-Americans were less likely than Caucasians to receive curative surgery for early-stage lung cancer, which is linked to increased mortality rates of African-Americans.⁶¹ In fact, the study showed that if African-American patients underwent surgery at a rate equal to Caucasians, their survival rate would approach that of Caucasian patients.⁶² According to a study conducted that same year by Harvard researchers, African-American Medicare patients received poorer basic care than Caucasians who were treated for the same illnesses.⁶³ The study showed that only thirty-two percent of African-American pneumonia patients with Medicare were given antibiotics within six hours of admission, compared with fifty-three percent of other pneumonia patients with Medicare.⁶⁴ Also, African-Americans with pneumonia were less likely to have blood cultures done during the first two days of hospitalization.⁶⁵ The researchers noted that other studies had associated prompt administration of antibiotics and collection of blood cultures with lower death rates.⁶⁶ In spite of all the government reports, initiatives, and research studies, health care disparities persist and, in some cases, have even worsened.⁶⁷ Innumerable reasons have been offered to explain the continuation of racial disparities in health care, including insurance status, education levels, and socioeconomic status.⁶⁸ Yet, research studies show that "even when all these factors are controlled[,] racial disparities in health care persist, leaving race as the only plausible answer for the continuation of disparities.,⁶⁹ The logical question, then, is why race? III. RACIAL BIAS: THE CENTRAL

CAUSE OF RACIAL DISPARITIES Some argue that biological difference between racial groups is the cause of racial disparities in health.⁷⁰ However, leading academics have discredited this claim.⁷¹ For example, in her landmark book, *Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century*, Dorothy Roberts states that "genetic explanations for health disparities are basically implausible."⁷² As noted by Nancy Krieger, the biological theory is based on three flawed assumptions: "that 'race' is a valid biological category; that the genes which determine 'race' are linked to the genes which affect health; and that the health of any community is mainly the consequence of the genetic constitutions of the individuals of which it is composed."⁷³ Thus, if race plays a role in racial disparities, it is because race "is a powerful determinant of the location and life-destinies of individuals within the class structure of the U.S. society."⁷⁴ More specifically, society has defined racial groups based on physical traits, such as skin color, which determine the distribution of resources, such as health care.⁷⁵ As David Williams and Pamela Jackson noted, "[r]ace is a marker for differential exposure to multiple disease-producing social factors. Thus, racial disparities in health should be understood not only in terms of individual characteristics but also in light of patterned racial inequalities in exposure to societal risks and resources."⁷⁶ Unfortunately, the significance of societal factors, such as racial bias in causing racial disparities in health care, is often ignored. Credible and robust research studies have suggested, however, that racial bias, which leads to unequal treatment, may be the chief factor in the continuation of racial disparities in health care.⁷⁷ Specifically, social psychologists, medical researchers, and legal scholars have suggested that interpersonal, institutional, and structural racial biases are the chief causes of racial disparities.⁷⁸ This Article next briefly discusses each type of racial bias and why it causes racial disparities in access to health and health status.⁷⁹

A. Interpersonal Bias

Interpersonal bias is the conscious (explicit) and/or unconscious (implicit) use of prejudice in interactions between individuals.⁸⁰ Prejudice is a negative pre-judgment against a person or group.⁸¹ An action based on racial prejudice is racial bias, while racism is racial bias plus power.⁸² Interpersonal racial bias can be defined as a conscious (explicit) prejudicial action or comment by a racist individual, which harms another person. Charles Lawrence notes, however, that such a definition fails to recognize the harm caused by an individual who, although unconscious of his or her prejudice, acts as a racist.⁸³ The full harm caused by interpersonal racial bias is best captured by social psychology research, which acknowledges both conscious (explicit) and unconscious (implicit) racial prejudice. According to psychiatrist Joel Kovel, there are two types of people who exhibit interpersonal racial bias: dominative and aversive racists.⁸⁴ A "dominative racist" is a person who is conscious of his or her prejudice that members of one racial group (such as Caucasians) are superior and acts based on these beliefs, while an "aversive racist" believes that everyone is equal but harbors contradicting, often unconscious, prejudice that minorities (such as African-Americans) are inferior.⁸⁵ Over four decades of social psychology research suggests aversive racism has become the dominant form of interpersonal racial bias between African-Americans and Caucasians in the United States.⁸⁶ More recently, medical research studies have begun to study aversive racism in health care by measuring physicians' unconscious prejudicial beliefs about African-Americans and the effect of these beliefs on physicians' treatment decisions.⁸⁷ These studies show that instead of relying on individual factors and scientific facts, physicians rely on their conscious and unconscious prejudicial beliefs. This reliance results in the unequal treatment of African-Americans, leads to racial disparities in medical treatment, and causes inequalities in mortality rates between African-Americans and Caucasians.⁸⁸ Empirical evidence of physician's prejudicial beliefs was first published in 1999 in the Schulman study. The study investigated primary care physicians' perceptions of patients and found that a patient's race and sex affected the physician's decision to

recommend medically appropriate cardiac catheterization.⁸⁹ Specifically, African-Americans were less likely to be referred for cardiac catheterizations than Caucasians, while African-American women were significantly less likely to be referred for treatment compared to Caucasian males.⁹⁰ One year later, Dr. Calman, a Caucasian physician serving African-American patients in New York, wrote about his battle to overcome his own and his colleagues' racial prejudices, which often prevented African-Americans from accessing quality health care.⁹¹ In 2000, van Ryn and Burke conducted a survey of physicians' perceptions of patients.⁹² The survey results showed that physicians rated African-American patients as less intelligent, less educated, and more likely to fail to comply with physicians' medical advice.⁹³ Physicians' perceptions of African-Americans were negative even when there was individual evidence that contradicted the physician's prejudicial beliefs.⁹⁴ In 2006, van Ryn repeated this study using candidates for coronary bypass surgery.⁹⁵ Again, the physicians that were surveyed exhibited prejudicial beliefs about African-Americans' intelligence and ability to comply with medical advice.⁹⁶ The physicians acted upon these prejudicial beliefs by recommending medically necessary coronary bypass surgery for male African-Americans less often than compared to male Caucasians.⁹⁷ In 2002 and 2006, research showed that African-American patients, when compared to Caucasian patients, were less likely to receive encouragement to participate in medical decision-making and less likely to receive sufficient information from their physicians about their medical condition.⁹⁸ Most recently, a 2008 study found that physicians subconsciously favor Caucasian patients over African-American patients.⁹⁹ In this study, physicians' racial attitudes and stereotypes were assessed and then physicians were presented with descriptions of hypothetical cardiology patients differing in race.⁰⁰ Although physicians reported not being explicitly racially biased, they held implicit negative attitudes about African-Americans,¹ and thus were aversive racists. The study further showed that Caucasian male physicians tend to exhibit higher levels of aversive racism compared to Caucasian female, African-American female and African-American male physicians.^{1 02} This is significant because seventy-five percent of African-Americans medical interactions are with physicians who are not African-American.^{0 3} Studies further found that medical interactions between racially different patients and physicians are "characterized by less patient trust, less positive affect, fewer attempts at relationship building, and less joint decision-making."¹⁰⁴ Finally, the stronger the implicit bias, the less likely the physician was to recommend the appropriate medical treatment for African-American patients.¹⁰⁵ For example, even though African-Americans, in general, have a higher rate of stroke and cerebrovascular death than Caucasians, African-American patients have a lower rate for carotid endarterectomy, a procedure that would greatly reduce fatalities from these conditions.¹⁶ Furthermore, in a study conducted in 1999, researchers evaluated the medical records of patients who underwent a coronary angiography during hospitalization to ascertain "whether there were differences by race and gender in the underutilization of [coronary artery bypass] surgery among patients for whom [this procedure] is the appropriate intervention."^{0 7} There were significant racial differences:^{0 8} after controlling for disease status, income level, and educational attainment, African-American patients were only sixty-four percent as likely as Caucasians to receive surgery.¹⁰⁹ This study, and a majority of these studies discussed in Section II.B, controlled for socioeconomic status, disease status, and education level, suggesting that race, specifically racial bias in the form of implicit (unconscious) racial bias, is the central cause of disparities in medical treatment.¹⁰ In addition to the harm caused by unequal treatment due to implicit racial bias, research shows that African-Americans perceive this implicit bias and respond negatively.¹¹ Data show that African-Americans reacted most negatively to physicians who were aversive racists (those individuals who exhibited low explicit, or conscious, prejudice, but high implicit, or unconscious, prejudice), compared to

physicians who were not racist (those that possessed low explicit and implicit bias) or were 'dominative racists' (those who exhibited either high explicit or conscious prejudice, or high implicit or unconscious prejudice).¹² Patients perceived aversive racists as deceitful compared to dominative racists, who were clear and honest about their prejudicial beliefs.¹³ African-Americans' perception of racial prejudice outside the health care system also results in negative health outcomes.¹⁴ Empirical evidence shows that perception of racial prejudice results in increased stress that negatively affects health status.¹⁵ In fact, perceived racial prejudice has been associated with poorer health status for African Americans.¹⁶ Several studies suggest that there is a higher positive correlation between perceived racial prejudice and increased cigarette and alcohol use among African-Americans as compared to Caucasians.¹⁷ The increased stress from perceived racial prejudice may also affect birth outcomes by increasing rates of infant mortality.¹⁸ During the last century, infant mortality rates in the United States decreased.¹¹⁹ Nevertheless, the ratio of disparity of infant mortality rates between African-Americans and Caucasians has continued, regardless of socioeconomic status, education level, or health insurance status.²⁰ Based on geographic area, the infant mortality ratio of African-Americans is 1.4 to 4.8 times the rate of Caucasians. Nationally, between 2000 and 2003, the African-American to Caucasian infant mortality ratio underwent only a slight increase from 2.3 to 2.4, while the absolute gap declined from 8.0 to 6.5 deaths per 1000.¹²² The main causes of death for African-American infants are preterm birth and low birth weight, which, according to Richard David and James Collins Jr., is caused in part by racial bias.²³ David and Collins' study compared the birth weights of three groups of women: African Americans, Caucasians, and Africans who had moved to Illinois.¹²⁴ The birth weights of Caucasian and African infants were almost identical, whereas the birth weights of African-American infants were substantially lower.²⁵ Researchers suggested that one reason African-American mothers have babies who weigh less at birth is that they are subject to stress caused by perceived interpersonal racial bias.¹²⁶ Between African-American women who had babies with normal weights at birth ("NLBW") and African-American women whose babies' birth weight was very low ("VLBW")—under three pounds—interpersonal racial bias played a significant role.²⁷ Specifically, "African American mothers who delivered VLBW preterm infants were more likely to report experiencing interpersonal racial discrimination during their lifetime than were African American mothers who delivered NLBW infants at term."¹²⁸ Hence, the perception of racial prejudice can negatively affect African-American health status at birth and throughout adulthood.²⁹ B. Institutional Bias Institutional bias operates through organizational structures and establishes "separate and independent" barriers through the neutral denial of access to quality health care that results from the normal operations of the institutions in a society.³⁰ Not all institutional actions that disproportionately affect minorities are racially biased. In order to constitute institutional racial bias, an action must reinforce the racial hierarchy of the inferiority of minorities and impose substantial harm on minorities.¹³¹ Once this occurs, the institution's actions constitute institutional racial bias, even if the actions are seemingly race-neutral.¹³² The most poignant example of institutional racial bias in health care is the closure of hospitals in predominately African-American communities.¹³³ These decisions may seem race neutral. According to Brietta Clark, however, hospital closures reinforce the racial hierarchy in health care that holds that African-Americans' health does not matter compared to the health of Caucasians.¹³⁴ Clark also argued that hospital closures have resulted in significant harm, including increased mortality rates of minorities.¹³⁵ In order to control costs, state and federal regulators have allowed hospitals to make this decision without balancing the needs of African-American communities.³⁶ Unfortunately, not only have closures failed to control costs, but they have also caused racial disparities in access to health care and health status. In the late 1970s, the

American Hospital Association published a study surveying hospital administrators to determine the primary reasons for hospital closures or relocations.¹³⁷ According to the survey, [o]f the 231 hospitals, the reasons for closure or relocation were broken down as follows: 27% [of hospitals] reported financial reasons for closure, 23% were replaced by a new facility; 14% closed due to low occupancy rate; 13% closed because they were outdated facilities; and 10% closed due to inadequate supply of physicians.³⁸ Due to the repeated assertions made by hospital administrators and this survey, administrators' fiscal justifications created the perception that hospital closures were beneficial for society and race-neutral; thus state and federal regulators routinely approved closures and relocations.¹³⁹ However, that is simply not the case: hospital closures increase costs, decrease access to health care, and are significantly linked to race.⁴⁰ The perception that hospital closures reduce excess hospital bed capacity, improve quality care and help save scarce public resources is false. Research shows that the anticipated benefits from hospital closures never materialize because as hospitals decrease the number of beds available in African-American communities, they simultaneously increase the number of hospital beds in predominately Caucasian neighborhoods.⁴¹ Thus, the number of beds stays the same. Additionally, this reduction of beds in minority communities, which generally have the greatest need for care, further compromises African-Americans' health by decreasing their access to health care, and thereby increasing health care costs.⁴² As these hospitals leave predominately African-American neighborhoods, the remaining hospitals are left to fill the void.⁴³ This often strains the remaining hospitals' resources and ability to provide quality care.⁴⁴ Consequently, the hospitals that remain to provide care to African-Americans gradually deteriorate and provide substandard care.⁴⁵ Not only is access to health care diminished because of a reduction of hospital services, but also because of physician departures.⁴⁶ Once a hospital has closed or relocated, the physicians practicing in the area often follow the hospital to more affluent neighborhoods, thereby further disrupting the primary care services in predominately African-American neighborhoods.⁴⁷ Evidence shows that primary care physicians often leave after the closure of a neighborhood hospital because the hospital provides a critical base for the their practice.¹⁴⁸ This disruption in care is significant because many predominately African-American neighborhoods already suffer from physician shortages prior to hospital closures and physician flight.⁴⁹ Moreover, as the number of primary care physicians decreases, African-Americans are forced to seek care in emergency rooms and public hospitals, which are often understaffed and not adequately maintained.¹⁵⁰ Lack of access to health services is not the only harm from hospital closures; patients and minority communities experience humiliation, frustration, and a sense of helplessness.¹⁵¹ The effect of these closures and physician departures on the surrounding community is best illustrated by California's health care crisis in the 1990s. Since 1990, more than seventy hospital emergency rooms and trauma centers have closed in California alone.⁵² As a result, patients have been unable to obtain timely and medically necessary health care. For instance, an emergency room physician in California noted that a woman who had a miscarriage was forced to wait in a hospital waiting room for hours with her fetus in a Tupperware dish before she could be seen, while a boy with serious head trauma went without medically necessary services.¹⁵³ These two patients, and many more, were not able to access medically necessary health care because of a shortage of physicians and overburdened emergency rooms, as a result of private hospital closures.¹⁵⁴ Most predominately Caucasian neighborhoods are full of health care services, while many African-American neighborhoods are left without health care services and often suffer unnecessary disability and deaths as a result of the absence of these services.¹⁵⁵ Moreover, the closures often exacerbate physician shortages and further overburden emergency rooms, leaving African-Americans humiliated, frustrated and feeling helpless. Thus, these hospital

closures appear to re-enforce a racial hierarchy that African-Americans' lives are less valued than Caucasians' lives. Additionally, hospital placement, closures, and removal of services has been linked to race since 1937.¹⁵⁶ In 2006, Alan Sager reported that as the African-American population in a neighborhood increased, the closure and relocation of hospital services increased for every period between 1980 to 2003, except between 1990 and 1997.¹⁵⁷ In the Jim Crow era, these hospital closures were overtly linked to race. Since the passage of Title VI, hospitals have justified closures and relocations based on financial concerns; however, hospital closures and relocations are still significantly correlated with race.¹⁵⁸ Those closing a hospital often fail to consider the importance of equal distribution of health care entities among all communities, and instead leave predominately African-Americans neighborhoods deprived of health care services by relocating services to over-serviced, predominately Caucasian areas.⁵⁹ This institutional decision to close a hospital may seem race neutral; however, research shows that irrespective of financial concerns, hospital closures still remain linked to race and re-enforce a racial hierarchy in health.¹⁶⁰ C. Structural Bias Structural racial bias operates at the societal level, denying some groups access to the resources of society, while privileging other groups.¹⁶¹ While seemingly similar, there is a significant difference between institutional and interpersonal bias on the one hand, and structural bias on the other. Both interpersonal and institutional biases focus on the direct racial effects of individual or institutional actions, whereas structural bias measures how non-race based factors, such as economic inequalities, indirectly affect racial minorities.¹⁶² Structural racial bias is a result of power relationships between racial groups, where one dominant group holds power over the other group and uses that power to secure material and social resources-such as health care.¹⁶³ The dominant group remains in power because its position in society enables it to retain power despite the will or aims of the groups it has power over. Specifically, structural bias allows those with privilege, such as wealthy Caucasians, to obtain the best quality health care available. The privileged obtain access because they are able to afford health insurance or pay for health care not covered by insurance. Those without privilege, such as minorities, who are disproportionately poor, have limited access to health care because they do not have health insurance and cannot afford to pay for it.¹⁶⁴ Adding insult to injury, the wealthy, who predominantly have health insurance, receive discounts on the cost of health care, negotiated by their insurers, while indigent minorities, who do not generally have health insurance, are charged more for the health care services they receive and are increasingly required to pay upfront for the care they receive.¹⁶⁵ Unable to afford the full cost of or pay upfront for health care, minorities often forego treatment until it is too late, resulting in racial disparities in mortality.¹⁶⁶ For example, a 2012 New York Times article noted that affluent patients who pay in cash can stay in elite hospital wings that offer marble baths, butler service, and bed linens by "Frette, Italian purveyors of highthread- count sheets [sold] to popes and princes."¹⁶⁷ Yet, the Article noted that one patient who could not afford the elite rooms was left in pain, on a gurney, without a bed pan.¹⁶⁸ The effect of this structural bias is also evidenced by empirical data of the health status and mortality rates of uninsured minorities.¹⁶⁹ Compared to the privately insured, the uninsured tend to be in worse health.¹⁷⁰ In fact, "[e]leven percent of the uninsured are in fair or poor health, compared to [five percent] of those [covered by private health insurance]."¹⁷¹ Moreover, nineteen years of data show that African-Americans have a higher death-rate from coronary disease, breast cancer, and diabetes than Caucasians.¹⁷² Between 2005 and 2006, "[t]he largest difference in doctor visits between insured and uninsured populations was seen among African- Americans and individuals of two or more races."¹⁷³ This racial difference in physician visits is not new; in 1986, for example, a national survey of the use of health care services found that "[e]ven after taking into account persons' income, health status, age, sex, and

whether they had one or more chronic or serious illnesses, blacks have a statistically significantly lower mean number of annual ambulatory [walk-in] visits and are less likely to have seen a physician in a year."¹⁷⁴ Due to their inability to pay for a doctor or health care in general, many African Americans often forgo care, leading to unnecessary deaths.¹⁷⁵ These are just a few examples of the well-documented racial disparities in access to health care due to structural racial bias, which have resulted in serious harm. The continuation of racial disparities is a complex issue, which cannot be solved by solely addressing institutional, interpersonal, or structural bias. In order to put an end to decades of racial disparities, policy makers must develop a variety of programs to address all three forms of bias in health care. Arguably, the ACA is the first step towards eradicating racial disparities; it provides health insurance to a large majority of the uninsured, who are largely minorities, and provides funding for disparity research. However, there is still much work to be done.

IV. HEALTH CARE REFORM: INSURANCE FOR EVERYONE

In the United States, some 49.1 million people do not have health insurance.¹⁷⁶ Naturally, there are severe health consequences for adults without health insurance.¹⁷⁷ In fact, studies show that "uninsured women with breast cancer . . . have their disease diagnosed later during its development, when treatment is less effective."¹⁷⁸ Furthermore, "[u]ninsured men with hypertension are more likely to go without screenings and prescribed medication and to skip recommended doctor visits, increasing the likelihood of serious harm."¹⁷⁹ Thus, there was, and clearly remains, a need for the ACA, which increases access to health insurance through an individual mandate, state health insurance exchanges, expansion of Medicaid, and employer requirements for certain levels of employee health insurance coverage.¹⁸⁰ Although the ACA addresses some issues related to structural bias by improving minorities' access to insurance, it does not address institutional and interpersonal bias, and this oversight may actually exacerbate the preexisting racial disparities in health care.

Section IV.A briefly discusses the need for the ACA. Next, Section 1V.B summarizes sections of the Act that increase access to insurance, address racial disparities, and prohibits discrimination. Finally, Section 1V.C discusses the strengths, while Section IV.D discusses the weaknesses of the Act.

A. The Need

Unfortunately, those most affected by a lack of insurance are racial minorities, who are disproportionately uninsured. "[O]f the 45.7 million non elderly Americans who were uninsured in 2008, more than half (55%) [were minorities]."¹⁸¹ Specifically, thirty-two percent of Latinos are uninsured, twenty-eight percent of Native Americans are uninsured, and twenty-one percent of African-Americans are uninsured, compared to thirteen percent of Caucasians.¹⁸² Additionally, public health care programs like Medicaid disproportionately serve minorities.¹⁸³ "African Americans and [Latinos] are more likely than [Caucasians] to work in lowwage jobs, and tend to have reduced access to employer-sponsored coverage relative to their higher-wage counterparts."¹⁸⁴ Consequently, low-income minority workers are more likely than Caucasians to be uninsured or covered by Medicaid.¹⁸⁵ As a result of their lack of employersponsored health care insurance and poverty, these minority families are disproportionately unable to afford to pay for health care. Thus, compared to the insured, a larger share of the uninsured are unable to pay their medical bills.¹⁸⁶ Data from the Institute of Medicine's 2002 report ("1OM Report"), Caring Without Coverage: Too Little, Too Late, showed that the uninsured received a fraction of the health services and access to health care that privately insured patients regularly received, and that the uninsured tended to wait longer and became sicker before seeing a doctor.¹⁸⁷ Moreover, the data indicated that "the uninsured [were] less likely to receive recommended preventive and primary care services, face[d] significant barriers to care, and ultimately face[d] worse health outcomes."¹⁸⁸ In addition, the uninsured report problems procuring dental care, filling a prescription due to cost, and accessing physician care.¹⁸⁹ The empirical data show that a lack of

insurance leads to the under-treatment of those that are unable to pay, such as the uninsured, which results in unnecessary deaths. The uninsured are 1.8 times more likely to die from their injuries from auto accidents, and are 2.6 times more likely to die from gunshot wounds, as compared to privately insured patients. 90 Dietrich Jehle, the first author of the study, explains that "uninsured adult patients in general have a 25% greater mortality rate than insured adults for all medical conditions."⁹¹ In addition, several previous research studies reached similar conclusions. That is, "the uninsured have a higher death rate from trauma injuries due to treatment delays, different care due to receipt of fewer diagnostic tests, and decreased health literacy."⁹² The data remain similar regardless of insurance status.¹⁹³ However, "the highest adjusted odds of death were for uninsured Hispanic patients.., followed by uninsured African American patients ... when compared with insured white patients, suggesting that insurance status has a stronger association with mortality after trauma.,¹⁹⁴ Thus, the lack of access to health insurance is a significant factor in African-American's access to health care, which may be addressed by the ACA.¹⁹⁵ B. The ACA The central focus of the ACA is to regulate the health insurance industry and increase access to health insurance for the uninsured.¹⁹⁶ Specifically, Title I of the Act contains an individual mandate for insurance and individual subsidies to purchase insurance, while Title II of the Act provides an expansion of Medicaid. By providing insurance coverage to the uninsured through the individual mandate, Medicaid expansion, and subsidies, the Act has the potential to increase access to health care for minorities by providing them access to health insurance. The Act also provides protections for the uninsured. For example, Section 9007 limits a charitable hospital's ability to charge uninsured patients more than the amount generally billed to insured patients for emergency and other medically necessary care.¹⁹⁷ Additionally, the Act not only provides measures for assessing health disparities in accessing health care and the provision of quality health care, but it also briefly mentions the nondiscrimination requirements of Title VI. In fact, throughout the ACA, research, data collection, and quality improvement measures are funded in order to better understand and put an end to health disparities.¹⁹⁸ Even though the Act does include language about health disparities in several sections, these disparities are broadly discussed and not always linked to race.¹⁹⁹ Section 6301 creates a Patient-Centered Research Institute that is required to identify a research agenda, which includes addressing health disparities.²⁰⁰ Sections 10302 and 10303 of the ACA mandate that the Secretary of HHS develop a national strategy to improve the quality of health to reduce health disparities.²⁰¹ Section 10303 further provides for the creation of quality development measures that allow the assessment of health disparities.²⁰² Medicare providers will also receive additional payment bonuses for rectifying health disparities by increasing staffing in long-term care facilities.²⁰³ Data collection concerning health disparities is discussed in Subtitle D of Title IV, entitled "Support for Prevention and Public Health Innovation."²⁰⁴ This Subtitle notes that racial disparities exist in access to health care. Section 4302 of this Subtitle amends the Public Health Service Act and strengthens federal data collection by requiring the Secretary of HHS to collect data to track health disparities under Medicaid and Medicare.²⁰⁵ Additionally, this Subtitle requires the Secretary of HHS to evaluate approaches to collect data concerning health disparities "that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status."²⁰⁶ The Secretary of HHS is required to analyze the data to detect and monitor trends in health disparities and report it to, among others, the Office of Minority Health ("OMH"), the National Center on Minority Health and Health Disparities, the Agency for Healthcare Research and Quality ("AHRQ"), the Centers for Disease Control and Prevention ("CDC"), the Centers for Medicare & Medicaid Services ("CMS"), the Indian Health

Service and epidemiology centers funded under the Indian Health Care Improvement Act, the Office of Rural health, and other agencies within HHS. Section 3501 creates quality improvement programs that provide technical assistance grants to health care providers to address health disparities.² ⁷ The Act also suggests putting an end to disparities through the use of preventative care, health education programs, language services, community outreach, and cultural competency trainings.² ⁸ To this end, Section 10503 of Act expanded access to primary health care by investing eleven billion dollars into the Health Research Services Administrations Community Health Center Program.²⁰ ⁹ Sections 4003, 4004 and 4201 provide for community-based solutions.²¹⁰ Section 4003 creates an independent Preventive Services Task Force, convened by the Director of CDC, which is required to develop community-based recommendations and interventions to address health disparities. The Secretary of HHS is also required under Section 4004 to plan and implement "a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness" and "describe[] the importance of utilizing preventive services to promote wellness, [and] reduce health disparities,"²¹¹ To promote healthy living and reduce disparities, Section 4201 provides prevention and community transformation grants for the implementation, evaluation, and dissemination of evidence-based community preventative health activities that address health disparities.²¹² Furthermore, the Act reorganizes OMH, making OMH a part of the Office of the Secretary, increasing the authority and stature of the office.² ¹³ It further creates offices of Minority Health in the CDC, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, AHCQ, the Food and Drug Administration, and CMS. A Director, who has "documented experience and expertise in minority health services research and health disparities elimination," heads each office.²¹⁴ Finally, the Act creates the National Institute on Minority Health and Health Disparities, an institute under the National Institutes of Health. However, the Act does not provide practical guidance on how these offices should address racial disparities, other than through health promotion programs and improving "language services, community outreach, and cultural competency training" mentioned above.²¹⁵ Thus, in respect to racial disparities, the central focus of the Act is increasing insurance coverage, data collection, promoting preventative care, and funding research to determine the cause of existing health disparities in access. In addition to implementing measures and creating new agencies to fix racial disparities, Section 1557 notes that the requirements of nondiscrimination apply to the ACA.² ¹⁶ Specifically, the Act states that civil rights laws, such as Title VI, which govern health care apply to the Act and remain unchanged, keeping the status quo. There are several strengths of the Act, such as the standardization of reporting racial data. However, the Act also has several flaws, such the separation of civil rights endeavors and racial disparities research.

C. Strengths: The First Step in Eradicating Racial Disparities

Government reports and industry insiders believe that the Act not only "represents the most significant federal effort to reduce disparities in the country's history,"^{2t} ⁷ but also "has the potential to do enormous good for the health needs of racial and ethnic minorities and more potential to reduce racial and ethnic health disparities than any other law in living memory."²¹⁸ Indeed, the Act provides several benefits. First, it equalizes the cost of health care for the uninsured receiving health care in charitable hospitals. In the past, the insured received discounts on the cost of health care, negotiated by their insurers, while indigent minorities, who did not have health insurance, were charged more for the health care services they received and were increasingly required to pay upfront for the care they received.² ⁹ The Act begins to address this problem by limiting a charitable hospital's ability to charge uninsured patients more than the amount generally billed to insured patients for emergency and other medically necessary care.²²⁰ Second, the Act empowers communities through funding to improve the

quality of health care. This is a laudable act because it empowers communities and gives them a voice in improving the conditions within their community. Third, it increases the stature of OMH and creates new offices of minority health. Prior to the Act, OMH was merely an office in the Office of Public Health Science, now it is an office within the Office of the Secretary, one of the central decision-making agencies in HHS. Fourth, it standardizes data collection of racial data and makes it a significant priority. Interestingly, HHS went to court in the 1990s fighting requests to collect racial data to fulfill its civil rights mandate.²²¹ With the passage of the Act, HHS not only is required to collect data, but is also required to standardize the data collection and disseminate data to the agencies within HHS. Finally, the Act increases health insurance coverage for minorities, addressing some of the issues of structural racial bias. People of color comprise one-third of the U.S. population, but they constitute more than half of the uninsured population.²²² As a result of their lack of employer-sponsored health care insurance, minorities are less able to access health care.²²³ In fact, according to an Urban Institute report, it is projected that the Act, through the individual mandate, expansion of Medicaid coverage, and subsidies to purchase insurance, will reduce the number of nonelderly uninsured individuals by nearly half.²²⁴ Moreover, in 2009, the Medicaid program provided services to "an average of 50 million people," which the Act could potentially expand by sixteen million by 2019.²²⁵ By reducing the number of uninsured, the government will reduce the amount it spends on uncompensated care by half.²²⁶ However, access to health insurance is not the only structural barrier to care for minorities, so too is their inability to pay for insurance because of poverty. Additionally, the significance of institutional and interpersonal bias in causing racial disparities in health is ignored in the ACA, even though these causes are listed in a plethora of empirical research studies and government reports and initiatives.²²⁷

D. Weakness:

Discounting the Problem of Racial Bias Although the Act provides many potential benefits to minorities who are uninsured, the Act has several noteworthy flaws. Most significantly, the Act ignores the significance of institutional and interpersonal racial biases in causing racial disparities and fails to discuss how Title VI, which prohibits racial bias, applies to programs that address racial disparities. If these shortcomings are not fixed, racial disparities in health care and poor health care outcomes for minorities will persist, if not get worse.

1. Ignoring Racial Bias The Act focuses mainly on individual solutions, which, unfortunately, will never fully eradicate racial disparities because there are systemic problems with the U.S. health care system beyond access to insurance that must be fixed. The structure of the U.S. health system is based on ability to pay, not need. Health care entities make decisions on placement of facilities based on profit, while providers make treatment decisions based on worthiness that is linked to racial bias. These issues will not be addressed through research, preventative measures, or community grants. Moreover, mere access to insurance will not necessarily equalize access to health care for African-Americans, as illustrated by the "Douglas Cases," the recent case argued before the U.S. Supreme Court challenging cuts in California's Medicaid reimbursement rates resulting in a threat to Medicaid beneficiaries' equal access to health care.²²⁸ The case brought by California pharmacists, hospitals, and Medicaid beneficiaries argues that state cuts to Medicaid reimbursement rates are so severe that providers will stop treating Medicaid patients, and thus significantly threaten Medicaid beneficiaries' access to care.²²⁹ Minorities' access to insurance may further be limited by ability to pay. Minorities disproportionately live in poverty. In 2007, the U.S. Census Bureau reported that 24.5% of African-Americans and 21.5% of Hispanics were living at the poverty level, compared to 8.2% of Caucasians.²³⁰ "In 2008, over half of Hispanics, African Americans, and American Indians and Alaska Natives were poor or near poor compared with 27% of [Caucasians] and 31% of Asians"²³¹ Thus, increasing access to insurance may not solve the problem because minorities still may not be able to afford health insurance

or pay for uninsured care, which is significant in a system that bases access on ability to pay rather than need. Even though the Act does try to equalize the cost the uninsured pay when visiting charitable hospitals, this policy does not apply to all hospitals or address the requirement of the uninsured having to pay up front. Thus, the Act does not fully rectify structural racial bias. Furthermore, the Act does not address interpersonal and institutional racial bias. As discussed in Section III.A, empirical research suggests that interpersonal racial bias inside and outside the health care system results in racial disparities in medical treatment, which compromise African- Americans' health status.²³² According to the IOM study, racial bias is widespread in health care and "begins at the point of entry and continues throughout the secondary and tertiary pathways of the system."²³³ If health care professionals continue to harbor implicit and explicit interpersonal bias against minority patients, which prevents them from providing quality health care to these patients, simply increasing minority patients access to health insurance and, thus access to health care services, is not going to improve overall care for minority patients. Moreover, increasing access to insurance and preventative services means very little when patients do not have a health care facility located in their neighborhood-a result of institutional bias. Focusing on solutions, such as health education programs to decrease infant mortality by eating right and seeking medical care, is not going to mitigate the detrimental effect of the stress caused by perceived racial bias, the loss of hospitals available in the area, or income inequalities that limit minorities access to health care.²³⁴ Consequently, the ACA's failure to discuss and recognize that institutional and interpersonal racial biases are the root causes of racial disparities allows for the perpetuation of racial disparities in health care, and the persistence of poor health care outcomes for minorities.

2. Keeping the Status Quo Perhaps balancing the potential losses against the potential gains, the only statement made that specifically addresses civil rights in the Act says that the current civil rights laws apply with no changes, keeping the status quo. Unfortunately, not only is the status quo not preventing interpersonal racial bias, but it also is ineffective in addressing structural and institutional racial bias. First and foremost, physicians are not covered under Title VI. Second, OCR does not collect racial data. In 1994, HHS decreed that it would not collect racial and ethnic data regarding services provided by health care entities receiving federal funding.²³⁵ In 1996, patients sued the Secretary of HHS for failing to enforce section 602 of Title VI.²³⁶ Specifically, the patients challenged the Secretary's failure to collect racial data and information needed to prove the continuation of racial bias in health care.²³⁷ The Court of Appeals for the Sixth Circuit ruled that this duty was discretionary, because HHS's only duty under Section 602 of Title VI was to obtain Title VI compliance reports from health care entities with as much information as necessary.²³⁸ According to the court, the extent to which HHS monitored and enforced Title VI was under HHS's own discretion.²³⁹ Therefore, although the language of Title VI says that the federal government must enforce Title VI, it does not say how.²⁴⁰ The court noted that the "how" is in the discretion of the Secretary; thus, as long as the government is investigating complaints and seeking voluntary compliance, it is enforcing Title VI.²⁴¹ Because OCR does not review any racial data of residents from the states²⁴² or collect any report on services provided, there is no opportunity to evaluate whether racial groups are treated disparately.²⁴³ Even though, presumably, the ACA rectifies this problem because it mandates that the Secretary collect, standardize, and disseminate health disparities data to assorted agencies in HHS, OCR is not listed among the agencies in the Act that will receive health disparities data. In the past, data regarding racial disparities in health care has not been shared with OCR and nothing in the ACA changes this policy.²⁴⁴ Thus, it is questionable whether OCR will ever obtain the data. Finally, although the language of Title VI clearly prohibits racial bias in health care by those receiving federal funding, the remedial scheme is

ineffectual. As evidenced by reports from the House of Representatives and the U.S. Commission on Civil Rights ("USCCR"), racial bias continues almost unfettered, as it did before the passage of Title VI.²⁴⁵ Hence, OCR has not fulfilled this mandate of Title VI.²⁴⁶ As mandated by law, the USCCR reviewed the progress of HHS's Title VI enforcement in 1974, 1996, and 1999.²⁴⁷ Each time the USCCR found that HHS was not fulfilling the mandates of Title VI.²⁴⁸ In fact, USCCR noted that there was ample evidence that HHS had consistently and systematically failed to enforce Title VI to prohibit racial bias in health care because of lax enforcement.²⁴⁹ Specifically, critics have noted that HHS "permitted formal assurances of compliance to substitute for verified changes in behavior, failed to collect comprehensive data or conduct affirmative compliance reviews, relied too heavily on complaints by victims of discrimination, inadequately investigated matters brought to the Department, and failed to sanction recipients for demonstrated violations."²⁵⁰ As early as 1987, the U.S. House of Representatives Committee on Government Operations determined "that OCR unnecessarily delayed case processing, allowed discrimination to continue without federal intervention, routinely conducted superficial and inadequate investigations, failed to advise regional offices on policy and procedure for resolving cases, and abdicated its responsibility to ensure that HHS policies are consistent with civil rights law, among other things."²⁵¹ The same committee "criticized OCR's reluctance to sanction noncompliant recipients and recommended that OCR pursue investigations of complaints as well as compliance reviews in more systematic ways."²⁵² Since this report, not much has changed. In its 2002 report, the USCCR noted that OCR's civil rights system was rudimentary.³ Although the USCCR found that HHS had established civil rights enforcement programs, the USCCR concluded that these programs were unsatisfactory.²⁵⁴ The USCCR "found [OCR's] efforts to develop policy and conduct civil rights enforcement activities to be halfhearted."²⁵⁵ Although Title VI provided the legal framework to eliminate racial bias in health care, the USCCR stated without equivocation that "HHS lacks a vigorous civil rights enforcement program, and the activities of OCR appear to have little impact on the agency as a whole."²⁵⁶ The federal government's failure to enforce Title VI, which prohibits government-funded racial bias, has led to the perpetuation of racially discriminatory practices in the health care system. The USCCR has stated that "[i]f OCR continues to focus its enforcement on the more tangible civil rights violations, without delving into the reasons they exist in the first place, it will fail to recognize and eliminate the true sources of inequity."²⁵⁷ Consistent with this perspective, the USCCR recommended a reorganization of the entire civil rights structure to prohibit racial bias in health care. Specifically, the USCCR suggested that "OCR ... conduct broad-based, systemic compliance reviews on a rotating basis in all federally funded health care facilities, at least every [three] years."²⁵⁸ Although USCCR's report was released ten years ago, none of its recommendations have been implemented and the ACA did noting to change the status quo. Thus, the civil rights enforcement system remains completely ineffective at putting an end to government prohibited racial bias in health care. Consequently, race continues to matter in health care even after the passage of the ACA. To fix the shortcomings of the Act, this Article suggests several regulatory solutions because the time seemingly has passed for statutory solutions.

V. RECOMMENDATIONS

Race matters because physicians continue to exhibit conscious and unconscious racial prejudice that affects physician's treatment decisions (interpersonal), health care entities closures and relocations remain linked to race and re-enforce racial hierarchy (institutional), and the health care system is based on ability to pay not need (structural). In order to put an end to racial disparities in access to health care and health status all three forms of racial bias need to be addressed. Additionally, changes need to be made to the regulatory structure of civil rights enforcement. These recommendations have the potential to improve the entire health care delivery system.

A. Addressing Racial Bias Recognizing and

acknowledging the significance of racial bias in causing racial disparities in accessing health care and health status is the first step in addressing interpersonal racial bias. Second, physicians need to be educated about their subtle, often unconscious, racial prejudice, which affects their medical treatment decisions. Medical professionals should be educated about the three levels of racial bias and how they impact the treatment of patients. Physicians also need to be educated about how experiencing racial bias affects their patients' interaction with the medical system and their health outcomes. In fact, research suggests that making physicians aware of how their unconscious racial prejudice can influence outcomes of medical encounters and sensitizing them to their own unconscious bias can help motivate them to correct their bias.²⁵⁹

Race-conscious CHNAs activate hospitals' capacity to remedy social contributors to health outcomes

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INTRODUCTION While some may assert we live in a post-racial era, a body of scholarship corroborates the presence of structural racism in contemporary settings.^{1e5} Most recently, a series of events have elevated social consciousness about the Black experience in America.⁶ Consequently, the Black Lives Matter movement gained momentum in 2012, serving as a "call to action and a response to the virulent anti-Black racism that permeates our society.⁷" The mission specifically focuses on addressing "ongoing and widespread devaluation of Black Lives and the social, political, and economical structures that result in unequal opportunity.⁷" Such forms of injustice have a profound effect on communities of color and are manifested through inequities in common correlates of health, including access to quality education, healthy foods, livable wages, and affordable housing. Moreover, a substantial body of evidence highlights the relationship between race, racism and health status.^{8e12} Blacks are disproportionately burdened by poorer access and lower quality of care even when controlling for factors, such as income, education, and insurance.^{8,13} They also represent higher rates of morbidity and premature mortality when compared with white counterparts. Some of the starker differences can be found in hypertension, diabetes, and asthma rates, resulting in higher frequencies of treatment for comorbidities and ambulatory care sensitive conditions.^{14e19} Such racial disparities have a significant financial impact and are estimated to cost \$35 billion in excess health care expenditures and \$10 billion in illness-related lost productivity.²⁰ In response to these disparities, many health care institutions have demographically stratified and analyzed health outcome data and incorporated best practices to create interventions to reduce or eliminate disparities in care. However, due to broader structural contexts, significant disparities persist. We assert that these trends will remain intractable until structural racism and its effects (bias, discrimination) are recognized as root causes of poor health. This approach is especially relevant as health reform is incentivizing health care leaders to find new and more creative ways to promote wellness, reduce readmissions, and manage the health of populations. By applying a racial equity lens in how they are governed and operated, hospitals, as anchor institutions, can advance their population health goals.²¹ Using health reform as a springboard, we articulate why this approach is important and close with a conceptual framework to stimulate thought and organizational practices that (1) promote racial equity within health care settings; and (2) contribute to the advancement of historically marginalized communities of color. **HEALTH EQUITY AND BLACK LIVES** In light of the magnitude and long-term psychological impact of racism, coupled with a history of implicit and explicit

injustices imposed on those of African descent, two definitions in the literature inform our interpretation of health equity within the context of Black Lives. In 2003, Braveman and Gruskin defined health equity as a goal of eliminating systemic disparities in health or in the major social determinants of health (i.e., education, housing, employment) between social groups who have different levels of underlying social advantage and disadvantage – that is, different positions in the social hierarchy.²² Camara Jones construes health equity as the assurance of the conditions for optimal health for all people, which requires valuing all individuals and populations equally, rectifying historical injustices, and addressing contemporary injustices by providing resources according to need.²³ Consequently, we assert that it is important for health care leaders to recognize institutionalized injustices in their own communities and carefully examine how they impact the health of the populations they serve. Note: The focus of this commentary is on Black Lives; we also use “minorities” and “communities of color” interchangeably based on contextual language.

INSTITUTIONALIZED RACISM AND ITS EFFECTS In order to be effective in improving health through a racial equity lens, it is important to recognize how the health care institution is a subset of a larger ecosystem with vestiges of institutionalized racism, stemming as far back as the 1600s.⁹ The legacy continues to influence how low income communities of color are structured and resourced.^{23,24} Institutionalized racism is defined as “the structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by race. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator.²³” Despite the passage of prominent legislation that makes explicit forms of racism illegal, remnants of historically grounded policies and practices that perpetuate poor health in contemporary settings are evidenced through racial segregation and unequal distribution of resources.^{24,25} The consequences of these injustices are multifactorial and detrimental to the well-being of society, but for the purposes of this commentary, we focus on the relationship between institutionalized racism and health. More specifically, a growing body of evidence suggests racism as a social determinant of health.^{24,26} For example, chronic exposure to discrimination creates a physiological or hormonal response (survival stress) that may stimulate or exacerbate chronic disease conditions making it challenging to improve individual health.^{24,26e28} This recognition is especially important to providers as a newly insured cadre of persons enter systems of care many of whom have low income e encountering day-to-day psychosocial barriers that emanate from discriminatory policies and practices. Within a historical context of medical care, persons of color have had a profoundly unique experience. Countless numbers of Blacks were medically exploited and subjected to inhumane and traumatic experiences. While the Tuskegee experiment is widely referenced in the literature, it is an isolated depiction of a more systemic, robust and pervasive agenda to advance medicine at the expense of Black Lives.²⁹ The legacy and trauma associated with the atrocities have deeply affected Black Americans’ perceptions about the health care system and how they consciously or subconsciously interact with providers.^{8,30} For example, scholars have found Blacks more likely than Whites to distrust the health care system and more likely to prefer racially concordant providers.^{30e35} Such distrust, coupled with underrepresented people of color in medicine,³⁶ impede patient engagement and may be culpable for late stage diagnoses and/or exacerbation of chronic disease conditions in persons of color.³⁰ In addition to distrust at the patient-level, providers are susceptible to decision-making based on implicit biases e attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.^{8,12,37e39} Documented occurrences of racially driven decisionmaking in clinical settings have not been characterized as intentional but partially attributed to subconscious perceptions that emanate from exposure to high frequencies of negative portrayals of Black Lives at a societal

level.^{40e42} Consequently, actions that stem from biases compromise quality of care through error, miscommunication, no referral or inappropriate referral to specialty care or medical procedures, and misdiagnosis of medical conditions.^{10,12,43,44} POPULATION HEALTH The gravity of these dynamics must be recognized within the context of population health e a term that has progressively increased in the literature since 2010.⁴⁵ While the interpretation and its utility tend to vary depending on discipline or profession, health care institutions are likely to perceive population health as clinically managing the patients under the auspices of their care. However, health outcomes for these patients are heavily influenced by structural conditions and the quality of assets that are available across the life span.

Therefore, we advocate for a more comprehensive interpretation. In 2003, Kindig and Stoddart defined the term as “the health outcomes of a group of individuals, including distribution of such outcomes within the group.”⁴⁶ They posit, “the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link the two.”⁴⁶ Young describes population health as a “framework for thinking about why some populations are healthier than others” including policy, research, and resource allocation.⁴⁷ By normalizing these interpretations through a racial equity lens, health care organizations have the potential to advance population health goals by improving the patient experience as well as the social conditions in which they live.

CONCEPTUAL FRAMEWORK
Hospitals are components of a larger ecosystem; they cannot take sole responsibility for addressing complex and intersectional inequities that perpetuate poor health in communities of color. However, as health care providers, they can be instrumental in eliminating racial disparities within clinical settings, and as anchor institutions, they can be socially impactful e using their business models to create opportunity and stimulate investments in historically marginalized communities. To incite a more strategic approach to population health improvement within the context of Black Lives, we offer a conceptual framework based on a bifurcated approach (Figure 1). Internal strategies focus on operational practices, including how clinical systems and services are organized and structured. External strategies focus on the community at-large, including how the health care institution, as an “anchor institution” supports or invests in upstream factors, resulting in equitable access to opportunity. While institutional capacity and community dynamics vary, we provide examples of strategies for both constructs, as well as their associated outcomes, and how the efforts stimulate systemic change.

Internal strategies Since racial differences within clinical settings are substantiated in quantitative and qualitative research designs, we define internal process activities as practices and guidelines within the health care institution that promote consistency in the patient experience, regardless of race, as well as allocation of support resources according to need. To achieve this objective, the relationship between race, racism, and health⁴⁸ must first be understood, internalized and normalized by the organization’s governing board and employee population. Furthermore, a carefully structured approach is necessary to help the groups identify their own biases and how those biases translate into unconscious decision-making within governance and practice contexts. The Implicit Association Test (IAT) is a validated instrument that can provide structure around this approach. Developed in 1998, the IAT allows participants to assess bias or preference for specific demographic identities (race, gender, religion, etc.).⁴⁹ Since its development, it has been used in various settings to raise individual and collective awareness around unconscious bias and its impact on communities of color. Through a carefully guided process, the IAT opens the door for safe and constructive dialogue that can heighten institutional awareness e helping board and staff cognitively intercept biased defaults. The benefits are numerous and can inform core business areas, such as board recruitment processes and general hiring practices, marketing and planning approaches, as well as quality, safety and patient experience metrics. Some

health systems are nationally recognized for governance and operational activities aimed at improving the patient experience, eliminating treatment disparities by race, and promoting economic advancement in communities of color. For example, Main Line Health is known for its approach to achieving board and staff diversity and the integration of social factors in clinical care.⁵⁰ Through its Health Disparities Solution Center, Massachusetts General Hospital aims to eliminate racial disparities in care through a series of workforce development and quality improvement initiatives.⁵¹ Georgetown University Medical Center's Kid Mobile Clinic provides comprehensive pediatric care and spearheads advocacy initiatives to promote health in historically underserved Black communities in the District of Columbia. Henry Ford Health system's "best in class" supplier diversity initiative has yielded more than 300 active minority and women-owned businesses in its supply chain management database.⁵² External strategies In the wake of health reform, the changing landscape is positioning hospitals with new opportunities to demonstrate their tax-exempt worthiness through community health improvement and community building activities.⁵³ The shift in resources presents a profound opportunity to identify racial inequities and invest in neighborhoods that have borne the brunt of decades of failed social policies and practices with racism at their core. Determining key health issues and the dynamics that contribute to those issues is the first step and the mandated triennial Community Health Needs Assessment (CHNA) for not-for-profit hospitals can be instrumental in facilitating the process. By conducting a race-conscious CHNA, hospitals will achieve better insight on how institutionalized racism impacts health outcomes in the communities they serve. Race conscious strategies may include designing quantitative and qualitative data collection measures aimed at assessing if or to what extent persons of color perceive or experience racism. Examining the history of the community or policies that have or continue to perpetuate differences in the distribution of resources will also be strategic. The process can also include assessment of community assets (institutional or organizational) for strategic partnerships since health care organizations are not likely to have the expertise nor the resources to assume a lead role within the racial equity space. Other CHNA strategies may include assessing the hospital's own data and honing in on morbidity and mortality racial disparities at the neighborhood level. Findings offer clues for more targeted interventions and how resources can be more equitably distributed. Based on CHNA findings, hospitals must identify health priorities and work in partnership with the community to develop an implementation plan that addresses the issue. Some health systems have made considerable progress in shifting their approach to community benefit through bold, unconventional tactics. Bon Secours Health System and its partners have invested in dilapidated row homes and converted them into 119 affordable apartments in West Baltimore.⁵⁴ University Hospitals, Cleveland Clinic and its partners have pooled resources to finance a wealth building initiative e the Evergreen Cooperatives, a network of employee-owned businesses that hire from systematically underserved neighborhoods.²¹ St. Joseph's Health System supports activities to build capacity at the grassroots level through community organizing, leadership development, and coalition building.²¹ MedStar Health and Seattle Children's Hospitals work with youth in communities of color e providing mentoring, job shadowing, and internships to promote healthy development and cultivate a pipeline to increase the number of underrepresented persons of color in health care.^{55,56} Goal Population health incentives are challenging health care institutions to value prevention and be more accountable to their communities. Moreover, it is clear that institutional racism and its effects (within the health care institution and beyond the health care institution) continue to have a negative impact on health outcomes of Black Americans and other persons of color. Therefore, we argue that a health care system's population health goals can be optimized by 1) employing internal strategies to improve the patient experience and

reduce or eliminate racial disparities within health care settings; and 2) employing external strategies to improve the social, political, economical, and environmental conditions of communities of color. For accountability purposes, a racial equity dashboard based on internal and external process measures can be helpful in documenting and tracking the breadth of the institution's capacity to effect change. Collectively, these strategies will support systemic change that is critical for improving the quality of health care and advancing local and national population health goals.

Auditing provider relocations prevents geographic barriers to access.

Ruqaiijay Yearby 12. Professor of Law, Case Western Reserve University, School of Law. 04/2012.
"Breaking the Cycle of Unequal Treatment with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias." Conn. L. Rev., vol. 44, p. 1281.

Finally, African-American patients need to be educated about the severe health consequences of failing to cope with the stress of perceived racial bias and provided with coping strategies. In order to put an end to institutional racial bias, both state and federal regulators must review institutional plans to close or relocate quality health care facilities only in predominately Caucasian neighborhoods for the disproportionate harm such plans have on African-American communities. This review will force hospitals and nursing homes to balance the benefits of closing, relocating, and over-concentrating quality facilities in predominately Caucasian neighborhoods against the detrimental effects on African-American communities that will result because of the disruptions of care. By instituting this review, the racial link will become clearer, and owners will have to consciously mitigate the harmful effects of closing, relocating, and over-concentrating quality facilities in predominately Caucasian neighborhoods. To improve the allocation of scarce health care resources for everyone, the underlying problem of access to basic health care services must be addressed. Health care must be delivered based on need, not ability to pay. The ACA has the potential to address these structural biases and provide access to insurance for African-Americans; however, it does not alleviates some of the problems with the allocation of health care based on ability to pay, not need. B. Addressing Regulatory Shortfalls To address civil rights failures the government must enforce Title VI against all health care providers, require health disparities impact statements prior to hospital closures and relocations, and integrate racial disparities research and programming with civil rights measures. These measures can be accomplished through the regulations implementing sections 10302, 10303, 1303, 1557, 1946, and 4302, which deal with programs to improve chronic disease and decrease racial disparities. First, health care professionals need to be targeted for civil rights violations. Data show that these providers continue to use race to determine treatment decisions, which may be a violation of Title VI. 260 This problem can be changed by including physicians in the definition of health care entities or by defining their payments as federal financial assistance. In fact, under the ACA, physicians and all health care professionals are defined as health care entities as it relates to assisted suicide.261 Thus, Title VI regulations can define physicians as a health care entity or the regulations can simply re-classify payments to physicians as federal financial assistance. Second, the regulations implementing the Act need to specifically spell out the requirements of civil rights enforcement, such as putting an end to institutional and structural racial bias. Thus, the regulations and/or governing policies need to include a discussion of what constitutes institutional and structural racial bias. For example, it should be noted that decisions by health care corporations to close facilities in minority neighborhoods may be an example of institutional racial bias. OCR should also require entities to submit health disparities impact statements. Health disparities impact statements should provide reports about whether the closure or

relocation would disproportionately harm African-Americans. If the closure would disproportionately harm a minority community, the hospital should be required to provide services that will limit the disparate impact by providing transportation to the new facility, coordinating care with the remaining facilities, or improving the provision of care. There is hope that OCR is already implementing this suggestion based on the recent case against the University of Pittsburgh Medical Center ("UPMC").²⁶² Recently UPMC entered into the voluntary agreement with OCR in an effort to resolve a complaint alleging that it violated provisions of Title VI when UPMC decided to close Braddock Hospital in January 2009. The hospital was located in a predominately African-American area and the hospital relocated to a predominately Caucasian neighborhood. Among other things, the agreement requires UPMC to provide door-to-door transportation services from Braddock and surrounding communities to its new outpatient facilities in Forest Hills, Pennsylvania, as well as to UPMC McKeesport Hospital. UPMC will also designate a patient ombudsperson to assist residents with obtaining health care and receive and address residents' complaints about access to health care. The agreement remains in effect for three years, and requires UPMC to make quarterly reports to OCR regarding compliance. The case is one of the first cases in which OCR not only required a hospital to consider the impact on communities of color before closing, but also mandated that the hospital take steps consistent with their Title VI obligations, to ameliorate the disparate impact on minorities. Yet, this is just one case. In order to institutionalize this win, OCR must formalize the requirement of health disparity impact statements. Finally, the regulations governing racial disparities must be linked to civil rights enforcement. This goal can be accomplished by requiring that racial disparities data obtained from programs under the ACA be transmitted to OCR. Moreover, there should be collaboration between OCR and those collecting racial disparities data under the Act in setting priorities in funding programs and drafting regulations to put an end to racial bias. Furthermore, civil rights enforcement must be integrated into every facet of regulation of health care facilities. Civil rights enforcement should be integrated with quality regulation enforcement through shared resources, personnel, and remedies. For example, when the government visits a nursing home to determine whether the nursing home is providing quality care to all of its residents, the government should also review whether there are racial disparities in access to health and health status. If there are disparities in care, and the government determines that the disparities are due to racial bias, the government should increase the remedies imposed for providing poor quality.²⁶³ As Sara Rosenbaum and Joel Teitelbaum note, "it no longer makes sense to divide the world of enforcement [from the world of civil rights] when the overall goal is the systemic improvement of program performance.²⁶⁴ By integrating these systems, the government "would make clear that a particular practice is desirable not only because it improves the racial equality of programs but also because it improves the quality of health care for persons who are the intended beneficiaries of the programs.,²⁶⁵

Legal change spills over by flipping the social inertia that normalizes unconscious discrimination in healthcare

Jamaal Abdul-Alim 16, staff writer @ Diverse Education, citing University of Colorado law professor Dayna Matthew, 3-18-2016, "Professor Says Only Law Can Cure Bias, Racism in Health Care," Diverse, <http://diverseeducation.com/article/82621/>

When it comes to eliminating the racial disparities that plague America's health care system and cause Blacks to "live sicker and die quicker" than Whites, University of Colorado law professor Dayna Matthew believes the cure is to be found in the law. "Law changes social norms and the social norm needs to be changed in this country," Matthew said during a lecture at Politics & Prose, a downtown bookstore

where she discussed her recently released book, "Just Medicine: A Cure for Racial Inequality in American Health Care." "Changing the social norm matters. (In) Brown versus Board of Education, we changed the social norm about explicit prejudice and racism in this country," Matthew said of the landmark decision that ended legal segregation in America's public schools. "We need to change the social norm about implicit, unconscious racism, unintentional racism also." Matthew contends that America's health care system is beset by unconscious bias and implicit racism. To bolster her point, she cited a study by former U.S. Surgeon General David Satcher and others that found that an estimated 84,000 "excess deaths" could be prevented each year in the United States if the Black-White "mortality gap" were eliminated. She also cited "Unequal Treatment"—an Institute of Medicine study that found that racial and ethnic minorities get a lower quality of health care in the U.S.—and other studies that discovered that physicians who were found to have implicit bias tend to prescribe inferior treatment plans to patients of color. To eliminate such disparities, Matthew espouses making changes with respect to the Civil Rights Act of 1964. First, Matthew said, implicit or unconscious bias or unintentional racism should become "actionable" under the act. Second, she said, the US Supreme Court should reverse Alexander v. Sandoval—a 2001 case in which the court decided that, under Title VI of the Act, private individuals can fight intentional discrimination by bringing "disparate treatment" claims but may no longer bring "disparate impact" claims based on unintentional discrimination that have a statistically demonstrated discriminatory effect on minorities, as she writes in her book. "Proving intentional discrimination is nearly impossible when few Americans are careless enough to create an evidentiary record of outright bigotry," Matthew writes in Chapter 1, titled "Bad Law Makes Bad Health." "This is one of the gifts that our dearly departed Justice Scalia left us," Matthew quipped during her talk. "We have to replace the private cause of action that worked so well with respect to explicit racism so that it's available as a cause of action pertaining to implicit racism." Matthew is cognizant of the fact that there will be critics to her approach. "How do we pattern it so that everyone who has a negative thought is not sued in the system that I'm proposing?" Matthew asked on behalf of her skeptics. "We employ a negligence standard in the Title VI regime," she said in answering her own question in legalese. "And the negligence standard simply says, if you as an institution or individual have done what is reasonably shown to address implicit bias, you have a perfect defense to a Title VI cause of action. "This would change the social norm," Matthew said. "It would create a system where the institutions that employ health providers would do what they've done with HIPAA (the Health Insurance Portability and Accountability Act). "HIPAA changed everything with respect to privacy," Matthew said. "Institutions became immediately active and proactive with respect to training, teaching and changing the social norms around privacy." Matthew said she understands that pursuing legal remedies is just part of what it takes to rid America's health care system of racial disparities. "I do not think we're going to litigate or sue ourselves out of implicit bias and its deadly impact on health care," Matthew said. "But I do believe we're going to change the social norm if we do what I've proposed

Public Option Fails

Public option is structurally incapable of reaping economic benefits

Lehrer 9 --- PBS, citing Robert Laszewski --- president of the consulting firm Health Policy and Strategy Associates (Jim Lehrer, 9-2-2009, "The Case Against the Public Insurance Option," PBS NewsHour, http://www.pbs.org/newshour/bb/health-july-dec09-health_09-02/, accessed 8-21-2017)

JEFFREY BROWN: And that view comes from Robert Laszewski. He's a former insurance executive, now president of the consulting firm Health Policy and Strategy Associates. Welcome to you. ROBERT LASZEWSKI: Thank you. JEFFREY BROWN: One criticism of the public option is that it — it will not just compete with private — the private sector... ROBERT LASZEWSKI: Right. JEFFREY BROWN: ... but crowd it out. ROBERT LASZEWSKI: Yes. JEFFREY BROWN: Explain that. Explain the fear. How would that work? ROBERT LASZEWSKI: Well, one of the things that the president has said about the public option competing with insurance companies is, why are insurance companies worried? After all, UPS and FedEx don't have a lot of trouble competing with the post office. The difference here is that Medicare, unilaterally, sets the prices it pays for the services that compose Medicare. So, if Medicare sets unilaterally the price it pays a doctor, it pays a hospital, it pays a drug company, that would be like the post office unilaterally telling its labor unions that it's going to pay 20 percent less than prevailing market rates, that it's going to pay 20 percent less for its leases on its post offices; it's going to pay 20 percent less for the electricity and the heat and the lights. If FedEx and UPS had to compete with a government entity that was paying 20 percent to 30 percent less, they couldn't possibly compete. And that's the fundamental problem. JEFFREY BROWN: Well, we had — Jacob Hacker was on, as you know. ROBERT LASZEWSKI: Right. JEFFREY BROWN: Yesterday, I talked to him. And he was saying that these are resourceful companies. They have 170 million customers. They have brand-name loyalty, market – in many markets, not even all that competitive. ROBERT LASZEWSKI: Yes. JEFFREY BROWN: So, they start with such an advantage. He was worried — instead of worrying about them — whether a government plan could even find its way in. Private insurance could not compete ROBERT LASZEWSKI: Well, do you think UPS and FedEx could compete with the post office if it could purchase space on airplanes for air express at a government-mandated price that was 20 percent to 30 percent less than what the market pays? So, that's the fundamental problem, is that government in Medicare right now unilaterally tells doctors and hospitals what they will pay for their services. And how can anyone compete with that kind of situation in any business? JEFFREY BROWN: And so, what's the fear? What's the draw us a picture of what would happen under a public option plan. What would the system look like? ROBERT LASZEWSKI: I think there are two kinds of fears. One is, is that I talk to people who run health insurance companies, even not-for-profit health insurance companies. They tell me that, if Medicare comes into the marketplace, and cuts what it pays doctors by 20 percent, and cuts what they pay hospitals by 30 percent — which is about what Medicare does in the private market now — then the insurance company will have no choice if it's going to survive, but to go to the doctor and hospital and demand the same prices. And that would create wholesale problems in terms of the relationship between doctors and hospitals. The other problem is, if the government public option did in fact get much lower prices from doctors and hospitals, it would have much lower prices in the marketplace. And, so, people who were poor, who couldn't afford the most expensive health insurance, employers who couldn't afford to buy the most expensive health insurance for their workers might very well end up being in that plan. We could very easily have a two-tiered health care system in this country. You know, there's choice in Britain today. Today, you can be in the government plan. You can be in the public health insurance plans. Twenty percent of the population of the United Kingdom is in private health insurance. JEFFREY BROWN: All right, but let -- a couple of things. A two-tiered system -- some people would say that's what we have now. We have people who can afford good plans... ROBERT LASZEWSKI: That's right. JEFFREY BROWN: ... and many people who can't and are left out of the system. ROBERT LASZEWSKI: And they would be right. But, today, the middle class is in the top tier, and that's the difference. If you had a two-tiered system today where some people don't have insurance and they're are in Medicaid and the rest of us are in good private insurance, that's a two-tiered system. But what if you had a system where 80 percent of the people were in government health insurance and 20 percent were in private? That would be a two-tiered system, too.

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And -- and I'm not suggesting the system we have got today is the best one, but I don't think I want to move to the other kind of two-tiered system. Cutting insurance prices JEFFREY BROWN: Now, I want to you explain a little bit more about the fear of the cuts, because, in principle, the idea of a public plan for everybody is to cut costs in the system, right? ROBERT LASZEWSKI: Right. Right. Right. JEFFREY BROWN: And that's the idea. ROBERT LASZEWSKI:

Exactly. JEFFREY BROWN: You want -- so, you want to bring -- you want to bring ... ROBERT LASZEWSKI: You want to cut prices. JEFFREY BROWN: You

want to cut prices. ROBERT LASZEWSKI: That's right. JEFFREY BROWN: So, why is that a problem? ROBERT LASZEWSKI: Well, because the

biggest problem in the American health care system is not prices. Most experts will tell you that the reason the American health care system costs so much is because of excess treatments, procedures at the time they're done, or administrative costs. The biggest problem we have in the American health care system is, upwards of 30 percent of it is wasteful. And there's one study after another that brings us to that conclusion. And I think people on both sides of the aisle would agree to that. So, what we need to be able to do with the American health care system is preserve the 70 percent of the system that is very efficient and very effective and high in quality, and try to get rid of as much of the 30 percent of the system that's waste as possible. We're never going to get rid of all of it, but that's what we have to focus on. The problem is that, if you just drive prices down, if you negotiate much lower prices with doctors and hospitals, you're going to go to the Mayo Clinic and you're going to go to the Cleveland Clinic, two of the better health care providers in the country. You're going to tell them that their reimbursement just got cut 20 percent or 30 percent. Then you're going to go to the doctor that -- or hospital that's inefficient, and you're going to cut their reimbursement 20 percent or 30 percent. What good does it do to cut the really good health care providers 20 percent or 30 percent?

What we need to do is to change the incentives in the system, the perverse incentives we have got now in the way people are paid, so we're focused on keeping the 70 percent that's quality and the 30 percent that's waste. Cutting everybody's prices

isn't going to get that job done. JEFFREY BROWN: But what you're talking about would -- would in effect push private insurers to cut costs, because the question is -- and I asked this to Jacob Hacker -- without a public option, what pushes them to act? Because the system... ROBERT LASZEWSKI: Right. JEFFREY BROWN: ... right now, most people... ROBERT LASZEWSKI: Right. JEFFREY BROWN: ... would say, they are not cutting costs or covering enough people. Democrats not containing cost ROBERT LASZEWSKI: That's right. One of the things I'm really gratified about with liberals and progressives who think that the public option is very important is, I hear them saying, if we don't have something in health care reform to change the cost and quality outcome, if we don't have something in there that pushes and makes this change, we really don't have health care reform. That's exactly right. Right now, none of the Democratic bills have any real decent cost containment in them. JEFFREY BROWN: You're agreeing with them there, but not on their prescription? ROBERT LASZEWSKI: But I think the public option people are barking up the wrong tree. They're going after price cuts, when the problem is utilization and -- and wasteful versus effective utilization.

JEFFREY BROWN: Now, I have to ask you -- come back to Medicare, because you brought that up a few times. ROBERT LASZEWSKI: Yes. Yes. JEFFREY BROWN: It's very. Jacob Hacker yesterday explicitly talked modeled -- about that as a model. Now, but to you, it's a bad model. To him, it was a good model. ROBERT LASZEWSKI: Well... JEFFREY BROWN: I mean, he's saying it's a -- it provides a broad choice of doctors and hospitals for people. It's helped... ROBERT LASZEWSKI: Yes. JEFFREY BROWN: It's a benchmark on keeping prices down. It's a system that has covered millions of people. ROBERT LASZEWSKI: Medicare is a good system. But, when we look at Medicare, what we find is, for example, the studies that have been done about whether we're wasting dollars or not, where's the most waste in the system?

The most significant study was done by the Dartmouth Medical School. It's called the Dartmouth Atlas. You may have read about it in a couple of the newspapers. But, at any rate, they took a hard look at how much waste we had in the system. They found enormous differences between the way people were treated in one part of the country and another, between efficient and inefficient health care. One hundred percent of the data used in that study was Medicare data.

Medicare's got serious, serious problems. It's not sustainable. It's going bankrupt. There are lots of good things about Medicare, but it's not sustainable. It's just as wasteful. And gee, golly, whiz, if Medicare is the solution, if making the rest of the health care system look like Medicare is the solution, well, why is Medicare going bankrupt and

why is it unsustainable all by itself? I don't think the question is Medicare or private sector. We have problems throughout this system in terms of waste and inefficiency that we have got to get at in order to make it affordable. Politics of health care JEFFREY BROWN: All right, just in our last minute, let me end where I ended with him, the -- the poli -- I know you're not a politician, but here we are today. ROBERT LASZEWSKI: Right. Yes. JEFFREY BROWN: The president, as Jim just said, is going to come back next week. There don't seem to be the votes for a public plan. ROBERT LASZEWSKI: That's correct. JEFFREY BROWN: And the people on Jacob Hacker's side saying, well, then maybe this is -- we're not going to get effective health -- health reform at pull. Your argument is, we can strip that out and still have some effective reform? ROBERT LASZEWSKI: No. I think, with or without the public plan, what we're on our way to doing is expanding the health care entitlement by \$1 trillion, cutting \$500 billion from doctors and hospitals and insurance companies, which is about 1 percent of what they're going to get over the

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next 10 years. We're cutting them -- it's chicken feed, what we're cutting them. And then we're raising taxes \$500 billion to pay for the rest. And we're doing nothing to control costs. JEFFREY BROWN: Raising taxes in some of the plans, in...

ROBERT LASZEWSKI: All -- all of the health care plans, all of the Democratic plans on the table would raise taxes, one way or another, about a half-a-billion dollars to pay for the costs. The president has said, we're going to pay for this half by savings to the Medicare and Medicaid system, and half by new revenue, which is taxes. So, it's half and half, no matter which plan you look at. So... JEFFREY BROWN: Although he hasn't said -- I mean, he has said it will only be on certain...

ROBERT LASZEWSKI: Well, the House bill has a \$550 billion millionaires tax in it, to be specific. I think one of the things the president's got to answer is, the president says, we need to be deficit-neutral in what we do for health care reform. Why? We have got a health care system that's 17 percent of GDP today, going to 22 percent of GDP, \$2.5 trillion of costs today going to \$4.5 trillion of costs in 10 years. Why would you want deficit-neutral health care reform? That means it isn't going to cost any more, but it's not going to cost any less. And if you -- if you have health care bills in the system cost no less, how is that reform?

JEFFREY BROWN: All right, Robert Laszewski, thank you very much. ROBERT LASZEWSKI: You're welcome.

Public option bad at coverage, doesn't solve admin complexity, or cause the aff

Adam Gaffney 17, Adam Gaffney is a physician whose work has appeared in Salon, Dissent, and In These Times, 7-19-2017, "The Case Against the Public Option," No Publication,
<https://www.jacobinmag.com/2017/07/trumpcare-obamacare-repeal-public-option-single-payer>

The saga of Trumpcare may finally be behind us. The wretched bill would have wrenched coverage from tens of millions, and — by many estimates — cost tens of thousands of lives a year. Liberals and leftists rightly united in opposition against it. And though Republicans are reportedly still planning on holding an Obamacare repeal vote next week, their agenda seems to have basically crumbled under the weight of mass opposition. But if the Right's health care agenda is dead, what is the next move for the Left? It is by no means a settled question, for once we move past the question of fighting the repeal of the Affordable Care Act (ACA), a divide opens up — including within the Democratic Party, which will sooner or later return to power. On the one side are the most ardent supporters of Medicare for All; on the other, those who couple a defense of the ACA with advocacy for more incremental reforms, like the public option, which in most current iterations would be a government-run health care plan that would compete against private insurers on the ACA's state-based marketplaces. Admittedly, there is some overlap between the two camps: many look to the public option as a short-term, feasible reform that could help millions of people today, while serving as a stepping stone to a universal system in the future. Yet there is another case to be made: that a public option would be a largely ineffective less-than-half-measure, the pursuit of which could prove to be a major diversion that would paradoxically serve to perpetuate the injustices of the status quo.

Which is it? This is a debate worth having right now, well in advance of the 2018 and 2020 elections that may well determine the fate of the US health care system. Before delving into this debate, it's first necessary to lay some groundwork: what is the public option, and where it did it come from? What might it achieve, and what would it leave undone? And finally: should we embrace it or reject it in the days to come? Choice and Competition in concept at least, the public option has its roots — as public health scholars David Himmelstein and Steffie Woolhandler have noted — in the early 1960s, as an alternative to Medicare. At the time, Wilbur Mills, the Democratic chairman of the House Ways and Means Committee and a well-known fiscal hawk, was obstinately holding up President Kennedy's Medicare bill. As Philip J. Funiglio describes in Chronic Politics: Health Care Security from FDR to George W. Bush, moderate Republican lawmakers Jacob Javits and John Lindsay offered two bills as a potential compromise to break the gridlock. "Important to Javits' proposals and to other alternatives offered at the time," historian Edward Berkowitz writes, "was the notion of choice. . . . [Consumers] could either accept government health insurance, to be run by the States, or a private health care plan." Therein lies the essence of the public option: it's designed to offer a choice between private and public insurance. Thankfully, Javits's and Lindsay's bipartisan bills were rejected: had a compromise been reached, Medicare as we know it today would simply not exist. Instead, Democrats went on to wallop the Republicans in the 1964 election, and Medicare was passed and signed into law the following year as a basically public program (for the time being, anyway). The current iteration of the public option is of a more recent vintage. Its genesis can be traced to two proposals that emerged in the first decade of the twenty-first century. In a 2010 article in Health Affairs, Helen Halpin and Peter Harbage locate the origins of the public option in a health care reform proposal called "CHOICE," which was developed by a group of health care leaders who convened in Berkeley in 2001–2, led by Halpin. CHOICE was a proposal for a "managed competition" model for California in which the public option competed against private plans in a state marketplace. (Most current public option proposals use something of the same template, albeit for the nation as a whole.) The plan fell by the wayside until the 2008 Democratic presidential primary, when John Edwards released a health care reform proposal that, Halpin and Harbage note, "encompassed the principles of CHOICE." While Edwards' campaign disintegrated in scandal, Hillary Clinton and Barack Obama followed his lead on the issue. The second key proposal was the work of political scientist Jacob Hacker — "the father of the 'public option,'" according to NPR's Planet Money — who, a mere two weeks before Edwards came out with his health care plan, published an updated version of his proposal for a Medicare-like public option for those under sixty-five. The public option that all three of the leading Democratic candidates ultimately embraced was, as a 2011 account describes, essentially "a recombination of Hacker's original Medicare Plus and Halpin's CHOICE models," and (rather less clearly) "the only major new idea in the reform debate." Yet this ostensibly new idea was to have a short life. Though it became an important focal point in the 2009 health care reform debate, it was eventually killed off by a former Democrat, Connecticut senator Joseph Lieberman, who vowed to oppose the

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ACA if it included a public option. He got his wish, and a public option-less ACA became law in 2010. In more recent years, conservatives and liberals have resurrected their own versions of the public option (although only the latter identify them as such). Republicans see it as an instrument for privatization. For instance, under the health care reform framework that Paul Ryan and the House Republicans published in 2016, traditional Medicare would be transformed into a public plan that would compete against private insurance plans in a "Medicare Exchange." Though Medicare privatization was not included in either the House or the Senate Obamacare repeal bills, the voucherization (and essential destruction) of Medicare remains on the Republicans' wish list. In Democratic circles, a public option (for those under sixty-five) is viewed as a potential solution to the inadequacies of the ACA. While Bernie Sanders mainly championed Medicare for All in the Democratic primary, Hillary Clinton — claiming that single-payer would "never, ever" happen — argued instead for a public option and, somewhat similarly, a Medicare "buy in." Republican proposals to convert Medicare into a public option for those over sixty-five would obviously take us backward, further privatizing a largely successful and overwhelmingly popular public program. But proposals to create a public option for those under sixty-five, though well intentioned, would fail to take us forward in any meaningful way. The truth is, both approaches have a common underlying flaw: the notion that "managed competition" between a mixture of public and private insurance plans could save the American health care system. But we don't need competing public and private insurance plans any more than we need competing public and private air traffic controllers. It adds nothing but waste and a not insignificant degree of hazard. The Public Option's Cardinal Flaws Obamacare, most agree, has been going through a rough patch. As of July 12, some 24,525 enrollees in thirty-eight counties were at risk of not having a single insurance option on the ACA marketplaces in 2018, according to the Kaiser Family Foundation. To some extent, this dysfunction stems from Republican sabotage, especially President Trump's sometimes-childish yet very consequential threats to cut off payment of Obamacare subsidies to health insurers. But that's not the whole story — the malaise in the marketplaces predicated Trump. Last summer, for instance, Aetna announced that it was withdrawing from most Obamacare marketplaces, a decision that followed exits by other insurers. Writing in Vox at the time, Hacker, like others, touted the public option as a solution to such troubles. "It's enough to make a frazzled health care consumer in one of those feeble markets wish there were another option — perhaps even (dare one say it?) a public option," he wrote. But here again lies one of the public's option's cardinal flaws: whatever it does for those buying insurance on the Obamacare marketplaces (which I'll return to in a minute), it does basically nothing for the large majority of the nation not insured through them. The so-called "Obamacare" plans cover some 12.2 million enrollees — a substantial number of people to be sure, but still a very small fraction of the population. What would a public option do, for example, for the 28.6 million US residents who are uninsured? According to the Congressional Budget Office's (CBO) 2013 scoring of a public option added to the ACA marketplaces, the answer is nothing: the public option, the CBO estimated, "would have minimal effects . . . on the number of people who would be uninsured." The goal of single-payer is to reduce that 28.6 million figure to zero; under the public option — at least according to this admittedly old CBO score of one particular variation of the public option — the number wouldn't so much as budge. Perhaps a more ambitious public option could do a bit better. Nonetheless, it's not clear that even a more robust plan would be a step toward universal coverage. And how about for the underinsured? The roughly half of the nation currently covered through their employer saw a 2016 deductible that was 300 percent higher than a decade ago. Such cost-shifting of health care costs to workers is a major cause of financial suffering, as well as deferred medical care. Yet the public option would do nothing for the great majority of these families. A longstanding aim of universal health care advocates — stretching back to the German Social Democrats' 1891 Erfurt Program, which called for "[f]ree medical care, including midwifery and medicines" — has been to eliminate out-of-pocket payments (for example, copayments and deductibles) at the time of health care use. In Canada and the United Kingdom, this goal has largely been achieved: most health care remains free when patients use it. The public option, however, would do little to nothing to bring us closer to this goal. Nor would the public option ameliorate existing deficiencies in the two big public insurance programs, Medicare and Medicaid. Medicare, like private insurance, often imposes high out-of-pocket payments on enrollees, and it excludes coverage for important health services like dentistry and long-term care. The partial privatization of the program (via Medicare Advantage plans, which are managed by private insurance companies) has yielded little but colossal waste over the years." And while Medicaid has broader benefits and usually minimal out-of-pocket payments, as a result of its lower reimbursements, it sometimes provides inferior access to providers (a vestige of its heritage as a "poor person's program). The public option wouldn't address the inadequacies of either public program. Finally, in terms of global costs, the public option's effect would again be quite minor, as single-payer advocates have long noted. Eliminating both uninsurance and underinsurance would cost money, and reduced administrative spending (\$503 billion dollars a year, according to one estimate) and reduced drug costs (\$113.2 billion a year) are typically cited as key sources of savings. But although a Medicare-like public option may have lower administrative costs, only a small fraction of the efficiency savings of single-payer would be achieved if the multi-payer

framework persisted (and drug prices wouldn't be controlled on a system-wide level). Or as Physician for a National Health Program's Don McCanne puts it, the "public option would be only one more player in our wasteful, administratively-complex, fragmented system of financing care." The upshot? It wouldn't generate anywhere near the savings needed to fund a truly universal expansion of health care.

Bureaucracy tanks solvency – fraud – doctors reject patients on the public option Hemingway, 16

(Mark, recipient of a Gold Award journalism fellowship from the Phillips Foundation and was a Global Prosperity Initiative fellow at the Mercatus Center at George Mason University, "Yes, the Public Option is a 'Trojan Horse' to Destroy Private Health Insurance", <http://www.weeklystandard.com/yes-the-public-option-is-a-trojan-horse-to-destroy-private-health-insurance/article/2003955>, August 24, 2016, Ak.)

There are a great many obvious reasons to oppose the public option. Perhaps the most neglected reason to oppose it is that the people arguing for the public option aren't telling the truth, because what they really want is not a publicly funded insurance plan that's serves as an alternative to private insurance. They want to crowd private insurers out of the marketplace altogether, leaving the government as the sole provider of health care, a.k.a. a "single-payer" system. Despite the obvious evidence that this is what they want, they insist that the public option is some sort of sensible middle ground and not the radical proposal to destroy private insurance that it is. Now watch this video from Jacob **Hacker**, "father of the public option," speaking at the Tides Foundation in 2008: If you can't watch the video here's what Hacker says: Someone once said to me, 'Well, this is a Trojan horse for single payer.' Well, it's not a Trojan horse, right? It's just right there! I'm telling you, we're going to get there over time, slowly, but we'll move away from reliance on employment based health insurance as we should. But we're going to do it in a way that we're not going to frighten people into thinking that they're going to lose their private insurance. At the time the video first surfaced in 2009, Hacker attempted to clarify his remarks. "I do not see my 'Health Care for America' proposal as a route to single payer," he told CNSNews.com. He further claims that he was simply trying to argue that he's open about his ambitions for the success of the public option, rather than trying to be deceptive. Maybe that's true, but explicitly making a meta-argument about not wanting to frighten voters by discussing the end goal of destroying the private insurance system is troubling on its own. Hacker's too clever by half; he's being honest—but only about the fact the public option will be sold to the public in such a way they won't understand the long-term consequences. Besides, we've already seen the consequences of this argument. Not wanting to "frighten people into thinking that they're going to lose their private insurance" is likely the reason why President Obama deliberately and repeatedly lied about "if you like your health insurance, you can keep your health insurance" under Obamacare, when some eight million Americans lost their insurance as a result of the law. Further, another much celebrated liberal health care wonk, M.I.T. economist Jonathan Gruber, has been caught lying about several aspects of Obamacare and mocking the "stupidity" of voters when it comes to health care policy. But say what you want about this approach—the lying worked. Obamacare was passed, and media organizations went to the mat to defend these lies. (Politifact repeatedly defended "if you like it, you can keep it," before they got so much egg on their faces they made it "Lie of the year.") By the time the lies were exposed, Obamacare was entrenched. After the experience with Obamacare, surely Hacker must understand that there's no reason to trust him or other health care wonks on the public option. Further, it's worth noting that many on the left, to their credit, don't like the public option. Why? As Mark Schmitt wrote in the American Prospect, "the political process turns out to be as resistant to stealth single-payer as it is to plain-old single-payer." They feel they'd be better off arguing for single-payer from the get-go, instead of waiting for a political backlash that will come with people realizing that the public option is a matter of bait-and-switch. To understand what's going on here, it helps to explicate the policy arguments against the public option. To think the public option is a good idea, you have to believe that, while private insurers with decades of experience in health care administration can't make money under Obamacare's mandates and coverage requirements, somehow a new government insurance enterprise built from the ground-up and run by federal bureaucrats would be much more efficient. There's a lot of health care **wonkery** one could descend into at this point to rebut the public option, and for more on that see this recent Bloomberg column where Megan McArdle did an excellent job systematically dismantling arguments for the public option. But it's worth just pointing out just a few basic things. First, health insurers operate on very narrow profit margins, so the amount of money saved by eliminating profits isn't as great as many imagine. Two, once you eliminate profits you also eliminate any incentive for an insurer to increase efficiencies or otherwise save money. In this respect, our current forays into government insurance are telling. Aside from tens of

trillions in unfunded liabilities, Medicare loses \$60 billion to fraud every year and there's little interest in fixing the problem. Arguing that eliminating profits would lead to better administration in government-run health insurance seems dubious. Finally, as McArdle notes, one of the most powerful arguments in favor of the public option is the belief that the "public option can force providers to accept below-market reimbursements for their services." Already government insurance programs are attempting to set rates below market cost, and it's not going well. If you're on Medicaid, good luck getting an appointment. Consulting firm Merritt-Hawkins periodically surveys major health care markets in the U.S. to examine average wait times for doctors. In their last 2014 survey, over 50 percent of doctors would not accept Medicaid patients and that percentage has increased significantly. Similarly, one in five doctors are now rejecting new Medicare patients. With private insurance paying better rates, it's become increasingly hard for government programs to force physicians to accept reimbursements that are below-market. Ah, but what if the government didn't have to compete with private insurance? Then they could set rates at whatever they wanted and save all kinds of money. (Of course, there are broader ramifications to government price controls. Specifically, they lead to rationing – and if those consequences aren't clear enough, I encourage you to try and schedule an MRI in Canada where health care prices are tightly controlled. They have fewer MRI machines in the entire country than Pittsburgh.)

public option avoids barriers, cost controls, and props up bias

Hoff, 9

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President Barack Obama is insisting that health care "reform" include an insurance plan operated by the federal government, claiming that this "public option" is necessary to provide competition against the private insurers. Senate Majority Leader Harry Reid (D-NV) has said that the government plan would play a role like that of the U.S. Post Office, which he apparently believes is keeping Federal Express and UPS honest and efficient.^[1] This upside-down rhetoric reflects a mindset stuck in the 1930s, deriving its guiding political philosophy from the joy and relief felt by John Steinbeck's Joads when they found shelter in a government-run camp on their migration from Oklahoma to California. It does not fit modern America. Advocates of the government insurance plan assure us that it would compete with private insurers on a level playing field. In reality, the "competition" would be rigged, with the government plan enjoying a number of advantages. As a result, the government plan would likely capture a large percentage of the insurance market, marginalizing and undermining private insurance. For example, the Lewin Group estimates that the America's Affordable Health Choices Act,^[2] the health reform bill currently under consideration in the House of Representatives, would reduce the number of Americans with private insurance by 83.4 million and that the new public plan would cover 103.4 million people.^[3] Coupled with the federal regulatory system that the legislation would impose on the remaining private plans, this would clearly by itself constitute a government takeover of health care. Even worse, the federal takeover would accelerate. The private plans' relatively small market share would likely render them increasingly uneconomical and lead to a death spiral in which private insurance would serve an ever-decreasing share of the market. In short, the federal insurance plan is a giant step toward the single-payer system that the President has admitted that he prefers. The single payer would be the federal government. This would create a nationalized health care system much like those in Europe and Canada. Tilting the Playing Field The President and his allies in Congress have attempted to allay fears about how the government plan would affect Americans' private insurance system by saying that it would merely provide them an additional choice and would compete on the same terms as the private plans offered through the new Health Insurance Exchange. To that end, the House bill even contains a section entitled "Ensuring a Level Playing Field."^[4] However, the actual terms of Section 221 do not live up to the title. Private insurers and the government plan would not compete on a level playing field. The provision that is touted as

"ensuring" a level playing field fails to do so in three respects. Tilt #1: **Provisions for leveling the playing field are limited to the requirements of the bill.** Most important, the scope of Section 221 is limited. It requires the "public health insurance option [to] comply with requirements that are applicable under" Title II of the bill to other insurance plans offered through the Health Insurance Exchange, including those that are related to consumer protections, benefits, cost-sharing, notices, and provider networks.^[5] Disregarding the grammatical conundrum of how an "option" can do anything, Section 221 makes the government plan subject only to the requirements that are imposed by Title II. It does not impose on the government plan the broad variety of other federal and state requirements with which private insurers must comply, such as taxes, antitrust laws, and licensing requirements. Undoubtedly, other requirements would quickly become apparent if the legislation were implemented. Depending on their tax status, **private insurers must pay federal and state taxes**, including premium taxes, property taxes, and income taxes. **The government insurance plan**, which would be run by the U.S. Department of Health and Human Services (HHS), **would not** pay these taxes, and Section 221 does not change this. Nor would the government plan be subject to the federal and state antitrust laws that regulate the operations of private insurers. Moreover, the bill is unclear on whether the government plan would be required to meet state licensing standards and obtain state licenses. Section 204 contains a general requirement that a plan offering insurance through the exchange must be licensed under state law for each state in which it offers coverage,^[6] yet **state laws do not apply to the federal government** unless federal law provides that they do. The general language in Section 204 and Section 221 may not be sufficiently explicit to require the government plan to obtain state insurance licenses. If not, **the government plan would avoid state solvency and other requirements** that **private plans must meet**. Similarly, the language is unclear on whether the government plan must provide specific benefits and include providers as required by state laws. Section 203 specifies that such state mandates "shall continue to apply" to plans offered through the exchange,^[7] but it is unclear whether this is a "requirement" within the meaning of Section 221 that would apply to the government plan. If not, **the government plan would avoid the expenses** that **private insurers incur** in complying with the extra benefit requirements imposed by the states. Whether these general provisions would require the government plan to comply with state law is complicated by Section 225, which explicitly makes state law applicable to the government plan's selection of providers. It specifies that the government plan can include only providers that are licensed or certified by the state. The absence of similarly explicit provisions in other sections would suggest--according to the rules of statutory construction--that **the government plan would not be subject to state laws in other aspects of its operation**. The **government plan would be shielded from the high costs of tort litigation** that private plans face. Unless exempted by the Employee Retirement Income Security Act as an employee benefits plan, a private insurer can be sued for **a variety of torts**, including actions for consequential and non-economic damages for death and injury resulting from a **wrongful denial of coverage**. Yet **the government plan**, as an arm of the federal government, **would** probably **be immune** from tort liability. The federal government can be sued under the Federal Tort Claims Act (FTCA), but not for discretionary actions of its agents, **and a coverage decision would** probably **qualify as** such **a discretionary act**. Even if suit could be brought against the government plan under the FTCA, it could not be heard in a state court or before a jury, and the government plan would not be liable for punitive damages. Furthermore, the FTCA imposes strict caps on attorneys' fees, which significantly reduces economic incentives to stir up suits against the government, which is certainly not the case in litigation against private parties.^[8] Tilt #2: Even with the requirements imposed by the bill, **the field is not level**. Because the bill does not spell out the scope of Section 221(b)(2), it is unclear precisely which "requirements...are applicable under" Title II. Title II requires plans to submit bids to the newly created Health Choices Commissioner, who would review the adequacy of their provider networks and presumably would make demands on price and service before accepting a bid and entering into a contract.^[9] Provider networks are briefly mentioned in Section 221 as one of the applicable requirements,^[10] but **the commissioner's obligation to enter into contracts with plans and the process** for doing so are not mentioned. The bill is unclear on whether these requirements are applicable under Title II and therefore whether Section 221 gives the commissioner the authority to require bids from the government plan and to negotiate contracts with it. Even if the bill does give the commissioner this authority, the structure of Title II makes it unclear what requirements the commissioner could impose on the government plan. The commissioner is required to develop standards on various aspects of plan operations in order to carry out the requirements of Title I. Even if the government plan is expected to negotiate with the commissioner as other plans do, it is unclear whether a requirement under Title I that is embodied in the commissioner's standards is a requirement applicable under Title II with which the government plan must comply.^[11] The bill does not explicitly require the commissioner to treat the government plan the same as it treats the other plans. In the absence of such clear direction, **it is unlikely that the government plan would face the same bidding and contractual process** (which, in essence, will be **the foundation of a costly regulatory regime**) that the **private plans face**. In fact, despite the language of Section 221(b)(2), other language in the bill leaves open to interpretation whether the government plan must meet any of the requirements of Title II or Title I. Section 100 states that the HHS Secretary, in connection with the government plan, "shall be treated as" offering an exchange-participating health benefits plan and that "the term 'qualified health benefits plan' means a health benefits plan that meets the requirements for such a plan under title I and includes the public health insurance option."^[12] This language could be read as requiring private plans to meet certain requirements under Title I but not requiring the government to do so. Because "treated as" and "includes" are used to describe the government plan's status, it might be argued that **the government plan is not required to meet those requirements through the operation of Title II or even those requirements included in Title II**, notwithstanding Section 221(b)(2). This language could be read as giving the government plan **a free pass to qualification**. In addition to creating **the illusion of a level playing field**, Section 221 is drafted craftily in other ways. It introduces the ambiguous requirement, discussed above, that the government plan comply with the provisions imposed by Title II with the qualifying phrase "consistent with this subtitle [Subtitle B]." Importantly, Section 221 also states that HHS's "primary responsibility" in creating the government plan is to create "a low-cost insurance plan."^[13] The qualification that the level playing field must be consistent with the subtitle could embolden the Secretary to claim exemptions from costly requirements of the bill on the grounds that

the exemptions are needed to carry out the mandate for a low-cost plan. These ambiguities could also support claims that the government plan is not required to submit bids, have its premiums approved by the commissioner, enter into a contract with the commissioner, submit to state mandate laws, or obtain state licenses. The bill also seems to give the government plan the ability to obtain proprietary information about competing private plans. It confers on the Health Choices Commissioner unspecified and virtually unchecked authority to collect data from plans, including the government plan. The commissioner is required to collect the data needed for carrying out his or her duties,^[14] and plans are required to report "such information as the Commissioner may specify."^[15] The information collected could include the health status of each person covered by insurance plans and which services were obtained from which providers. It could also include information on the terms of providers' participation in plans, how much each provider is paid by the plan, the profits earned by a plan, and other information relevant to plan operations. Disturbingly, the commissioner is authorized to "share" this information with the HHS Secretary, the operator of the government plan, without any restriction on the Secretary's use of the information.^[16] Thus, the government plan may obtain extensive data about the operations of competing private plans, but private plans will not have access to this information about either the government plan or each other.^[17]

Tilt #3: A government-operated plan has other inherent advantages. The government plan would have a number of other advantages. It would be marketed with the imprimatur of the federal government, and that status itself would be persuasive to many potential enrollees. In addition, the government could use its ongoing contacts with the citizenry to market its insurance plan. Nothing in the bill would explicitly prohibit the government from including promotional materials in mailings or as an electronic message accompanying automatic deposit of government benefits, such as Social Security checks and tax refunds. The bill requires the Health Choices Commissioner to set "uniform marketing standards" for all insurance plans selling through the exchange.^[18] Whether these standards would apply to the government plan is unclear. Nor is it clear whether the government plan would be subject to the same information-disclosure requirements as private plans.^[19] These provisions are contained in Title I of the bill, and, as discussed, Section 221 explicitly imposes only the Title II requirements on the government plan. The government plan would also have the advantage of having law-making authority behind it. The bill would make reimbursement rates for doctors and hospitals under Medicare applicable to the government plan.^[20] These are unilaterally imposed by the government—a power that no private plan would have—and are lower than what private plans have been able to negotiate in the market. Even if this is changed to require the government plan to "negotiate" reimbursement rates, its larger size and clout would give it bargaining advantages that no private plan could match. In any event, neither of these reimbursement methodologies would likely be the last word. The bill gives the government plan blanket authority to establish reimbursement rates for providers unilaterally as long as they are "innovative."^[21] Finally, in competing with private plans, the government plan will enjoy one overriding advantage: Because the government can force the taxpayer to make up any shortfalls, the government plan can charge premiums that do not cover its costs. The bill requires the government plan to charge premiums as necessary to meet its costs, plus a margin for contingencies.^[22] However, political realities and the pressure to provide "affordable" insurance could result in this being disregarded or fudged. How costs are calculated will undoubtedly be complex and controversial. The government plan could charge less than its costs because the U.S. taxpayer initially, lenders to the federal government, could be tapped. Private plans do not have the ability to lower prices below cost and tax the taxpayer to make up the difference. The resulting taxpayer subsidies to the government plan could easily make Fannie Mae and Freddie Mac look like careful and disciplined actors in the mortgage market.^[23]

Furthermore, unlike the proposed government plan, they were not even government agencies when they were bailed out. Conclusion In a number of ways, the America's Affordable Health Choices Act would fail to "ensur[e] a level playing field." It is unclear whether the government plan would be subject to a number of requirements that the private plans would be required to meet. It would appear to give the HHS Secretary and the Health Choices Commissioner the discretion to decide these ambiguities in favor of the government plan and to find that various requirements do not apply to the government plan because of its overriding mission to offer a low-cost plan. However, even without including these potential advantages, the government plan would clearly be free of a number of requirements and expenses that private plans face.^[24] Happy talk of creating a level playing field between the government insurance plan and private plans should be viewed with strong skepticism and even disbelief. The government plan would be heavily favored, leading to the marginalization of the private insurance market and the creation of a de facto single-payer system—a nationalized health system.

Coverage gaps – Either the public option excludes patients save costs, because it can't stably consolidate the risk pool

Demoro, 17

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With the collapse of the dismal Republican healthcare bill, some Democrats are reviving talk of a public option as the cure for the holes in the Affordable Care Act that opened the door for the GOP attack. Some even project the public option as the path to real transformative reform, an improved and expanded Medicare for all. It's not. The **public option** bears more in common with **fool's gold**. It may look shiny, but it will still leave you broke. And there's a significant danger that a public option **would** not only **fail to improve** the **ACA**, it could **undermine** the movement for **single payer**, discrediting a fully publicly financed system that is not a feeble adjunct to the private insurance market. Granted, the ACA did enact some important course corrections, especially the expansion of Medicaid, to a profit-focused healthcare system that had plummeted to 37th in World Health Organization rankings. But ignoring the highly successful and popular model of a proven system, Medicare, the ACA architects instead opted for an alternative that left 28 million Americans uninsured and failed to reign in the price gouging practices of the private market. The inevitable result was **millions of newly insured** people **paying premiums for insurance they** increasingly **could not use because of** ever-rising deductibles, co-pays and other out of pocket **costs**. Enter the proposal for a public option, now again in vogue as the solution for driving down costs by offering competition for the private insurers. The public option, the argument goes, can offer less expensive coverage because it doesn't have to divert massive sums for administrative costs, mainly profits, lush executive pay packages, claims denial paperwork, and marketing. But in practice, the outcome would be far different. **Medicare works** in large part **by including all the people** it covers **in one large risk pool** so that healthier patients balance out sicker patients in costs that must be reimbursed to providers. But the public option would not have that protection. One of two scenarios is likely: A. **To actually compete**, the **public option has to employ the same cutthroat tactics private insurers employ** to limit their costs. Insurance companies reap profits by **collecting premiums and restricting payments for care**. They accomplish that goal **by denying claims** — data from California and Connecticut have shown insurers deny from one-fifth to one-fourth of all claims—**or excluding patients** likely to be **sicker and in need of more costly care**. The ACA barred insurers from refusing to sell plans to people they used to summarily reject with even minor pre-existing conditions. But the **insurers have decades of experience** in **gaming the system**, such as the use of **restrictive provider networks and drug formularies**. As Adam Gaffney and Danny McCormick wrote in The Lancet in April, in the massive New York market only one insurer, a consumer cooperative that ultimately collapsed financially, covered care at the city's top cancer center. Another popular scam is **charging their enrollees more for essential drugs for AIDS, cancer or other serious illnesses**. So the **public option** can engage in **the same skullduggery to exclude sicker, more costly patients**, or

OR, it bankrupts itself and upends existing coverage

Demoro, 17

(Roseann, Executive director of National Nurses United and of the California Nurses Association/National Nurses Organizing Committee. DeMoro also serves as national vice president and executive board member of the AFL-CIO, "The public option in health care — doomed from the start", http://www.salon.com/2017/07/25/the-public-option-in-health-care-doomed-from-the-start_partner/, July 25, 2017, Ak.)

B. **The public option becomes the ACA escape valve** by **welcoming in the sickest people selected out by the private insurers**, in effect **another bailout for a failed private insurance market**. Noble, but **fatal**. Thus the public option has **far higher operating costs than** the **private plans**. **To** effectively **compete, it must either** greatly

jack up its rates, eliminating it as a less expensive alternative, or endure the bankrupted fate of that consumer coop in New York. To top it all off, the Congressional Budget Office in 2013 concluded that adding a public option would not even slice the number of uninsured, and could even encourage employers to dump workers they now cover into the ACA exchanges. With millions still either uninsured or paying exorbitant costs for care, imagine promoting a publicly financed Medicare for all to a public that sees a public option that is just as unethical as the notorious private insurers, or a financial wreck that just went belly up. In 1957, the Ford Motor Co. had the hot idea of a glitzy new car that would capture new market share. It was called the Edsel, which soon became a synonym for a flop. Nurses have a message to the public option purveyors. Stop trying to sell us an Edsel.

Public plans fail if they don't keep private carriers in fair competition

Bertko & Nichols 9 (Len Nichols, John Bertko. New America Foundation – Health Policy Program. “A Modest Proposal for a Competing Public Health Plan”, March 2009.

https://www.researchgate.net/profile/Len_Nichols/publication/237502696_A_Modest_Proposal_for_a_Competing_Public_Health_Plan/links/0c9605359671de9bf5000000.pdf)

The new public plan must be actuarially sound. This means it must charge premiums that cover its costs. The public plan may not be subsidized using additional government revenues (but low-income subsidies will likely be used by people choosing between the public and private plans). In addition, the public plan cannot leverage Medicare (or any other public program) to force providers to participate. For example, the public plan cannot require providers to serve public plan patients as a condition of participating in the Medicare program (sometimes called “cram-down”). Likewise, the plan should not be required to use Medicare payment rates. Instead it must offer rates that elicit voluntary participation, which means providers should have the same freedom to negotiate with the public plan as they do with other private carriers. As a result, the public plan’s payment rates and its provider networks might differ from those of its competitors and from Medicare. We do not suggest using the public plan’s pricing power to control costs. Therefore, we must deal with cost growth symmetrically across plans, instead of primarily through the public plan. We address the issue of cost containment later in this paper.

Plan decks the market

Cannon, 9

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A full accounting, however, shows that government programs are less efficient than private insurance. Administrative costs are higher in government programs such as Medicare, because they avoid administrative activities that increase efficiency and incur other administrative costs that are purely wasteful. Government programs also suppress innovation, and thereby reduce the quality of care for all patients, whether publicly or privately insured. The central problem with proposals to create a new government program is not that government is less efficient than private insurers, however, but that government can hide its inefficiencies and draw consumers away from private insurance, despite offering an inferior product. If the government plan’s premiums reflected its full costs—and private insurance premiums reflected only their actual costs—there would be no reason not to let the government enter the market. As Dionne suggests, the market would test the idea’s strength. Yet government possesses both the power to hide its true costs (which keeps its premiums artificially low) and to impose costs on its competitors (which unnecessarily pushes private insurance premiums higher). It makes no difference whether a new program adopts a “co-operative” model or

Medicare For All Master File

any other. The government possesses so many tools for subsidizing its own program and increasing costs for private insurers—and has such a long history of subsidizing and protecting favored enterprises—that unfair advantages are inevitable. This is in no small part because supporters of a new government program want it to have unfair advantages. Literally Ousting Patients from Their Health Plans In a speech to the American Medical Association, President Obama reiterated a promise that he has made repeatedly since the 2008 presidential campaign: No matter how we reform health care, we will keep this promise to the American people. If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what. 16 After the Congressional Budget Office estimated that as many as 15 million Americans could lose their existing coverage under Senator Kennedy's legislation, 17 the Associated Press reported, "White House officials suggest the president's rhetoric shouldn't be taken literally." 18 Indeed, a new government program would literally oust millions of Americans from their current health plans and threaten their relationships with their doctors, as employers choose to drop their current employee health plans and as private health plans close down. A Lewin Group analysis estimated that Obama's campaign proposal would move 32 million Americans into a new government-run plan. 19 Lewin subsequently estimated that if Congress used Medicare's price controls and opened the new program to everyone, **it could pull 120million Americans out of private insurance—more than half of the private market.** 20 The share of Americans who depend on government for their health care would rise from just over one quarter to two-thirds. 21 Many of those millions would be involuntarily ousted from their current health plans—much like President Obama suggested ousting 10 million seniors 22 from their private Medicare Advantage plans and forcing them into the traditional Medicare program. 23 Yet even those who voluntarily chose a new government program over their existing coverage would do so not because the government program provides better value for the money, but because the government program would hide some of its cost. A health insurance "exchange," where consumers choose between private health plans with artificially high premiums and a government program with artificially low premiums, would not increase competition. Instead, it **would reduce competition by driving lower cost private health plans out of business**. President Obama's vision of a health insurance exchange is not a market, but a prelude to a government takeover of the health care sector. In the process, millions of Americans would be ousted from their existing health plans, and all would suffer the consequences of government run health care.

~They can't access an internal link- public option is rigged for the government and creates de-facto single payer which fails

Hoff 9 (John, Trustee and founding Board Member of the Galen Institute. He served as a Deputy Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services from 2001 to 2005. ["The Public Health Insurance Option: Unfair Competition on a Tilting Field" <http://www.heritage.org/health-care-reform/report/the-public-health-insurance-option-unfair-competition-tilting-field>] NvP

Advocates of the government insurance plan assure us that it would compete with private insurers on a level playing field. In reality, **the "competition" would be rigged, with the government plan enjoying a number of advantages**. As a result, the government plan would likely capture a large percentage of the insurance market, marginalizing and undermining private insurance. For example, the Lewin Group estimates that the America's Affordable Health Choices Act,[2] the health reform bill currently under consideration in the House of Representatives, would reduce the number of Americans with private insurance by 83.4 million and that the new public plan would cover 103.4 million people.[3] Coupled with the federal regulatory system that the legislation would impose on the remaining private plans, this would clearly by itself constitute a government takeover of health care. Even worse, the federal takeover would accelerate. The private plans' relatively small market share would likely render them increasingly uneconomical and lead to a death spiral in which private insurance would serve an ever-decreasing share of the market. In short, the federal insurance plan is a giant step toward the single-payer system that the President has admitted that he prefers. The single payer would be the federal government. This would create a nationalized health care system much like those in Europe and Canada. Tilting the Playing Field The President and his allies in Congress have attempted to allay fears about how the government plan would affect Americans' private insurance system by saying that it would merely provide them an additional choice and would compete on the same terms as the private plans offered through the new Health Insurance Exchange. To that end, the House bill even contains a section entitled "Ensuring a Level Playing Field."^[4] However, the actual terms of Section 221 do not live up to the title. Private insurers and the government plan

would not compete on a level playing field. The provision that is touted as "ensuring" a level playing field fails to do so in three respects. Tilt #1: Provisions for leveling the playing field are limited to the requirements of the bill. Most important, the scope of Section 221 is limited. It requires the "public health insurance option [to] comply with requirements that are applicable under" Title II of the bill to other insurance plans offered through the Health Insurance Exchange, including those that are related to consumer protections, benefits, cost-sharing, notices, and provider networks.^[5] Disregarding the grammatical conundrum of how an "option" can do anything, Section 221 makes the government plan subject only to the requirements that are imposed by Title II. It does not impose on the government plan the broad variety of other federal and state requirements with which private insurers must comply, such as taxes, antitrust laws, and licensing requirements. Undoubtedly, other requirements would quickly become apparent if the legislation were implemented. Depending on their tax status, private insurers must pay federal and state taxes, including premium taxes, property taxes, and income taxes. The government insurance plan, which would be run by the U.S. Department of Health and Human Services (HHS), would not pay these taxes, and Section 221 does not change this. Nor would the government plan be subject to the federal and state antitrust laws that regulate the operations of private insurers. Moreover, the bill is unclear on whether the government plan would be required to meet state licensing standards and obtain state licenses. Section 204 contains a general requirement that a plan offering insurance through the exchange must be licensed under state law for each state in which it offers coverage,^[6] yet state laws do not apply to the federal government unless federal law provides that they do. The general language in Section 204 and Section 221 may not be sufficiently explicit to require the government plan to obtain state insurance licenses. If not, the government plan would avoid state solvency and other requirements that private plans must meet. Similarly, the language is unclear on whether the government plan must provide specific benefits and include providers as required by state laws. Section 203 specifies that such state mandates "shall continue to apply" to plans offered through the exchange,^[7] but it is unclear whether this is a "requirement" within the meaning of Section 221 that would apply to the government plan. If not, the government plan would avoid the expenses that private insurers incur in complying with the extra benefit requirements imposed by the states. Whether these general provisions would require the government plan to comply with state law is complicated by Section 225, which explicitly makes state law applicable to the government plan's selection of providers. It specifies that the government plan can include only providers that are licensed or certified by the state. The absence of similarly explicit provisions in other sections would suggest--according to the rules of statutory construction--that the government plan would not be subject to state laws in other aspects of its operation. The government plan would be shielded from the high costs of tort litigation that private plans face. Unless exempted by the Employee Retirement Income Security Act as an employee benefits plan, a private insurer can be sued for a variety of torts, including actions for consequential and non-economic damages for death and injury resulting from a wrongful denial of coverage. Yet the government plan, as an arm of the federal government, would probably be immune from tort liability. The federal government can be sued under the Federal Tort Claims Act (FTCA), but not for discretionary actions of its agents, and a coverage decision would probably qualify as such a discretionary act. Even if suit could be brought against the government plan under the FTCA, it could not be heard in a state court or before a jury, and the government plan would not be liable for punitive damages. Furthermore, the FTCA imposes strict caps on attorneys' fees, which significantly reduces economic incentives to stir up suits against the government, which is certainly not the case in litigation against private parties.^[8] Tilt #2: Even with the requirements imposed by the bill, the field is not level. Because the bill does not spell out the scope of Section 221(b)(2), it is unclear precisely which "requirements...are applicable under" Title II. Title II requires plans to submit bids to the newly created Health Choices Commissioner, who would review the adequacy of their provider networks and presumably would make demands on price and service before accepting a bid and entering into a contract.^[9] Provider networks are briefly mentioned in Section 221 as one of the applicable requirements,^[10] but the commissioner's obligation to enter into contracts with plans and the process for doing so are not mentioned. The bill is unclear on whether these requirements are applicable under Title II and therefore whether Section 221 gives the commissioner the authority to require bids from the government plan and to negotiate contracts with it. Even if the bill does give the commissioner this authority, the structure of Title II makes it unclear what requirements the commissioner could impose on the government plan. The commissioner is required to develop standards on various aspects of plan operations in order to carry out the requirements of Title I. Even if the government plan is expected to negotiate with the commissioner as other plans do, it is unclear whether a requirement under Title I that is embodied in the commissioner's standards is a requirement applicable under Title II with which the government plan must comply.^[11] The bill does not explicitly require the commissioner to treat the government plan the same as it treats the other plans. In the absence of such clear direction, it is unlikely that the government plan would face the same bidding and contractual process (which, in essence, will be the foundation of a costly regulatory regime) that the private plans face. In fact, despite the language of Section 221(b)(2), other language in the bill leaves open to interpretation whether the government plan must meet any of the requirements of Title II or Title I. Section 100 states that the HHS Secretary, in connection with the government plan, "shall be treated as" offering an exchange-participating health benefits plan and that "the term 'qualified health benefits plan' means a health benefits plan that meets the requirements

for such a plan under title I and includes the public health insurance option."^[12] This language could be read as requiring private plans to meet certain requirements under Title I but not requiring the government to do so. Because "treated as" and "includes" are used to describe the government plan's status, it might be argued that the government plan is not required to meet those requirements through the operation of Title II or even those requirements included in Title II, notwithstanding Section 221(b)(2). This language could be read as giving the government plan a free pass to qualification. In addition to creating the illusion of a level playing field, Section 221 is drafted craftily in other ways. It introduces the ambiguous requirement, discussed above, that the government plan comply with the provisions imposed by Title II with the qualifying phrase "consistent with this subtitle [Subtitle B]." Importantly, Section 221 also states that HHS's "primary responsibility" in creating the government plan is to create "a low-cost insurance plan."^[13] The qualification that the level playing field must be consistent with the subtitle could embolden the Secretary to claim exemptions from costly requirements of the bill on the grounds that the exemptions are needed to carry out the mandate for a low-cost plan. These ambiguities could also support claims that the government plan is not required to submit bids, have its premiums approved by the commissioner, enter into a contract with the commissioner, submit to state mandate laws, or obtain state licenses. The bill also seems to give the government plan the ability to obtain proprietary information about competing private plans. It confers on the Health Choices Commissioner unspecified and virtually unchecked authority to collect data from plans, including the government plan. The commissioner is required to collect the data needed for carrying out his or her duties,^[14] and plans are required to report "such information as the Commissioner may specify."^[15] The information collected could include the health status of each person covered by insurance plans and which services were obtained from which providers. It could also include information on the terms of providers' participation in plans, how much each provider is paid by the plan, the profits earned by a plan, and other information relevant to plan operations. Disturbingly, the commissioner is authorized to "share" this information with the HHS Secretary, the operator of the government plan, without any restriction on the Secretary's use of the information.^[16] Thus, the government plan may obtain extensive data about the operations of competing private plans, but private plans will not have access to this information about either the government plan or each other.^[17] Tilt #3: A government-operated plan has other inherent advantages. The government plan would have a number of other advantages. It would be marketed with the imprimatur of the federal government, and that status itself would be persuasive to many potential enrollees. In addition, the government could use its ongoing contacts with the citizenry to market its insurance plan. Nothing in the bill would explicitly prohibit the government from including promotional materials in mailings or as an electronic message accompanying automatic deposit of government benefits, such as Social Security checks and tax refunds. The bill requires the Health Choices Commissioner to set "uniform marketing standards" for all insurance plans selling through the exchange.^[18] Whether these standards would apply to the government plan is unclear. Nor is it clear whether the government plan would be subject to the same information-disclosure requirements as private plans.^[19] These provisions are contained in Title I of the bill, and, as discussed, Section 221 explicitly imposes only the Title II requirements on the government plan. The government plan would also have the advantage of having law-making authority behind it. The bill would make reimbursement rates for doctors and hospitals under Medicare applicable to the government plan.^[20] These are unilaterally imposed by the government--a power that no private plan would have--and are lower than what private plans have been able to negotiate in the market. Even if this is changed to require the government plan to "negotiate" reimbursement rates, its larger size and clout would give it bargaining advantages that no private plan could match. In any event, neither of these reimbursement methodologies would likely be the last word. The bill gives the government plan blanket authority to establish reimbursement rates for providers unilaterally as long as they are "innovative."^[21] Finally, in competing with private plans, the government plan will enjoy one overriding advantage: Because the government can force the taxpayer to make up any shortfalls, the government plan can charge premiums that do not cover its costs. The bill requires the government plan to charge premiums as necessary to meet its costs, plus a margin for contingencies.^[22] However, political realities and the pressure to provide "affordable" insurance could result in this being disregarded or fudged. How costs are calculated will undoubtedly be complex and controversial. The government plan could charge less than its costs because the U.S. taxpayer--initially, lenders to the federal government--could be tapped. Private plans do not have the ability to lower prices below cost and tax the taxpayer to make up the difference. The resulting taxpayer subsidies to the government plan could easily make Fannie Mae and Freddie Mac look like careful and disciplined actors in the mortgage market.^[23] Furthermore, unlike the proposed government plan, they were not even government agencies when they were bailed out. Conclusion In a number of ways, the America's Affordable Health Choices Act would fail to "ensur[e] a level playing field." It is unclear whether the government plan would be subject to a number of requirements that the private plans would be required to meet. It would appear to give the HHS Secretary and the Health Choices Commissioner the discretion to decide these ambiguities in favor of the government plan and to find that various requirements do not apply to the government plan because of its overriding mission to offer a low-cost plan. However, even without including

these potential advantages, the government plan would clearly be free of a number of requirements and expenses that private plans face.^[24] Happy talk of creating a level playing field between the government insurance plan and private plans should be viewed with strong skepticism and even disbelief. The government plan would be heavily favored, leading to the marginalization of the private insurance market and the creation of a de facto single-payer system—a nationalized health system.

Public Option fails under Trump – he will circumvent or roll back

Mike Cummings, 07-26-2017, "Assessing the healthcare debate, with Jacob Hacker," Yale News, <https://news.yale.edu/2017/07/26/assessing-healthcare-debate-jacob-hacker>, Cummings quoting Jacob Hacker, a Yale Political Science correspondent

I would argue that we should move toward the system I proposed in the 2000s, which provided the template for the more progressive versions of what became the Affordable Care Act. It's worth remembering that President Obama initially supported a much more extensive and robust system and what emerged from the legislative process had been whittled down to something that could pass through the gauntlet of interest groups. What did those more robust policies contain? They all had a public option — a health-insurance plan modeled after Medicare that would be available to anyone who is seeking coverage through the so-called health insurance exchanges. This would mean that anyone who didn't have coverage through their employer would have access to a Medicare-like plan that offers a broad choice of physicians with reasonable rates and low administrative costs. When I talk to Trump supporters about healthcare, which I do more often than you might think, they often say they oppose the ACA's requirement that individuals obtain health insurance, but they would be fine with giving everyone access to Medicare. There are ways that Medicare can transcend the partisan divide because it is so familiar to people — their family members use it; it is simple and intuitive; and it gives people a choice between private and public plans. There are ways that Medicare can transcend the partisan divide because it is so familiar to people ..." Creating this more extensive system would require three things. First, you need to have Medicaid expansion in all the states. Second, employers either have to provide health insurance or help enroll workers in the new Medicare-like public plan. Finally, you should have this public insurance plan available nationwide. If you did this, the only people who would lack health insurance would be those who fall through the cracks of Medicaid and have no ties to the workforce. That's a fairly small population. Is this politically feasible? This can't happen with Donald Trump in the White House.

Public option can't lower prices---it just bankrupts the health care industry.

McArdle 16. (Megan McArdle is a Bloomberg View columnist. She wrote for the Daily Beast, Newsweek, the Atlantic and the Economist and founded the blog Asymmetrical Information. She is the author of "'The Up Side of Down: Why Failing Well Is the Key to Success.' Obamacare's Public Option Is No Longer Defensible. August 19, 2016. <https://www.bloomberg.com/view/articles/2017-06-13/he-voted-to-impeach-clinton-this-looks-bigger>)

At the moment, their cost structure is covered by a mix of public insurance paying lower reimbursement rates and private insurance offering higher reimbursements. Hospitals and medical practices manage that balance quite carefully to ensure that they can cover salaries and overhead. If the individual market is taken over by a public insurer paying less than they're currently getting, how many hospitals go into the red? How many doctors decide that they can no longer afford to take any public insurance? In short, while a public option might appear to fix one problem, that's a mirage: The

"problem" it would fix does not exist, and worse yet, it would create new problems. Health care regulation often has this problem, which is why much-heralded reforms so often fail to live up to their promise. Keeping costs down turns into a giant game of whack-a-mole 2 : You knock them down in one area, and they just show up somewhere else. Or they show up as politically toxic shortages that have to be fixed by ... spending more money. There are two unavoidable realities of making the American health-care system less costly: Americans must use less care, and our nation's legion of well-paying, stable jobs in the health-care sector need to be both less numerous and less well paid. What no one can figure out is how to generate the political will to make this happen. The public option doesn't fix that political problem. The public option was best sold as a way to keep insurers from taking excess profits off of a customer base that was required to buy their product. But as it turns out, that's the exact opposite of the problem we actually have. Which makes it a little mystifying that the public option is still seen as the solution. Somehow in supporters' minds, it has become a harmless homeopathic remedy that will cure any disease that ails you. In medicine, when we see such claims, most of us know that we're looking at a useless quack nostrum. In policy, we should be similarly skeptical of miracle cures.

Political pressure ensures it can't solve.

McArdle 16. (Megan McArdle is a Bloomberg View columnist. She wrote for the Daily Beast, Newsweek, the Atlantic and the Economist and founded the blog Asymmetrical Information. She is the author of ""The Up Side of Down: Why Failing Well Is the Key to Success." Obamacare's Public Option Is No Longer Defensible. August 19, 2016. <https://www.bloomberg.com/view/articles/2017-06-13/he-voted-to-impeach-clinton-this-looks-bigger>)

Could a "public option" fix the problems on the exchanges? More precisely, the question is: What problem would a public option solve? Way back in 2010, when the idea of a government-run nonprofit health insurance option was hotly debated, supporters gave three answers to that question: A public option does not need profits, so it can sell insurance cheaper than an insurer that wants to mark up coverage for profit margin. A public option will have lower administrative costs than a private insurer. A public option can force providers to accept below-market reimbursements for their services. The first argument turns out to be irrelevant, because with the exception of Medicaid managed-care plans, few insurers seem to be taking sizeable profits out of the exchanges. Indeed, since the public option was conceived as self-funding (meaning it covers its costs out of premiums, with no subsidies), there's a high risk that the public option would prove as doomed as the co-ops, because it would have neither the experience in caseload management to make money nor the other lines of business to subsidize losses on the exchanges. However, supporters argue that a public option would have competitive advantages that would allow it to break even where others are currently losing money. One of those competitive advantages is lower administrative overhead -- in theory, at least. I've already outlined, however, why I'm skeptical of this: While Medicare does have lower administrative costs than insurers, a lot of that benefit lies either in outsourcing normal administrative costs to other parts of the government (where they are still costly, but not on Medicare's books) or in not doing things that insurers have to do, like all the boring customer service and billing that comes with selling to the public, rather than enrolling every citizen over the age of 65. And then there are provider prices. Medicare pays providers less than private insurers. The idea is that the public option could pay more than Medicare, but less than private insurers (say, Medicare rates plus 5 to 10 percent), and thereby offer a cheaper product than private insurance. In some sense, it's hard to argue with this: A public option could do this. In theory. But ... if this idea is so clever, why haven't insurers done it? Probably because they will have difficulty finding enough

providers who will accept those reimbursements. Now, the public option could, with legal support, perhaps force providers to take those rates -- say "If you don't accept public option patients, you can't see Medicare patients either." The problem is that if you try that, all the groups who would be affected: hospitals, doctors, auxiliary service providers, health-care workers' unions and so forth -- will descend upon their legislators with the white-hot fury of a thousand suns. These folks are well organized. They are extremely mediagenic. No lawmaker wants to be seen cutting the salaries of nurses in the neonatal intensive care unit.

Plan causes massive tax hikes---passed on to consumers

Nascimento 2016 (Nathan, senior policy adviser at Freedom Partners Chamber of Commerce, "Not an Option"

<https://www.usnews.com/opinion/articles/2016-08-31/the-public-option-would-worsen-obamacare-health-care-failures>)

. Even while praising a potential public option in 2009, Obama acknowledged "legitimate concerns" on the part of private insurers who wouldn't be able to compete with a plan "subsidized by taxpayers endlessly." Those concerns aren't any less legitimate now. A public option insurance plan can set whatever prices the government chooses and would have bargaining power backed by regulatory and legislative fiat. Furthermore, since it's backed by the American taxpayer, the public option allows the government to hide its true cost, lowering premiums while forcing taxpayers to pick up the tab. The end result would be to crowd out private insurance altogether. As health care scholar Michael Cannon at the Cato Institute notes, "unfair advantages are inevitable" with the public option. Sure enough, when the public option was still under consideration in 2009, the health care consulting company The Lewin Group determined that its implementation would shift nearly 120 million Americans into government insurance. The Obama administration has been trying something similar to the public option for years now, in the form of Obamacare's 24 nonprofit insurance providers called co-ops. Their government-conferred advantages allowed them to offer plans with some of the lowest premiums on the exchanges, discouraging traditional insurers from competing in the same markets. Yet the co-ops' approach quickly proved unsustainable. The majority of the 24 state co-ops have ceased operations due to financial difficulties (and one never opened its doors at all), sending shock waves through the insurance market in spite of over \$1.5 billion in taxpayer funded loans and grants. This bears directly on the public option. Unlike co-ops, the government would deem it "too big to fail," leaving taxpayers to cover the public option's inevitable losses. Americans would be constantly subsidizing a health-insurance plan that can't compete on its own, likely costing us billions of dollars year after year. What's even more concerning is that the public option is little more than another step on the road to nationalizing American health care under a European-style single-payer system. Don't take my word for it; supporters of the public option admit as much. The author of the precursor to the public option titled her proposal "Getting to a Single Payer System Using Market Forces: The CHOICE Program." Former Democratic New York Rep. Anthony Weiner, a frequent advocate for single-payer insurance, eventually settled for demanding a public option, casting it in terms of not "[letting] the perfect be the enemy of the good." And Democratic Sen. Bernie Sanders – the most prominent supporter of single-payer health coverage in recent memory – recently endorsed Hillary Clinton's public option proposal. But haven't we learned our lesson with Obamacare? Millions of Americans are facing higher costs and fewer choices thanks to its top-down, one-size-fits-all approach. The public option would only make the situation worse by shifting more costs to taxpayers and killing private health insurance altogether. If politicians want to push for a single-payer system, we should have that debate. In the meantime, single-payer advocates should stop paying lip service to consumer choice when really they're just putting nails in its coffin.

Public option fails to increase revenue

Skala 9 --- former senior research associate Physicians for a National Health Program. He is currently a Juris Doctor candidate and Harry L. Kinser Scholar for Health Law at Northwestern University School of Law (Nicholas Skala, 6-16-2009, "Public Option' Pales Next to Single Payer," Common Dreams, <https://www.commondreams.org/views/2009/06/16/public-option-pales-next-single-payer>, accessed 7-17-2017)

The following remarks were delivered to a closed-door meeting the Congressional Progressive Caucus on June 4, 2009: Today the Congressional Progressive Caucus faces a choice. That choice is whether Members should maintain their unflinching support for single-payer, or to accede to intense political pressure to support the plan currently being developed in Congress under the direction of President Obama: a mandate for Americans to purchase an insurance plan from a massive new regulatory “exchange,” with one plan potentially being a “public option.” The difference between these choices could not be more stark: single-payer has at its core the elimination of U.S.-style private insurance, using huge administrative savings and inherent cost control mechanisms to provide comprehensive, sustainable universal coverage. The “public option” preserves all of the systemic defects inherent in reliance on a patchwork of private insurance companies to finance health care, a system which has been a miserable failure both in providing health coverage and controlling costs. Elimination of U.S.-style private insurance has been a prerequisite to the achievement of universal health care in every other industrialized country in the world. In contrast, public program expansions coupled with mandates have failed everywhere they’ve been tried, both domestically and internationally. Many progressives accept that the “public option” is inferior to a single-payer system, yet support it because of its perceived political expedience. It is my aim today to convince you that the “public option” program currently being developed is not only bad health policy, but bad health politics. On two separate occasions last month, physicians and nurses were dragged from the Senate Finance Committee in handcuffs for demanding that single-payer be considered in our nation’s health reform debate. These were American doctors and nurses, people who care for patients, people who want to practice medicine, not protest and disrupt Congress. But these professionals risked their careers and their freedom. They did this not because they thought that the “public option” was “good” and single-payer “better.” They did it because they are firmly convinced, by well-established health policy science, that the so-called “public option” has no hope of remedying the systemic defects that cause their patients to suffer and die, sometimes before their very eyes. Millions of dollars have been spent by political advocacy groups to commission polls and statistics “proving” that their health reform is “politically feasible.” Yet political winds do not make good health policy. Careful examination of science and experience do. And it is in the science and experience that we see that single-payer offers the only way to truly comprehensive, universal and sustainable health care, and that “public option” schemes offer only more of the same: tens of millions of uninsured, rapidly deteriorating coverage, an epidemic of medical bankruptcy, and skyrocketing costs that will eventually cripple the system. First, because the “public option” is built around the retention of private insurance companies, it is unable - in contrast to single-payer - to recapture the \$400 billion in administrative waste that private insurers currently generate in their drive to fight claims, issue denials and screen out the sick. A single-payer system would redirect these huge savings back into the system, requiring no net increase in health spending. In contrast, the “public option” will require huge new sources of revenue, currently estimated at around \$1 trillion over the next decade. Rather than cutting this bloat, the public option adds yet another layer of useless and complicated bureaucracy in the form of an “exchange,” which serves no useful function other than to police and broker private insurance companies. Second, because the “public option” fails to contain the cost control mechanism inherent in single-payer, such as global budgeting, bulk purchasing and planned capital expenditures, any gains in coverage will quickly be erased as costs skyrocket and government is forced to choose between raising revenue and cutting benefits. Third, because of this inability to control costs or realize administrative savings, the coverage and benefits that can be offered will be of the same type currently offered by private carriers, which cause millions of insured Americans to go without needed care due to costs and have led to an epidemic of medical bankruptcies. Supporters of incremental reform once again promise us universal coverage without structural reform, but we’ve heard this promise dozens of times before. Virtually all of the reforms being floated by President Obama and other centrist Democrats have been tried, and have failed repeatedly. Plans that combined mandates to purchase coverage with Medicaid expansions fell apart in Massachusetts (1988), Oregon (1992), and Washington state (1993); the latest iteration (Massachusetts, 2006) is already stumbling, with uninsurance again rising and costs soaring. Tennessee’s experiment with a massive Medicaid expansion and a public plan option worked - for one year, until rising costs sank it. The Federal Employee Health Benefit Program (the model for a health insurance exchange) leaves hundreds of thousands of federal workers uninsured, and has proven unable to contain costs. Negative results in a recent series of randomized trials explodes the hope that chronic disease management will cut costs. And the CBO has thrown a wet blanket on the notion that electronic medical records save money. As Drs. David Himmelstein and Steffie Woolhandler, co-founders of Physicians for a National Health Program, have remarked, a public plan option does not lead toward single-payer, but toward the segregation of patients, with profitable ones in private plans and unprofitable ones in the public plan. A quarter-century of experience with public/private competition in the Medicare program demonstrates that the private plans will not allow a level playing field. Despite strict regulation, private insurers have successfully cherry-picked healthier seniors, and have exploited

regional health spending differences to their advantage. They have progressively undermined the public plan - which started as a single-payer system for seniors and have now become a funding mechanism for HMOs - and a place to dump the unprofitably ill. Progressive supporters of the "public option" readily concede that single-payer is a superior system. Indeed, their response to evidence that their plan won't work is to commission more charts and graphs emphasizing its political feasibility. The "public option" is truly the embodiment of health policy designed by sound bytes, cobbled together from snippets of information gathered from focus groups and public opinion polls, and centered around well-polled buzzwords such as "choice" and "shared responsibility." Such a plan may be enough to excite the political classes in Washington, who care more about what they think can pass the Congress than what will actually deliver universal, comprehensive health care for all. But doctors and nurses, the people who actually work in the health system, see right through it. They are going to jail because they know that this plan won't work for their patients.

Public option doesn't increase access

Cannon 9 --- director of health policy studies at the Cato Institute and coauthor of "Healthy Competition: What's Holding Back Health Care and How to Free It" (Michael Cannon, 8-6-2009, "Fannie Med? Why a **"Public Option"** Is Hazardous to Your Health," Cato Institute, <https://object.cato.org/sites/cato.org/files/pubs/pdf/pa642.pdf>, accessed 7-7-17)

Cost Containment vs. Spending Containment Advocates of a new government health care program also claim that government contains overall costs better than private insurance. Jacob Hacker writes, "public insurance has a better track record than private insurance when it comes to reining in costs while preserving access. By way of illustration, between 1997 and 2006, health spending per enrollee (for comparable benefits) grew at 4.6 percent a year under Medicare, compared with 7.3 percent a year under private health insurance." 42 In fact, looking at a broader period, from 1970 to 2006, shows that per-enrollee spending by private insurance grew just 1 percentage point faster per year than Medicare spending, rather than 2.7 percentage points. 43 That still omits the 1966–1969 period, which saw rapid growth in Medicare spending. More importantly, Hacker's comparison commits the fallacy of conflating spending and costs. Even if government contains health care spending better than private insurance (which is not at all clear), it could still impose greater overall costs on enrollees and society than private insurance. For example, if a government program refused to pay for lifesaving medical procedures, it would incur considerable nonmonetary costs (i.e., needless suffering and death). Yet it would look better in Hacker's comparison than a private health plan that saved lives by spending money on those services. Medicare's inflexibility also imposes costs on enrollees. Medicare took 30 years longer than private insurance to incorporate prescription drug coverage into its basic benefits package. The taxes that finance Medicare impose costs on society in the range of 30 percent of Medicare spending. 44 In contrast, there is no deadweight loss associated with the voluntary purchase of private health insurance. Hacker nods in the direction of nonspending costs when he writes, "Medicare has maintained high levels of . . . patient access to care." 45 Yet there are many dimensions of quality other than access to care. It is in those areas that government programs impose their greatest hidden costs, on both publicly and privately insured patients

Public option is not universal coverage---it leaves most out---conflating them wrecks precision

Hunting 10 – Sam Hunting, Town Committee Member, Orono, "On Public Option", Bangor Daily News, 3-17, <https://bangordailynews.com/2010/03/17/opinion/march-18-letters-to-the-editor/?ref=comments>

On public option

I write to correct an error in Susan Goodwillie Stedman's OpEd of March 13 on health care. She wrote: "We are the only industrialized, western society that doesn't have universal health care — known here as the public option."

The so-called "public option" is not "universal health care." In fact, the "public option" never has been clearly defined. It began as an academic proposal from policy entrepreneur Jacob Hacker that would have included 130 million enrollees in a Medicare-style program. It ended as House legislation that would have covered 9 or 10 million, a number clearly insufficient to bring pressure to bear on the insurance companies, its ostensible rationale.

At all times, the public option was one component of the administration's larger, market-based solution, and in no case was coverage ever universal; in some proposals, as many as 21 million people were left out.

Other countries have achieved truly universal coverage with the centrist single payer solution (Canada) or with fully socialized medicine (the UK), and achieved better health outcomes at half the per capita cost. In this country, the equivalent solution would be Medicare for all. I'm at a loss to understand how Stedman, who seems eminently qualified, could conflate the "public option" with universal coverage.

The public option only affects those already buying through ACA exchanges---it's far short of universal coverage

Gaffney 17 [Adam Gaffney Instructor in Medicine at Harvard Medical School, and a staff physician at the Division of Pulmonary and Critical Care Medicine at the Cambridge Health Alliance, 7-19-2017 <https://www.jacobinmag.com/2017/07/trumpcare-obamacare-repeal-public-option-single-payer>]

But here again lies one of the public's option's cardinal flaws: whatever it does for those buying insurance on the Obamacare marketplaces (which I'll return to in a minute), it does basically nothing for the large majority of the nation not insured through them. The so-called "Obamacare" plans cover some 12.2 million enrollees — a substantial number of people to be sure, but still a very small fraction of the population.

What would a public option do, for example, for the 28.6 million US residents who are uninsured? According to the Congressional Budget Office's (CBO) 2013 scoring of a public option added to the ACA marketplaces, the answer is nothing: the public option, the CBO estimated, "would have minimal effects . . . on the number of people who would be uninsured."

The goal of single-payer is to reduce that 28.6 million figure to zero; under the public option — at least according to this admittedly old CBO score of one particular variation of the public option — the number wouldn't so much as budge. Perhaps a more ambitious public option could do a bit better. Nonetheless, it's not clear that even a more robust plan would be a step toward universal coverage.

And how about for the underinsured? The roughly half of the nation currently covered through their employer saw a 2016 deductible that was 300 percent higher than a decade ago. Such cost-shifting of health care costs to workers is a major cause of financial suffering, as well as deferred medical care. Yet the public option would do nothing for the great majority of these families.

A longstanding aim of universal health care advocates — stretching back to the German Social Democrats' 1891 Erfurt Program, which called for “[f]ree medical care, including midwifery and medicines” — has been to eliminate out-of-pocket payments (for example, copayments and deductibles) at the time of health care use. In Canada and the United Kingdom, this goal has largely been achieved: most health care remains free when patients use it. The public option, however, would do little to nothing to bring us closer to this goal.

Con

Costs

General Cost Increases/Sending Links

Net increase in spending

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

KEY POINTS Both liberal and conservative think-tanks have estimated that a single-payer program would increase federal spending by approximately \$32 trillion over a decade. Federal spending would rise in part because provisions provisions of the plan—eliminating cost-sharing, and a very expensive benefit package—would encourage individuals to consume more care than they need. Single payer would also extend health benefits to more people, including individuals unlawfully present in the United States, and potential benefit tourists seeking to capitalize upon “free” health care funded by American taxpayers. Potential sources of savings, like reduced administrative costs, cannot offset the extra spending caused by additional demand for health care—unless the federal government sets provider payments very low, or otherwise restricts the available supply of care. Multiple data points indicate that recipients often do not value the government-provided health coverage they have now, suggesting that the enormous expense of a single-payer plan would not represent a good value for taxpayers' money. The number seems almost too large to comprehend. \$32 trillion—or, to be more precise, \$32,000,000,000,000. That sum exceeds the United States' entire economic output in 2018 by about 40%, or roughly \$12 trillion.¹ That means 40% more than all the goods and services all Americans, in the world's largest economy, produce in a year. Yet that number also represents the amount by which multiple studies estimate a single-payer program would increase national taxpayer spending over the course of a decade.

Medicare for All means a net increase of a \$1 trillion in spending

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

Chapter 4 then focuses on how to finance this level of health care spending for Medicare for All—i.e. \$2.93 trillion in total costs. There will be two sources of financing for Medicare for All. The first is the same public health care revenue sources that presently provide about 60 percent of all U.S. health care financing. These include Medicare and Medicaid, which together finance nearly 40 percent of all health care funding. It also includes tax subsidies for health care expenditures by individuals and households, which equal about 10 percent of total funding. Overall, existing public sources of funds will provide \$1.88 trillion to finance Medicare for All. That means that the remaining \$1.05 trillion to fund Medicare for All will need to be provided by new revenue sources. Table S3 summarizes these figures. For the purposes of this analysis, we assume that the target for additional funding will be \$1.08 trillion, i.e. \$30 billion more than our estimate of the additional revenue required. By incorporating this additional \$30 billion into our estimated revenue requirement, we are targeting that Medicare for All will operate with a surplus equal to about 1 percent above the total system budgetary requirement of \$2.93 trillion. Even

when we assume that our additional revenue target is \$1.08 trillion rather than \$1.05 trillion, it is still the case that financing Medicare for All will entail an overall level of funding that is nearly 10 percent lower than the funding requirements for the existing U.S. health care system. In working through the total revenue needs for Medicare for All, it is useful to keep in mind this overall framework as a basic reference. That is, because Medicare for All is able to operate at a funding level that is 9.6 percent below the current overall funding level for U.S. health care, it implies that, on average, all households and private businesses will be able to pay into Medicare for All about 9.6 percent less than they are

Medicare for All would cost 50 trillion

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

Medicare for All would be not just disruptive but expensive, too. A study by Charles Blahous, a scholar at the Mercatus Center, estimated that Medicare for All would add between \$32.6 trillion and \$38.8 trillion to the federal budget over its first 10 years. The total cost to the federal government could run between \$54.6 trillion and \$60.7 trillion over its first decade, according to Blahous.²⁷ Research from the left-leaning Urban Institute has arrived at similar numbers.²⁸ It's hard to fathom how big those figures are. The entire federal government is on track to spend a grand total of \$57.8 trillion over the next decade. That means Medicare for All would increase total federal spending by more than 55 percent.²⁹ Even doubling individual and corporate federal income tax receipts would be insufficient to cover the cost of Medicare for All.³⁰ To finance his bill, Senator Sanders has floated several ideas, including a new 4 percent income tax for families, hikes in payroll and estate taxes, and new fees on major financial institutions.³¹ Sanders, Jayapal, and company are well aware of these estimates. That's why they haven't bothered to release detailed financing plans for their bills. Instead, they claim that a 14-figure price tag is a deal. They say Medicare for All would reduce the country's health bill by \$2 trillion over 10 years by empowering the government to drive a harder bargain with pharmaceutical companies and reduce administrative waste in our current multi-payer system.³² But the multitrillion-dollar estimates that Sanders and friends decry are almost certainly low. The Mercatus Center report, for example, gave Medicare for All the benefit of the doubt—and assumed its proposed payment cuts would go off without a hitch. Blahous told the Washington Post that "to lend credibility to the \$2 trillion savings number, one would have to argue that we can cut payments to providers by about 40 percent at the same time as increasing demand by about 11 percent."³³ It's improbable that hospitals, doctors, and other providers would agree to do more work and receive less money in return. But that's the assumption behind Medicare for All. The bill's purported administrative savings are unlikely to materialize, either. Cheerleaders for government-run care cite the current Medicare program's purportedly low administrative costs—just 1.1 percent of total spending in 2018.³⁴ But that figure is misleading. For starters, other government agencies help administer Medicare. The IRS collects the taxes that fund it. The Department of Health and Human Services pitches in with office space and accounting help. The money those agencies spend helping Medicare doesn't appear on the program's balance sheet. Second, Medicare's current beneficiaries are seniors and a small number of disabled individuals, who generally have much higher health costs than the general population. So by necessity the program devotes a much larger share of its expenses to medical claims than a private insurer with a person of average health might. This reality doesn't tell us whether Medicare is more efficient than private insurers. It just reveals that the

program spends a lot on medical care. Third, Medicare is beset by fraud. In 2017, the agency made \$52 billion in “improper payments.”³⁵ That’s about 7 percent of the program’s total expenditures that year.³⁶ Reducing administrative costs is pointless if it allows health care providers to submit fraudulent claims with impunity. In addition, many of Medicare for All’s supposed administrative “savings” will simply be offloaded onto providers.³⁷ Hospitals today spend close to \$40 billion a year complying with federal rules and regulations. In 2016 alone, the federal government produced nearly 24,000 pages of regulations governing hospitals and acute care providers.³⁸ Medicare for All would require providers to regularly submit reams of additional data to the feds, including “annual financial data, the number of registered nurses per staffed bed, and spending on health IT.”³⁹ Then there are the costs associated with the destruction of the private health insurance sector. Jaypal acknowledges that about 1 million people who currently work in the insurance industry could lose their jobs.⁴⁰ She proposes setting aside up to 1 percent of her national health budget to assist these workers.⁴¹ That’s billions of taxpayer dollars. Further, the government would have to hire scores of employees to run Medicare for All. Finally, single-payer health care’s advocates ignore the ugly fiscal history of federal health care programs. Medicare suffered massive cost overruns almost as soon as it launched in 1965.⁴² Hospital costs increased 21.9 percent in the program’s first year and continued to grow an average of 14 percent in each of the next five years.⁴³ Two years after Medicare opened for business, President Lyndon Johnson had to promise in his State of the Union address that he’d tackle runaway medical price inflation.⁴⁴ Pipes, Sally . False Premise, False Promise (pp. 20-21). Encounter Books. Kindle Edition.

Single payer costs

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

In calculating the tax increases necessary to finance single-payer’s increased spending, the Mercatus Center’s study helpfully quantified the new program’s under-funding. During the decade from 2022 through 2031, the study estimates that federal health expenditures under the single-payer program would total \$54.6 trillion.³⁴ By comparison, the paper uses Congressional Budget Office estimates for federal spending on health care—net federal spending for Medicare, Medicaid, and Obamacare subsidies, along with the tax subsidies provided for employer-sponsored health insurance—to quantify the existing resources that the bill would re-purpose toward the new program. That spending totals \$21.9 trillion—or only 40.2% of the total estimated spending on the single-payer program.³⁵ As the Mercatus study also notes, current corporate and individual income tax rates would have to more than double to pay for all this proposed new spending, at a time when our nation already faces trillions of dollars in deficits to pay for existing government spending. Moreover, the Mercatus Center study uses a series of assumptions very favorable to single-payer supporters.³⁶ The Mercatus study does not assume any increase in spending from “benefit tourism”—that is, individuals traveling to the and Obamacare subsidies, along with the tax subsidies provided for employer-sponsored health insurance—to quantify the existing resources that the bill would re-purpose toward the new program. That spending totals \$21.9 trillion—or only 40.2% of the total estimated spending on the single-payer program.³⁵ As the Mercatus study also notes, current corporate and individual income tax rates would have to more than double to pay for all this proposed new spending, at a time when our nation already faces trillions of dollars in deficits to pay for existing government spending. Moreover, the Mercatus Center study uses a

series of assumptions very favorable to single-payer supporters.³⁶ The Mercatus study does not assume any increase in spending from “benefit tourism”—that is, individuals traveling to the United States, whether temporarily or permanently, to access “free” health care. However, it does assume that the new single-payer program can 1) drive down drug costs by increasing usage of generic drugs, 2) generate significant savings through lower administrative costs, and 3) force both hospitals and doctors to accept lower, Medicare-level reimbursement rates. If any of the Mercatus Center’s very favorable assumptions about single payer prove incorrect, total spending on the new program would rise significantly. For instance, the Urban Institute’s estimate included \$2.9-\$3.6 trillion in spending on long-term supports and services—services not included in the Mercatus study, but recently added to the single-payer bill.³⁷ Including this additional spending would raise the cost of the single-payer program even further—and worsen its under-funding.

There will be new spending

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

NEW ENTITLEMENT WILL RAISE SPENDING One particular provision in the single-payer bills will lead to a sizable increase in overall health spending. While prior iterations of single payer did not pay for long-term care supports and services, the bills introduced in 2019 now include these services, raising program spending. The House and Senate versions of the legislation take slightly different approaches to providing long-term care benefits. The House bill would have taxpayers pay for such supports and services, whether provided in an institutional setting (i.e., a nursing home) or in a home-based setting; however, it requires that “unless an individual elects otherwise...recipients shall receive home and community-based” services.¹⁷ By contrast, the Senate legislation only provides for coverage of home and community-based services through the federal program. Under the Senate bill, states would retain coverage of nursing home benefits through their existing Medicaid systems, but nursing home residents would receive health-care benefits through the federal program.¹⁸ In both cases, however, the single-payer program will result in higher spending. Under current law, Medicare covers long-term care only in very limited circumstances. While state Medicaid programs do cover long-term supports and services, individuals must meet income and asset tests to qualify for coverage. Moreover, while state Medicaid programs must cover nursing home care as a mandatory benefit, they may cover home and community-based services as an optional benefit.¹⁹ Because individuals must meet asset and income tests to qualify for Medicaid coverage of long-term supports and services, and because most state Medicaid programs limit their coverage of home and community-based care, many individuals who might otherwise seek such services do not. Instead, unpaid care—whether from friends, relatives, or both—often serves as a substitute for formal, paid care. Estimates suggest this unpaid care totaled \$470 billion in 2013—more than the \$366 billion in formal spending on such services as of 2016.²⁰ However, if a single-payer system pays for long-term supports and services, many households that rely solely on unpaid care now would likely use them. This change means broader coverage for long-term care would raise health-care spending. The CBO report on single payer noted that broader coverage of home-based care would result in a “particularly large,” and therefore costly, shift from unpaid and informal care to paid, formal care.²¹

The Urban Institute estimated that covering long-term supports and services would cost approximately \$3 trillion over a decade.²² The Rand Corporation concluded that providing these services as a covered benefit would triple—lead to a 200% increase in—spending on formal home care, and a 10% increase in spending on nursing home care.²³ Of course, the new government health plan could mitigate this rise in spending the way state Medicaid programs do now, by restricting access to benefits. Because states are not required to cover home and community-based services, they can—and many do—impose waiting lists for care. At present, more than 707,000 individuals with disabilities remain on Medicaid waiting lists for home and community-based services.²⁴

Tax Increases (Including Capital Gains)

Taxes will increase

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

One of the problems with single-payer systems is that nobody knows exactly how much their care costs. In Canada and the United Kingdom, health costs are covered mostly by general tax revenue.¹¹ Canadians and Britons may know what they pay in taxes but have little idea how their money filters through the health care system. They may not get a bill when they check out of the doctor's office or hospital—but they're paying handsomely for their care. Consider just some of the taxes Canadians and Britons must shoulder. There's the value-added tax (VAT)—a wide-ranging sales tax of sorts added onto the value of just about every good or service as it passes through a supply chain.¹² All Canadians face a 5 percent federal VAT, called the goods and services tax. Additionally, many provinces have chosen to adopt some form of a provincial sales tax (PST), generally around 8 percent. In provinces with their own PST, the two taxes are blended into the harmonized sales tax, which usually amounts to 13 percent overall. New Brunswick and Newfoundland residents face a 15 percent VAT.¹³ Great Britain has broadly higher income tax rates than does the United States.¹⁴ And each Canadian province forces at least some of its residents to pay double-digit income tax rates. Manitoba taxes its residents' first dollar of income at 10.8 percent!¹⁵ In the United States, only California maintains an income tax rate north of 10 percent—and only on individuals making more than \$286,000. This “temporary” millionaires’ tax passed as a ballot initiative in 2012 but has since been extended to 2030.¹⁶ In 2015, taxes made up just 26 percent of the U.S. GDP. In Canada and the United Kingdom, taxes accounted for closer to 35 percent of GDP.¹⁷ The tax burden is higher in these countries because single-payer health care is so expensive. According to the Fraser Institute, single Canadians paid an average of C\$4,544 in taxes for health care in 2019. That number jumps to C\$13,163 for childless couples. The addition of a single child causes that burden to rise to C\$13,208. And the average family of four pays just over C\$13,300 in taxes for health care.¹⁸ Canadian health care taxes are on the rise. Since 1997, they've risen close to 75 percent for childless couples, and close to 70 percent for the average family of four. Single parents with two children have seen their health care tax burden rise nearly 80 percent over that same period.¹⁹ Health costs are growing faster than the cost of just about everything else Canadians purchase. As the Fraser report notes, “Between 1997 and 2019, the cost of public health care insurance for the average Canadian family increased 3.2 times as fast as the cost of food, 2.1 times as fast as the cost of clothing, 1.8 times as fast as the cost of shelter, and 1.7 times faster than average income.”²⁰ In Britain, meanwhile, the NHS costs more than £5,000 per household each year. That per household cost is up 75 percent since 2000.²¹ And this figure will likely climb sharply. A report from two British think tanks determined that every British household would need to pay £2,000 more each year to keep the NHS running as the country’s population ages.²² We’ve seen the toll that staffing shortages take on patients in the United Kingdom. Addressing those shortages would be expensive, if the NHS ever got around to doing so. According to the Commonwealth Fund, the average general practitioner salary in the United Kingdom is US\$134,671. Multiply that by the 7,000 general practitioner vacancies anticipated by 2024, and the tab is a whopping \$945 million.²³ Of course, salaries aren’t the only potential costs facing the NHS. The Service is so desperate to get more doctors that it recently announced it will pay British doctors working

abroad more than £18,500 in “relocation support” to come back to the country. Officials are also trying to lure doctors out of retirement with special incentives.²⁴ Those added costs won’t be obvious to British citizens paying the bills.

Financing Medicare for All means increasing taxes, including capital gains taxes

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Financing Medicare for All. There will be two sources of financing for Medicare for All. The first is the same public health care revenue sources that presently provide about 60 percent of all U.S. health care financing, including funding for Medicare and Medicaid. Existing public sources of funds will provide \$1.88 trillion to finance Medicare for All. Given our estimate that the overall costs of Medicare for All will be \$2.93 trillion, the system therefore needs to raise an additional \$1.05 trillion from new revenue sources. We provide a set of illustrative financing proposals that, in combination, can generate \$1.08 trillion, thus producing a revenue surplus of about 1 percent for the system. Other approaches are also workable. We emphasize at the outset that, regardless of the specific funding framework utilized for Medicare for All, all households and private businesses will be able to pay into the system an average of 9.6 percent less than they are presently contributing to the U.S. health care system. This is, straightforwardly, because Medicare for All is able to operate at a funding level that is 9.6 percent below the current overall funding level for U.S. health care. Our proposals include the following: i Business health care premiums cut by 8 percent relative to existing spending per worker. Revenue generated = \$623 billion. All businesses that now provide health care coverage for their employees will be guaranteed to receive proportional benefits during Medicare for All's initial 2-3 years of operation. Firms that are not offering coverage for some or all of their employees would pay \$500 per uncovered worker. Small businesses would be exempt from these premium payments. We also develop proposals for either an 8.2 percent payroll tax or 1.78 percent gross receipts tax that would apply both to new businesses and more generally after the first 2-3 years under Medicare for All. Both of these measures would generate the same revenue level as the 8 percent premium reduction for those businesses now providing coverage. i 3.75 percent sales tax on non-necessities. Revenue generated = \$196 billion. This includes exemptions for spending on necessities in four areas: food and beverages consumed at home; housing and utilities; education and non-profits. We also include a 3.75 percent income tax credit for families currently insured through Medicaid. It is also the case that, on balance, other countries that provide universal health care generate superior health outcomes relative to the U.S. Another 2017 study summarizes some key evidence as follows: “In other countries, a shift to universal health care has been associated with reduced mortality. Specifically, 34 countries score higher than the USA on the Health Access and Quality Index, a metric based on amenable mortality, or death that could be averted with medical care. All of these countries provide a form of universal care. Medicaid. i Net worth tax of 0.38 percent. Revenue generated = \$193 billion. We propose that the first \$1 million in net worth are exempted from this net worth tax. The tax would therefore apply to only the wealthiest 12 percent of U.S. households. i Taxing long-term capital gains as ordinary income. Revenue generated = \$69 billion.

Increased capital gains taxes

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Amherst. He is also the founder and President of PEAR (Pollin Energy and Retrofits), an Amherst, MA-based green energy company operating throughout the United States, Economic Analysis of Medicare for All, [file:///Users/stefanbauschard/Downloads/Medicare_For_All_12.5.18%20\(1\).pdf](file:///Users/stefanbauschard/Downloads/Medicare_For_All_12.5.18%20(1).pdf)

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Long-term capital gains are gains earned on assets held for one year or longer. Currently, there are three tax rates on long-term capital gains: zero for those in the 10 or 15 percent marginal tax brackets; 15 percent for those in the 25 – 35 percent marginal tax brackets; and 20 percent for those in the top tax bracket. Short-term capital gains are already treated equally for tax purposes as ordinary income. In Table 20, we show our estimates as to the revenue potential from these four sources. As we see, within our proposed framework, about 58 percent of total revenue required would come from business premiums, amounting to about \$623 billion in total. The remaining 42 percent would come from individuals and family sources, for a total of \$458 billion. Among the individual/family sources, we see that the sales tax will generate \$196 billion and the net worth tax \$193 billion. Taxing long-term capital gains as ordinary income generates the remaining \$69 billion needed to reach the overall revenue total of \$1.08 trillion.

Single Payer would require massive tax increases – your assumptions of cost savings are politically absurd and empirically denied

Pollack, Professor at the University of Chicago School of Social Service Administration,

2015, (Harold, “Medicare for All — If It Were Politically Possible — Would Necessarily Replicate the Defects of Our Current System” Journal of Health Politics, Policy and Law 2015 Volume 40, Number 4: 923-931, published online before print June 29, 2015, doi: 10.1215/03616878-3150172, p925-926)

Then there is the minor matter of raising taxes by perhaps 8 percent of gross domestic product (GDP) as we move health care spending more fully onto public budgets. To Seidman’s credit, he acknowledges the need for a large tax increase to bring health care onto the public budget. This is a subject that often attracts embarrassed hand-waving among single-payer advocates. Seidman identifies important elements that should be in the mix: a payroll tax, a valued-added tax, an income tax surcharge. That is a heavy lift.

It may be an even heavier lift. Seidman’s essay claims that we might reduce health care spending from 18 percent to 15 percent of GDP. I find this politically implausible. We’re not going to wring nearly one-fifth out of our health care economy while we simultaneously impose radical changes to health care financing. Such contraction is the precise opposite of what we did in establishing Medicare. It will be a miracle if we hold medical spending steady at 18 percent given our aging population. In one 2013 analysis, Michael E. Chernew (2013: 861) calculates that “if the gap between inflation-adjusted per beneficiary Medicare spending and GDP growth per capita drops to zero—a level never sustained for a significant period—Medicare spending will rise from 3.7 percent of GDP to 5.1 percent in 2035.” Under any financing system, we will probably require substantially greater revenue to prevent health care from deeply damaging the federal budget. Neither political party has acknowledged this reality.

Although the electorate and its congressional representatives like to believe that they support fiscal discipline, the evidence to back up these protestations is thin. The ACA's most unpopular elements are those concerned with cost control.

or deficit reduction: the Independent Payment Advisory Board, the Cadillac tax, the employer mandate, reduced subsidies to Medicare Advantage plans, the medical device tax, reduced Medicare reimbursement rates to hospitals, the individual mandate. At least the first five of these items are unlikely, politically, to survive in current form.

High tax rates hurt the economy.

Carroll, Research Fellow at Tax Foundation, 2009 (Robert, "The Economic Cost of High Tax Rates", <https://taxfoundation.org/economic-cost-high-tax-rates/>, DoA 8/19/2017)

Economic Effects of High Tax Rates

High tax rates discourage work, saving and entrepreneurship. They also encourage taxpayers to rearrange their tax affairs to receive more of their compensation in less heavily taxed forms and to take greater advantage of the myriad tax preferences in today's tax code. For example, taxpayers can reduce their tax bill by financing more of a home purchase, receiving more of their compensation as tax-free fringe benefits, or rebalancing their investment portfolios towards tax-exempt state and local government bonds.

It's important to remember that every time a taxpayer makes a decision based on tax considerations rather than economic merit, we all lose. It wastes resources by redirecting them to less productive uses. The cost of high tax rates is not trivial. Research on the major changes in tax rates over the last several decades—the lower tax rates enacted in 1981, 1986 and 2001 or the higher tax rates enacted in 1993—finds that the behavioral responses can be large. This research generally finds that for every 1 percent decrease in the after-tax reward from earning income, taxpayers reduce their reported income by about 0.4 percent.

This does not mean that tax cuts pay for themselves. Rather, tax rate changes can have a profound effect on the size of the tax base, with lower tax rates increasing the size of the tax base and higher tax rates, such as those proposed by President Obama, shrinking the tax base. A shrinking tax base is not only suggestive of the economic costs of high tax rates, but also means that the government will take in less revenue than the casual observer might assume.

High Tax Rates Will Shrink the Federal Income Tax Base

Consider the combined effect of President Obama's proposal to raise the top tax rate from 35 percent to 39.6 percent and the new surtax. This means high-income households will receive 54 cents rather than 65 cents from every dollar they earn; that is, the after-tax reward from earning income falls by 17 percent. Based on the research mentioned above, with such large increases in tax rates, we can expect taxpayers facing the top tax rates to reduce their reported incomes by nearly 7 percent.

What is critically important from the government's perspective is that while it collects an extra 10 cents for every dollar subject to the higher rates, it loses over 45 cents for every dollar by which reported income falls due to taxpayers working less or otherwise reporting less income.

Overall, simulating the effect of the higher tax rates in 2011 shows that the federal government can expect to raise at most only 60 cents on the dollar. While "large" is always in the eye of the beholder, losing 40 cents on a dollar should cause us all to question this policy. Moreover, this is a cautious

estimate. It is based on the behavioral response estimated for the overall taxpaying population, even though high-income households are likely to be much more responsive. Thus, we might expect an even faster shrinkage of the federal tax base from these tax increases.

Effect of High Tax Rates on the Entrepreneurial Sector

The impact of the higher tax rates on the entrepreneurial sector is also particularly troubling. An often underappreciated feature of our tax system is that roughly one-third of all business taxes are paid by owners of flow-through businesses—the sole proprietorships, partnerships, and S corporations that are often small in size and entrepreneurial—when they file their individual tax returns. These businesses are an important source of innovation and risk taking. The relatively large size of this sector also distinguishes the U.S. from other developed nations and adds to the flexibility and dynamism of the U.S. economy as these businesses are highly capable of bringing new ideas and products to market.

Despite the importance of these businesses to the U.S. economy, they will bear a substantial portion of the higher tax rates. About one-quarter of taxpayers who derive at least 50 percent of their income from a flow-through business will be subject to the higher tax rates (see below table). Moreover, a substantial share of the new revenue—40 percent for the increase in the top two tax rates and 29 percent for the high-income surtax—can be attributed directly to the income reported for flow-through businesses by their owners.[5]

These tax hikes will destroy the economy and innovation – as tax rates get higher the damage rises dramatically

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The twentieth century provided two important observations on the determinants of long-run growth. The first observation is that the tax rates adopted by different countries are generally uncorrelated with their growth performance. So, are incentives to invest irrelevant for long-run growth? The second observation is that countries that drastically reduce private incentives to innovate and invest severely hurt their growth performance. One salient example is the performance of China between 1949, when communists took over and abolished property rights, and the introduction of reforms by Deng Xiaoping in 1979. Another prominent example is the performance of India under the "permit raj" that lasted from 1947 until the reforms introduced by Rajiv Gandhi and Narasimha Rao in 1984 and 1991, respectively. Interestingly, when these countries gradually restored modest incentives to invest, growth rates increased dramatically.¹ Here, incentives to invest seem to matter for growth. To reconcile these two observations, we propose a model in which the effects of taxation on growth are highly nonlinear. Low or moderate tax rates have a small impact on long-run growth rates. But as tax rates and other disincentives to investment rise, their negative impact on growth rises dramatically. To explain the source of this nonlinearity, it is useful to describe the structure of our

model. We combine the growth model proposed by Romer (1990) with the Lucas (1978) model of occupational choice. As in Romer (1990), Grossman and Helpman (1991), and Aghion and Howitt (1992), growth comes from innovation. As in Lucas (1978), the economy is populated by agents who differ in their ability as entrepreneurs/innovators. These agents decide optimally whether to become workers or innovators. Innovators earn profits from their patents, and these profits are subject to capital income taxation. Motivated by the plethora of evidence on the presence of right skewness in the distribution of patents, scientific paper citations, income, and profits, we assume that the distribution of entrepreneurial ability is skewed. Because of this skewness, most of the innovation in our economy comes from a small number of highly productive innovators, the Bill Gates and Steve Jobs of the model. Increasing the capital income tax rate reduces incentives to be an entrepreneur and generates exit from the innovation sector. But since the marginal innovator is much less productive than the average innovator, this exit has a small impact on the growth performance of the economy. In other words, the top entrepreneurs in our model are so productive that they are not deterred from innovating by low to moderate tax rates. As a result, there is a range of tax rates that are associated with similar growth outcomes. When taxes and other disincentives to innovate become high, high-quality entrepreneurs exit and the growth engine stalls. We use our model economy to compute the capital income tax rate chosen by the median voter and by a benevolent planner. We first show that even when the median voter is a worker, he chooses a tax rate on capital income on the flat region of the function relating the tax rate to the growth rate. The reason for this choice is that workers benefit from growth in wages that results from the innovation process and understand that high taxes would severely reduce growth prospects. Our model implies that punitive tax rates are unlikely to be adopted for extended periods of time in well-functioning democracies or, more generally, in political regimes whose decision makers value growth more than preserving the status quo or maintaining political control.² The optimal choices made by the median voter in our model generate a censored sample in which the observed variation in tax rates has a small impact on growth. So the model is consistent with the absence of a strong correlation between tax rates and growth that we observe in the data. One important implication of the model is that the lack of correlation between taxes and growth is not a global property that holds for all tax rates, but rather an artifact of the endogenous nature of taxation: tax rates that are highly detrimental to the growth process are generally not implemented. We relate our model to the recent work of Diamond and Saez (2011), who argue that the optimal marginal income tax rate for high-income individuals is 73 percent. We argue that the Diamond-Saez calculation suffers from an important shortcoming: it considers only the static effect of taxation on current tax revenue. Implicitly, this calculation ignores dynamic effects, that is, changes in the growth rate resulting from changes in tax rates. In our model these dynamic effects are small and can be safely ignored when tax rates are low. But it is exactly when tax rates are high, in the range recommended by Diamond and Saez, that these dynamic effects become important.

Life Expectancy Answers

US has higher cancer life expectancy rates and health care is just one factor

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

Single-payer supporters often claim that the United States' poor life expectancy rate compared to other developed countries reflects a poor health system, making the argument for socialized medicine. However, many other factors also affect Americans' health relative to other countries—for instance, our much more heterogeneous population and other countries found substantially higher colon cancer survival rates for American elderly seniors (those over age 75), in large part because screening did not decline with age in the United States.³² While other countries limit access to screening and treatment for older individuals in ways that raise death rates, the United States' death rates decline relative to its peers as seniors age, precisely because American seniors maintain access to treatments. Single-payer supporters often claim that the United States' poor life expectancy rate compared to other developed countries reflects a poor health system, making the argument for socialized medicine. However, many other factors also affect Americans' health relative to other countries—for instance, our much more heterogeneous population when compared to smaller European nations. Moreover, Americans' higher obesity rates appear to affect death and life expectancy rates, as do higher rates of violent deaths (both homicides and suicides).³³ These issues may provide some commentary on American society, but they do not directly speak to the merits of America's health-care system relative to its peers'. On that front, the United States has long boasted superior outcomes from cancer treatment—the leading cause of death in developed nations—than its European counterparts. For individuals diagnosed during the years 1995-1999, American patients had an average survival rate of 11.1 years, or nearly 16% greater than the 9.3 years faced by European patients.³⁴ The survival gap between American and European patients has remained constant going back for more than a decade.³⁵ Moreover, while Americans spend more on cancer treatment than Europeans, they also receive more benefits, in the form of longer survival times. From 1983 through 1999, American patients received a net financial benefit—that is, increased survival compared to their European peers, even after accounting for higher spending levels—of \$598 billion, or about \$43 billion per year.³⁶ Better access to treatment, better survival times, and more benefits to patients—the arguments for the American health system over single payer seem obvious, except to those on the left.

Jacobs, Chris. The Case Against Single Payer . Republic Book Publishers. Kindle Edition.

Life expectancy isn't largely determined by health care

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

LIVING (AND DYING) IN AMERICA Similarly—and perhaps counterintuitively—life expectancy isn't an accurate measure of the quality of a nation's health care system. That's largely because so many of the factors that influence life expectancy have nothing to do with health care. These are just the factors that drive down U.S. life expectancy. For example, the United States has a much higher homicide rate than

other developed countries. In 2016, there were 5.3 murders per 100,000 people in the United States.³⁴ That same year, the United Kingdom had just 1.2 murders per 100,000 people; Canada had about 1.7.³⁵ Americans are also more likely to die in car accidents. According to the WHO, there were over 34,000 “road traffic deaths” in the United States in 2013, compared to just over 1,800 in the United Kingdom and over 2,100 in Canada.³⁶ Per capita, the United States has nearly four times as many traffic deaths as the United Kingdom, and nearly twice as many as Canada. The suicide rate in the United States is higher than in Canada and almost double that in the United Kingdom.³⁷ Then there is America’s epidemic of drug overdoses. According to the United Nations Office on Drugs and Crime, in 2015 the United States had around 246 drug-related deaths per 1 million people aged 15–64.³⁸ Compare that to just under 105 per million in Canada in 2007, the most recent year for which data are available. The United Kingdom’s drug-related death rate was 67 per million people aged 15–64 in 2014—again, the most recent year for which data are available.³⁹ Unfortunately, drug-related deaths have only grown more common in the United States. The death rate from drug overdoses increased between 2013 and 2017 in all but three states.⁴⁰ These statistics are disheartening. And they have serious implications for public policy. But it’s hard to see how implementing single-payer health care in the United States would drive down the country’s rate of murders or traffic accidents. Even within the United States, health care doesn’t correlate all that much with life expectancy. A study in the Journal of the American Medical Association found that life expectancy varies from 66 to 87 years in the United States, mostly because of behavioral and socioeconomic factors. Only 27 percent of the difference can be attributed to health care.⁴¹ Economists Robert L. Ohsfeldt and John E. Schneider have calculated that the United States has a higher life expectancy than all other OECD countries after adjusting for fatal injuries.⁴² And what about the WHO’s all-encompassing health system rankings? The methodology leaves much to be desired. One-quarter of the ranking comes from life expectancy—a metric we now know to be flawed. Another 25 percent derives from “financial fairness.”⁴³ In other words, the WHO prizes health care systems that treat patients the same over those that treat them well. As a result, the rankings aren’t just flawed—they’ve stacked the deck in favor of single-payer systems.

US health care better than other countries

Sally Pipes, 2020, *False Promise: The Disastrous Reality of Medicare for All*, Pipes is the President & CEO, Pacific Research Institute .

Focus on actual health outcomes, and it’s clear the United States outperforms most other countries, especially those with single-payer care. Americans are healthier because our health care system devotes more resources to the best treatments, technology, and physicians. The United States may spend more on health care than other countries, but Americans are getting the most bang for their buck. This shouldn’t come as a surprise. Markets are the most efficient way to allocate scarce resources.

Rising demand for care will outpace supply

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

Medicare For All Master File

Obviously, this analogy has its limits. Few rational individuals would subject themselves to invasive, and potentially painful or dangerous, medical procedures just to "get their money's worth" out of the health-care system. But making health care so easy to access would encourage additional spending. In fact, as we shall soon see, two analyses of single-payer health plans assumed that demand for health care would rise so quickly that the available supply could not meet it.

Single Payer – if it reduces costs – does so by taking money away from the medical system – increased coverage will reduce actual access to care

Book, Heritage Foundation Senior Research Fellow specializing in Health Economics

2009, (Robert A, "Single Payer: Why Government-Run Health Care Will Harm Both Patients and Doctors", April 3, 2009, available at <http://www.heritage.org/health-care-reform/report/single-payer-why-government-run-health-care-will-harm-both-patients-and-accessed> 8/19/17)

What many fail to appreciate, however, is the extent to which the existence of multiple, competing payers prevents government payers such as Medicare from reducing their payment levels to much lower levels than prevail now. As it stands, a reduction in Medicare payment rates can induce physicians to drop Medicare patients and try to make their living from a higher percentage of (or even only) privately insured patients. This would inevitably result in reduced access to care for Medicare patients and thus political pressure from those patients for increased Medicare payments to improve access. The Medicare Model If Medicare or something like it were the "single payer"—the sole purchaser of health care—no such pressure would exist. If the single payer established lower payment rates, by definition physicians could not drop out and make their living from other patients, because there wouldn't be any other patients.^[3] The only alternative for a physician would be to cease the practice of medicine and either retire or find another profession. While this would certainly happen to some degree, a large percentage of physicians—who have invested many dollars and years of training in their practices—would be unable to find an alternative profession that is nearly as satisfying or as remunerative. The inevitable result would be much lower payment rates and lower income for physicians.^[4] Patients would suffer as well, especially in the long run. Because fewer highly talented people would be willing to undergo the years of training (under difficult working conditions and low pay) to become physicians, patients would suffer decreased access to health care and longer wait times. Lower payments would mean that physicians would invest less in advanced medical equipment and would likely spend less time with each patient. In addition, with fewer people undergoing the training necessary to conduct medical research, new treatments and cures would be developed at a slower rate, costing many lives. Medicare Payment Levels Medicare determines the level of its payments to physicians based on a complex formula involving crude estimates of the relative costs of providing different services,^[5] annual adjustments based on estimates of demand for services, and growth in the Medicare population and the overall economy. The annual adjustment process is expressed in the "Sustainable Growth Rate" (SGR) rule^[6] which attempts to constrain the growth in Medicare spending and "make up" for the differences between previous years' estimated and actual utilization. Each year since 1999, the SGR calculation has called for a reduction in the Medicare payment levels (a "negative update") for physician services, because actual use outstripped previous forecasts, and forecasted future utilization outstripped the growth rate of the Medicare population and gross domestic product (GDP). And each year, physicians' representatives have gone to Congress to argue that reducing payments will cause some physicians to drop out of the Medicare program, reducing elderly Americans' access to health care. Negative updates were allowed to go into effect in only three of the last 11 years—in the other eight years, after intensive lobbying from physician groups, Congress has intervened and passed legislation either freezing payments or providing a positive update.^[7] Competition Among Buyers The basis for the physicians' now-annual argument to Congress is that reducing Medicare payments will cause more physicians to drop Medicare patients and make their living from privately insured and self-paying patients only. Indeed, anecdotal evidence indicates that some physicians have already done so,^[8] as Medicare payments are already significantly below those of private insurance by almost 20 percent for physician services overall and by 12 percent for primary care.^[9] As if to demonstrate the effects of lower payments, in most states Medicaid payments are even lower than Medicare's, and far fewer physicians participate in Medicaid. Not surprisingly, states with relatively lower Medicaid payments compared to other states have lower rates of physician participation in Medicaid.^[10] Access Issues Physician advocacy groups make the reasonable-and-believable-argument that every reduction in the Medicare payment rates will result in a further reduction in the number of physicians who find it worthwhile to take Medicare patients and instead try to make their living from patients with private payers. A survey found that in response to a proposed 10 percent cut in Medicare rates, 28 percent of physicians would stop accepting new Medicare patients, 8 percent would stop treating Medicare patients already under their care, and much higher percentages would discontinue nursing home visits, reduce available hours, or defer investment in medical and health IT equipment.^[11] Obviously, this would not affect physicians in all specialties equally. Most pediatricians have very few if any Medicare patients^[12] and would hardly be affected at all, but cardiologists and oncologists, for example, would be hit hard, since a large percentage of their potential patients are over age 65. The impact on nephrologists would be especially severe, because anyone with end-stage renal disease is covered by Medicare regardless of age. Yet for every reduction in the payment level, a few more physicians would find it better to drop Medicare than to stay in. The absence of other payers would give the "single payer" the freedom to reduce payments far more than Medicare can in the presence of a large percentage of privately insured patients. The result would be substantially lower payments—the "single payer" would be a "stingy payer." Physicians' income would be substantially reduced. Indeed, in countries with single-payer health systems, the average income of physicians is substantially lower than in the United States. For example, physicians in the Britain and Canada have incomes more than 30 percent lower than their U.S. counterparts.^[13] The existence of multiple private payers limits not only the ability of Medicare but also that of private payers themselves to reduce payment levels. Although physicians usually face "take it or leave it" contracts from insurance companies, and most physicians have little ability to actually negotiate, a health plan that sets payment rates too low will find that many physicians choose to "leave it." When enough physicians leave, patients have difficulty obtaining access to care and eventually leave the health plan. In order to continue to sell the health plan (either to individuals or to employers), the insurance company will have to increase payments to induce physicians to join. While this process is slow and imperfect compared to market mechanisms in other industries, it

Medicare For All Master File

does limit the ability of plans to set arbitrarily low payment rates.^[14] "Stingy Payer" Damages Future Generations as Well The establishment of a "single payer" health care system would inevitably result in lower payments for physician and other health care providers. The immediate effect of having a single ("stingy") payer would be lower incomes for physicians and a reduction in the supply of active physicians, thereby impairing access to health care for all patients. However, the result of "single/stingy payer" health care will not only be lower incomes for physicians now but reduced access and lower quality health care for future generations as well.

Single Payer Cost savings come from cutting medicine

Klein, Vox health care editor 2016, (Ezra, "Bernie Sanders's single-payer plan isn't a plan at all" Jan. 17, 2016, available at <https://www.vox.com/2016/1/17/10784528/bernie-sanders-single-payer-health-care> accessed 8/19/17 TOG, * WAVE ONE*)

Sanders calls his plan "Medicare for all." But it actually has nothing to do with Medicare. He's not simply simply expanding Medicare coverage to the broader population — he makes that clear when he says his plan means "no more copays, no more deductibles"; Medicare includes copays and deductibles.

The list of what Sanders's plan would cover far exceeds what Medicare offers, suggesting, more or less, that pretty much everything will be covered, under all circumstances. Bernie's plan will cover the entire continuum of health care, from inpatient to outpatient care; preventive to emergency care; primary care to specialty care, including long-term and palliative care; vision, hearing and oral health care; mental health and substance abuse services; as well as prescription medications, medical equipment, supplies, diagnostics and treatments. Patients will be able to choose a health care provider without worrying about whether that provider is in-network and will be able to get the care they need without having to read any fine print or trying to figure out

how they can afford the out-of-pocket costs. Sanders goes on to say that his plan means "no more fighting with insurance companies when they fail to pay for charges." To be generous, it's possible that Sanders is just being cynical in his wording, and what he means is that under his plan, individuals have to fight with the government rather than private insurers when their claims are denied. But the implication to most people, I think, is that claim denials will be a thing of the past — a statement that belies the fights patients have every day with public insurers like Medicare and Medicaid, to say nothing of the fights that go on in the Canadian, German, or British health care systems. What makes that so irresponsible is that it stands in flagrant contradiction to the way single-payer plans actually work — and the way Sanders's plan will have to work if its numbers are going to add up. Behind Sanders's calculations, for both how much his plan will cost and how much Americans will benefit, lurk extremely optimistic promises about how much money single-payer will save.

And those promises can only come true if the government starts saying no quite a lot — in ways that will make people very, very angry. What Sanders doesn't tell us that we really need to know "They assumed \$10 trillion in health care savings over 10 years," says Larry Levitt, vice president at the Kaiser Family Foundation. "That's tremendously aggressive cost containment, even after you take the administrative savings into account."

The real way single-payer systems save money isn't through cutting administrative costs. It's through cutting reimbursements to doctors, hospitals, drug companies, and device companies. And Sanders gestures toward this truth in his plan, saying that "the government will finally have the ability to stand up to drug companies and negotiate fair prices for the American people collectively." But to get those savings, the government needs to be willing to say no when doctors, hospitals, drug companies, and device companies refuse to meet their prices, and that means the government needs to be willing to say no to people who want those treatments. If the government can't do that — if Sanders is going to stick to the spirit of "no more fighting with insurance companies when they fail to pay for charges" — then it won't be able to control costs.

The issue of how often the government says no leads to all sorts of other key questions — questions Sanders is silent on. For instance, who decides when the government says no? Will there be a cost-effectiveness council, like Britain's National Institute for Health and Care Excellence? Or will the government basically have to cover every treatment that can be proven beneficial, as is true for Medicare now? What will the appeals process be like?

This might sound technical, but it's absolutely critical. Sanders implies everything will be covered because he knows how important that question is to people. But everything won't be covered. So who decides, how do they decide, what gets covered, and what doesn't? Without knowing that, it's impossible to say whether a particular single-payer system is a good idea or a really, really bad one. Another crucial question is whether Sanders envisions the possibility of exit inside his system.

Technically, a single-payer system is a system with, well, a single payer. Private insurers are outlawed — otherwise, it would be a multi-payer system. But the term is often used more loosely than that, and many systems that get mentioned during discussions of single-payer, like the French system, include various kinds of supplementary, private insurance that people generally purchase. The role of private insurers matters because it drives the government's bargaining power. If

drug companies either sell to the government or they go out of business, then the government can get better prices. The problem there is obvious, though: What do people do if the government doesn't cover a treatment they need? But if there are private insurers selling add-on policies to wealthier Americans, then drug companies can deal only with them, and the government's negotiating power wanes. Another question Sanders's plan doesn't answer but is crucially important: How do you guarantee physical access to medical care? Right now hospitals charge Medicaid one price, Medicare a somewhat higher price, and private insurers an even higher price. If the entire system is squeezed down to Medicare pricing, a lot of hospitals are going to close. How will Sanders keep that from happening? Or will he let it happen, even if it means people in rural areas need to drive hours for care?

Absent Primary Care expansion – plan will fail in improving health outcomes

Heintzman et. al. 2014 (John Heintzman, assistant professor Oregon Health and Science University, Department of Family Medicine, Rachel Gold, investigator Kaiser Center for Health Research, Steffani R Bailey, assistant research professor, and Jennifer E DeVoe, chief research officer OHICN, "The Oregon experiment re-examined: the need to bolster primary care." The BMJ 349 (2014),

In a qualitative analysis of a representative sample of new Medicaid enrollees in the Oregon experiment, interviewees described the need for continuity in their relationship with a primary care provider who could work with them over months—or years—to catch up on previously delayed healthcare needs and help coordinate necessary care.¹⁶ **Baicker and colleagues' finding that patients who gained Medicaid coverage reported few health improvements in the short term could be because they lacked access to primary care**,

because the follow-up period was too short to see the benefits of partnering with a primary care provider, or both. Indeed, many patients in Baicker et al's study lost their new Medicaid coverage within six months,¹⁵ giving them little time to establish such partnerships and work towards achieving long term health gains. Another study, however, showed that when patients retain coverage they eventually use primary care services at rates similar to other insured patients.¹⁷ This study, by Gold and colleagues, used electronic health record data from 67 federally qualified health centers in Oregon to study how patients used primary care medical services one year before and one year after gaining Medicaid. Gold and colleagues found a sharp increase in the use of primary care services by newly insured patients immediately after coverage began. This suggested pent-up demand for primary care among uninsured patients. However, within three months the level of use among newly insured patients fell to the level of other insured patients. Those who remained uninsured throughout the study period continued to receive fewer primary care services than those with coverage.¹⁷ This study also showed that patients who were registered with a federally qualified health center before getting Medicaid coverage sought more primary care services from this same health center after they gained coverage. This suggests that for those with existing access to a primary care clinician, gaining public insurance coverage facilitates the utilization of primary care, and it does so in a pattern equivalent to other insurance types with similar primary care access. The association between new Medicaid coverage and increased use of emergency departments reported by Taubman and colleagues¹⁴ was likely mitigated (or not significant) for those receiving good primary care services—it has been demonstrated in many settings that adequate availability of primary care reduces visits to the **emergency department and hospital admissions and that insurance coverage and primary care availability are interdependent in improving outcomes and providing services.**^{18 19 20 21 22 23 24} **Indeed, a recent editorial in The BMJ highlighted that in Massachusetts insurance expansion alone did not reduce hospital readmissions,**²⁵ possibly **because** it was not accompanied by expanded access to primary care.

In summary it is unwise to analyse coverage expansion without considering (and, ideally, controlling for) how access to, and quality of, primary care affects study outcomes. The importance of a high quality primary care infrastructure, coupled with adequate insurance coverage, cannot be overstated. Oregon has made significant progress since the 2008 expansions: the introduction of coordinated care organizations and a renewed focus on population health, primary care, and Medicaid payment changes are associated with significant reductions in emergency department visits and hospital admissions and greater use of primary care.²⁶ Where do we go from here? **International evidence indicates that a robust primary care infrastructure must accompany coverage expansions in order to maximize individual and population health gains.**¹⁸

¹⁹ **Yet the US faces a critical shortage of primary care clinicians, which is associated with overuse of emergency departments, hospitals, and other high cost resources.**^{20 27 28} **As millions of American people obtain new coverage, primary care shortages may grow more painful—a system unable to meet current demand will struggle even more as that demand rapidly expands.** Thus achieving the US Institute for Healthcare Improvement's triple aims of improving population health, improving the experience of care, and lowering the cost of care²⁹

requires people to have both insurance coverage and adequate primary care. The Affordable Care Act will help people obtain insurance, but where will they go for primary care? We suggest several measures. Education of medical graduates (largely funded by US taxpayers) must be matched to the population's healthcare needs. This will require the creation of new systems to regularly assess needs, prioritize resources, and develop new support programs to train the necessary primary care workforce. The accountability of this workforce to society has been emphasized recently in a report from the Institute of Medicine of the National Academies, which called for greater transparency in the US graduate medical education system.³⁰ Alternative payment structures must also be developed to better support and incentivize primary care clinicians and patient centered medical homes to meet the needs of newly insured patients. Current pilot programs should be rigorously evaluated and replicated if they prove effective.^{31 32} Public healthcare dollars should be allocated based on the value of primary care. Finally, new research methods are needed to study the process, outcomes, and complexity of primary care. The fields of complexity science, multilevel evaluation and intervention, dissemination and implementation, and others must help build understanding of how to most effectively deliver and evaluate primary care. Conclusion **If primary care isn't bolstered other efforts to improve the US healthcare system may fail.**

healthcare system may fail. Health reform efforts that do not enhance primary care infrastructure can only tackle part of the population's true needs. Oregon is now seeing early signs of success from combining insurance reform and expansions with the reorganization of primary care.²⁶ We hope that these early signs and the lesson that primary care infrastructure is a necessary companion to insurance expansions—in the US and in any healthcare system—are not lost among the attention paid to more politically provocative research findings.

Can't Solve -- Demand for Doctors, especially with increased coverage, outstrips supply

IHS report for the Association of American Medical College, 2015, ("The Complexities of

Physician Supply and Demand: Projections from 2013 to 2025," prepared for the Association of American Medical Colleges by

IHS Inc., Washington, DC: Association of American Medical Colleges, available at

https://www.aamc.org/download/426242/data/ihscopyportdownload.pdf?cm_mmc=AAMC-_ScientificAffairs_-PDF-_ihscopyport,

Study results suggest the demand for physician services is growing faster than supply. While growth in the supply of APRNs and other health occupations may help to alleviate projected shortfalls to an extent, even taking into consideration potential changes in staffing, the nation will likely face a growing shortage in many physician specialties—especially surgery-related specialties. A multi-pronged strategy will be needed to help ensure that patients have access to high-quality care.

All supply and demand projections are reported as full time equivalent (FTE) physicians, where an FTE is defined for each specialty as the average weekly patient care hours for that specialty. 2 Key findings include:

- Demand for physicians continues to grow faster than supply, leading to a projected shortfall of between 46,100 and 90,400 physicians by 2025. Although physician supply is projected to increase modestly between 2013 and 2025, demand will grow more steeply (Exhibit ES-1). Across scenarios modeled, total physician demand is projected to grow by 86,700 to 133,200 (11-17%), with population growth and aging accounting for 112,100 (14%) in growth. By comparison, physician supply will likely increase by 66,700 (9%) if labor force participation patterns remain unchanged, with a range of 33,700 to 94,600 (4-12%), reflecting uncertainty regarding future retirement and hours-worked patterns.
- Projected shortfalls in primary care will range between 12,500 and 31,100 physicians by 2025, while demand for non-primary care physicians will exceed supply by 28,200 to 63,700 physicians. The shortfall range reflects comparisons of all the supply scenarios to all the demand scenarios, and uses the 25th to 75th percentiles of projected shortages across the comparisons. These percentiles reflect that the extreme shortage/surplus projections are least likely to occur as the extreme shortage/surplus projections compare the highest/lowest demand projections to the lowest/highest supply projections.
- Expanded medical coverage achieved under ACA once fully implemented will likely increase demand by about 16,000 to 17,000 physicians (2.0%) over the increased demand resulting from changing demographics. The Congressional Budget Office estimates that 26 million people who otherwise would be uninsured in the absence of ACA eventually will have medical insurance. Taking into consideration the health and risk factors of the population likely to gain insurance and estimated changes in care utilization patterns associated with gaining medical insurance, the projected increase in demand for physician services is about 2.0%. The increase is highest (in percentage terms) for surgical specialties (3.2%), followed by primary care (2.0%), medical specialties (1.7%), and "all other" specialties (1.5%). Within these broad categories there are differences in the impact of ACA for individual specialties.
- The lower ranges of the projected shortfalls reflect the rapid growth in supply of advanced practice clinicians and the increased role these clinicians are playing in patient care delivery; even in these scenarios, physician shortages are projected to persist. New payment methodologies, including bundled payments and risk-sharing arrangements, and innovations in technology, suggest that the work of health professionals may be restructured in the coming years. Given the number of nurse practitioners, certified nurse midwives, and certified registered nurse anesthetists graduating each year, if labor force participation patterns remain unchanged then the supply of advanced practice nurses (APRNs) will grow more rapidly than is needed to keep pace with growth in demand for

services at current APRN staffing levels. These trends suggest that an additional 114,900 APRNs could be available to absorb into the health care system to both expand the level of care currently provided to patients and help offset shortages of physicians. Similarly, the supply of physician assistants (PAs) is projected to increase substantially between 2013 and 2025, though additional research is needed to quantify the expected impact. While this rapid growth in supply of APRNs and PAs could help reduce the projected magnitude of the physician shortage, the extent to which some specialties (e.g., surgery specialties) can continue to absorb more APRNs and PAs given limited physician supply growth is unclear.

- Due to new data and the dynamic nature of projected assumptions, the projected shortfalls of physicians in 2025 are smaller than shortfalls projected in the earlier study. We project that demand for physicians in 2025 will exceed supply by 46,100 to 90,400. This compares with a 130,600 shortfall projected in the 2010 study. Current projections suggest primary care physician demand in 2025 will exceed supply by 12,500 to 31,100 physicians (the 2010 study projected a 65,800 shortfall, about half the overall shortage). The projected shortfall for non-primary care is 28,200 to 63,700 (versus a projected shortfall of 64,800 in the 2010 study). Factors explaining differences between the 2015 and 2010 projections include:
 - The U.S. Census Bureau revised downward its 2025 population projections by about 10.2 million people (from 357.5 million to 347.3 million). This downward revision equates to approximately 24,000 lower FTE demand for physicians.
 - The number of physicians completing their graduate medical education has risen from about 27,000 to about 29,000 annually.
 - The new projections more closely reflect implementation of ACA, growth in supply of advanced practice clinicians, and trends in use of health care services.
 - The 2010 study assumed that supply and demand were in equilibrium in 2008 for all specialties except primary care, whereas this update assumes supply and demand were in equilibrium in 2013 for all specialties except primary care and psychiatry. Hence, the new demand projections extrapolate a "2013" level of care delivery compared with the "2008" level of care delivery extrapolated by the earlier 2010 projections.

Oregon experiment shows that increased coverage did not improve health outcomes despite increasing costs by 35% - no measurable improvement in physical health

Baicker et al, professor of health economics in the Department of Health Policy and Management at the Harvard School of Public Health, 2013 (Katherine Baicker, Sarah L.

Taubman, Heidi L. Allen, Mira Bernstein, Jonathan H. Gruber, Joseph P. Newhouse, Eric C. Schneider, Bill J. Wright, Alan M. Zaslavsky, and Amy N. Finkelstein. "The Oregon experiment—effects of Medicaid on clinical outcomes." *New England Journal of Medicine* 368, no. 18 (2013): 1713-1722 available at <http://www.nejm.org/doi/full/10.1056/NEJMsa1212321#t=article> accessed 5/24/17

Mean Values and Absolute Change in Health Care Utilization and Spending, Preventive Care, Access to and Quality of Care, and Smoking and Obesity with Medicaid Coverage. shows the effects of Medicaid coverage on health care utilization, spending on health care, preventive care, access to and quality of care, smoking status, and obesity. Medicaid coverage resulted in an increase in the number of prescription drugs received and office visits made in the previous year; we did not find significant changes in visits to the emergency department or hospital admissions. **We estimated that Medicaid coverage increased annual medical spending** (based on measured use of prescription drugs, office visits, visits to the emergency department, and hospital admissions) **by \$1,172, or about 35%** relative to the spending in the control group. Medicaid coverage also led to increases in some preventive care and screening services, including cholesterol screening (an increase of 14.57 percentage points; 95% CI, 7.09 to 22.04; P<0.001) and improved perceived access to care, including a usual place of care (an increase of 23.75 percentage points; 95% CI, 15.44 to 32.06; P<0.001). We found no significant effect of Medicaid coverage on the probability that a person was a smoker or obese.

DISCUSSION

This study was based on more than 12,000 in-person interviews conducted approximately 2 years after a lottery that randomly assigned access to Medicaid for low-income, able-bodied, uninsured adults — a group that comprises the majority of persons who are newly eligible for Medicaid under the 2014 expansion.¹² The results confirm that Medicaid coverage increased overall health care utilization, improved self-reported health, and reduced financial strain; these findings are consistent with previously published results based on mail surveys conducted approximately 1 year after the lottery.⁴ With these new data, we found that increased health care utilization observed at 1 year persisted, and we present new results on the effects of Medicaid coverage on objectively measured physical health, depression, condition-specific treatments, and other outcomes of interest.

Medicaid coverage had no significant effect on the prevalence or diagnosis of hypertension or high cholesterol levels or on the use of medication for these conditions. It increased the probability of a diagnosis of diabetes and the use of medication for diabetes, but it had no significant effect on the prevalence of measured glycated hemoglobin levels of 6.5% or higher. Medicaid coverage led to a substantial reduction in the risk of a positive screening result for depression. This pattern of findings **with respect to clinically measured health** — an improvement in mental health but not in physical health (Table 2) — was mirrored in the self-reported health measures, with improvements concentrated in mental rather than physical health (Table 3). The improvements appear to be specific to depression and mental health measures; **Medicaid coverage did not appear to lead to an increase in self-reported happiness**, which is arguably a more general measure of overall subjective well-being.

Hypertension, high cholesterol levels, diabetes, and depression are only a subgroup of the set of health outcomes potentially affected by Medicaid coverage. **We chose these conditions because they are important contributors to morbidity and mortality, feasible to measure, prevalent in the low-income population in our study, and plausibly modifiable by effective treatment within a 2-year time frame.**¹³⁻¹⁶ Nonetheless, our power to detect changes in health was limited by the relatively small numbers of patients with these conditions; indeed, the only condition in which we detected improvements was depression, which was by far the most prevalent of the four conditions examined. The 95% confidence intervals for many of the estimates of effects on individual physical health measures were wide enough to include changes that would be considered clinically significant — such as a 7.16-percentage-point reduction in the prevalence of hypertension. Moreover, although we did not find a significant change in glycated hemoglobin levels, the point estimate of the decrease we observed is consistent with that which would be expected on the basis of our estimated increase in the use of medication for diabetes. The clinical-trial literature indicates that the use of oral medication for diabetes reduces the glycated hemoglobin level by an average of 1 percentage point within as short a time as 6 months.¹⁵ This estimate from the clinical literature suggests that the 5.4-percentage-point increase in the use of medication for diabetes in our cohort would decrease the average glycated hemoglobin level in the study population by 0.05 percentage points, which is well within our 95% confidence interval. Beyond issues of **power, the effects of Medicaid coverage may be limited by the multiple sources of slippage in the connection between insurance coverage and observable improvements in our health metrics**; these potential sources of slippage include access to care, diagnosis of underlying conditions, prescription of appropriate medications, compliance with recommendations, and effectiveness of treatment in improving health.¹⁷

Anticipating limitations in statistical power, we prespecified analyses of subgroups in which effects might be stronger, including the near-elderly and persons who reported having received a diagnosis of diabetes, hypertension, a high cholesterol level, a heart attack, or congestive heart failure before the lottery. We did not find significant changes in any of these subgroups. To try to improve statistical power, we used the Framingham risk score as a summary measure. **This allowed us to reject a decrease of more than 20% in the predicted 10-year cardiovascular risk or a decrease of more than 10% in predicted risk among the participants with high-risk diagnoses before the lottery. Our results were thus consistent with at best limited improvements** in these particular dimensions of physical health over this time period, in contrast with the substantial improvement in mental health.

Turn: Studies Show Payment cuts lead to increased deaths

Wu, Ph.D., M.S., assistant professor, Sol Price School of Public Policy, University of Southern California, and Shen, assistant professor Graduate School of Business and Public Policy, Naval Postgraduate School 2014 [Vivian Y Wu and Yu-Chu Shen. "Long-Term Impact of Medicare Payment Reductions on Patient Outcomes." *Health Services Research* 49.5 (2014): 1596–1615. PMC. Web. 20 Aug. 2017 <http://doi.org/10.1111/1475-6773.12185>, TOG, * WAVE ONE*]

Health policy researchers and decision makers have long been concerned about the relationship between provider payment generosity and quality of care for many reasons. One view about Medicare spending suggests that there is much inefficiency in the system so that it might be safe to reduce provider payments without hurting quality. Studies by leading researchers have demonstrated that Medicare often operates beyond the "flat of the curve," where areas with additional care/spending are not associated with better outcomes (Fisher et al. 2003a,b; Baicker and Chandra 2004; Skinner, Staiger, and Fisher 2006). By contrast, several recent studies indicate that higher spending may be valuable, especially in the hospital setting. Greater hospital inpatient spending is shown to be associated with lower mortality rates in teaching hospitals (Ong et al. 2009), in selected states such as California (Romley, Jena, and Goldman 2011), Florida (Doyle 2011; Doyle et al. 2014), and Pennsylvania (Barnato et al. 2010); for a set of nationally representative hospitals (Romley et al. 2013) or for several medical (Kaestner and Silber 2010) or surgical (Chandra and Staiger 2007; Silber et al. 2010) conditions.

This important topic has sparked a long stream of research examining the effect of payment reductions on patient outcomes in the past. The literature points to a general finding that past payment reductions have led to cost-cutting responses in the management and provision of care (Feder, Hadley, and Zuckerman 1987; Newhouse and Byrne 1988; Hodgkin and McGuire 1994; Cutler 1995; Bazzoli et al. 2005, 2007, 2008; Lindrooth, Clement, and Bazzoli 2007; Zhao et al. 2008); and while more patients were being discharged in unstable condition (Kosecoff et al. 1990), there was limited or no adverse impact on patient outcomes (Kahn et al. 1990a,b; Rogers et al. 1990; Staiger and Gaumer unpublished data; Cutler 1995; Shen 2003; Volpp et al. 2005; Seshamani, Schwartz, and Volpp 2006; Seshamani, Zhu, and Volpp 2006). However, the literature has focused primarily on short-term impact. Our study fills the gap by examining the long-term effect of provider payment cuts by using a plausibly exogenous shock to hospital revenue—the Balanced Budget Act of 1997 (BBA). Understanding the long-term impact of the BBA on patient quality is especially timely in light of the recent Affordable Care Act (ACA) of 2010, which includes permanent Medicare payment cuts to providers that began in 2012.

Several facts highlight the importance of the BBA. First, the BBA contained the most significant Medicare payment reductions in decades. With the exception of the Prospective Payment System (PPS), the BBA is the only legislation that reduced Medicare inpatient payments in nominal terms, rather than just slowing down the growth rate. Second, BBA payment cuts could have a long-lasting effect on hospitals because the legislation not only reduced diagnosis-related group (DRG) payment levels between 1998 and 2002 but also permanently altered the formula for special add-on payments.¹ As illustrated in Figure Figure1,1, even though hospital payments grew at the full "market basket" update after the 1998–2002 period, the gap in payment across hospitals was permanent (a more detailed explanation of Figure Figure11 is presented in the Results section). Third, Medicare BBA reductions occurred after a sustained period of declining inpatient admissions and lengths of stay, as well as aggressive payment negotiations from managed care plans (Wu 2009) that limited hospital ability to cost shift to private payers (Wu 2010). As a result, hospital actions to produce further savings in this environment were more likely to have direct consequences on patient outcomes than in previous decades.

Economy Imacts

Economic Decline Turns Health Care Arguments

A strong economy is also important to population health

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

At the same time, these findings do not mean that the universal provision of decent health care is the only significant factor in determining health outcomes in the U.S. or elsewhere. Rather, overall health outcomes also depend substantially on the broader set of conditions and life opportunities provided to people in any society. The transition to Medicare for All should encourage more systematic initiatives focused on the social determinants of health, including income inequality and poverty, employment opportunities, education, housing, transportation, nutrition, environmental quality, violence, and the criminal justice system

presently contributing to the U.S. health care system. There are multiple ways through which the U.S. federal government could raise \$1.08 trillion in additional revenues to finance Medicare for All. We examine here one set of new measures that would be capable of generating a total of \$1.08 trillion in an equitable and efficient manner. But we emphasize that additional approaches could also be workable.

Medicare for All Destroys the Economy

Economic Collapse

The plan hits the chain of profits in healthcare, triggering asset price collapse and a market crash

Waelbroeck 15 – Henri Waelbroeck, Global Head of Research at Portware LLC, Vice President and Director of Research at Pipeline Financial Group, Inc., “Excess Corporate Profits: A Bubble, or the New Publicani?”, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2658394

For example, we overpay for health care to finance a chain of profits: from insurance companies to hospital groups to pharmaceutical companies, distributions to investors have never been higher. If equities were owned by the consumers in the same proportion as consumption, this would be fine, but equity ownership is more concentrated than consumption. In this article we will use the terms “consumer” to indicate those primarily dependent on wages for consumption, and “investor” for those for whom investment income dominates. For consumers, the gap between consumption and wages must be covered by new borrowing or asset sales. Government borrowing also weakens the consumer, through the deferred tax burden of interest payments. As the chart below shows, the sum of mortgage and Treasury debt as a % of GDP has been growing with the wage/output gap since 19803.

In recent years deficits have been on the decline and exceptionally low interest rates have eased the debt situation, leading to a flattening of aggregate debt to GDP ratio towards the right of the chart. However, as we will explain below, the apparent improvement in debt ratios mask a continuing problem, as the wage-output gap has not narrowed.

What has enabled debt ratios to flatten in a high corporate profit environment? 4. Two words: asset sales. Home ownership has fallen from 67.2% in 2009 to 64% in 2014, a rate of approximately 1% GDP/yr. Pension equity assets as a percentage of market capitalization suggest net sales of \$744bn over the last 4 years, again approximately 1% GDP/yr (see chart below). The share of wealth of the top 3% and bottom 90% reveals a similar story (J. Bicker et al., 2014): multiplying the reduction in share of wealth by aggregate household wealth, we estimate that the bottom 90% of the US population has been selling assets to the top 3% at a rate of \$468bn/yr, or 2.6% GDP/yr. In the chart, we illustrate this trend by showing the ratio of pension assets held in US equities to the Spiders fund SPY which tracks the US equity market.

Two other factors have played a role in debt stabilization: interest rates on mortgage and consumer debt have been 3% lower than prior to the credit crisis; with household liabilities at 80% of GDP this represents a savings of 2.4% of GDP. The share of consumption by the wealthy has also risen - BMW has done better than Walmart - profits earned by luxury firms and distributed to the consumers of luxury items do not harm buying power.

Historical perspective

This is not the first time the world has experienced a structural flow of wealth from a population group with a growing debt burden to one with a growing share of investment wealth. Assets are used as collateral and asset prices depend on profits, in a high leverage economy the profits of the investor elite become vital to the continued stability of the system and even uninterested parties in government regard the status quo as less risky than reform. Yet the system weakens under the burden of debt: the hoarding of wealth slows the velocity of money, weakens consumption and results in recurrent debt-deflation crises.

The script will seem familiar to those with an interest in Roman history. Before the collapse of the Roman Republic, publicani collected taxes on behalf of Rome but strived to collect as much as possible and pay Rome as little as they could get away with. Not only did they pocket a large profit, their payments to Rome were considered loans and earned interest. In addition to tax collection, Rome increasingly contracted out public works, toll collection, security, ports and roads, mines and saltworks to the publicani. These partnered to form companies (societates) recognized by the state. Their shares (partes) were publicly traded in the Forum. As always, excess profits were matched with excess debt. Inevitably some debts became unpayable; forced land sales depressed price of collateral causing more foreclosures. There is evidence of “quantitative easing” from 90 to 88 BC: coinage by the Roman mint expanded from 120 obverse dies in 92 BC to a peak of 2372 in 90 BC in preparations for the Social War, down to 807 in 88 BC, but minting coins required a supply of metals and eventually the treasury's assets were depleted. In 88 BC, temple gold was used to pay for the war in Asia (C. T. Barlow, 1980). In 86 BC L. Valerius Flaccus carried a bill reducing all debts, private and public, by 75%. But the structural source of the problem was not corrected: the excess profits of the publicani also remained intact and debt deflation cycles recurred until the fall of the Republic. Their privileges were finally terminated by the first Roman emperor Augustus.

Circumstances leading to excess profits and debt have recurred many times in history, most recently with the great depression - circumstances vary, but the dynamics of credit and investment tend to retrace the same path. Occasionally, excess profits persist long enough to enable an

economic elite to exert control over public policy and lock in its privileges, causing recurring debt crises - in the case of the publicani, this lasted a century and ended in dictatorship.

Will corporate profits return to normal levels?

It is difficult to walk down an asset price mountain without losing one's footing. One could easily imagine public policy initiatives to remove barriers to competition and shift a greater part of the fruits of labor to benefit workers, be it de-regulation, efforts to curtail anti-competitive practices, progressive tax policy, mandated profit sharing or a single-payer health care system, the list is long. Such measures may not find much support in a political system dependent on the support of the economic elite, but in any case, reductions in excess profits could backfire, because the economy has become dependent on high asset prices through the curse of financial leverage – reducing earnings at a time when the P/E ratio is unusually high risks triggering a market crash: a sharp downturn in asset values likely harm public welfare on a much more rapid timescale than excess corporate profits. This is the conundrum facing public policy: excess profits hurt consumers, but so does a bear market; we will discuss possible solutions in the last section.

Single Payer Destroys the Economy

Single-payer healthcare wrecks the economy – wages, jobs and income

Tanner 17 (Michael, CATO Institute senior fellow and author of several books on public policy, “Embracing the Hard Realities of Health-Care Reform,” 6/7/17, <https://www.cato.org/publications/commentary/embracing-hard-realities-health-care-reform>, DOA 6/7/17) NCC

On the national level, who could forget Bernie Sanders's proposed “Medicare for All” system, which would have cost \$13.8 trillion over its first decade of operation? Bernie would have paid for his plan by increasing the top U.S. income-tax rate to an astounding 52 percent, raising everyone else's income taxes by 2.2 percentage points, and raising payroll taxes by 6.2 points. Of course, it is no surprise that Medicare for All would be so expensive, since our current Medicare program is running \$58 trillion in the red going forward. It turns out that “free” health care isn’t really free at all. How, though, could a single-payer system possibly cost so much? Aren’t we constantly told that other countries spend far less than we do on health care? It is true that the U.S. spends nearly a third more on health care than the second-highest-spending developed country (Sweden), both in per capita dollars and as a percentage of GDP. But that reduction in spending can come with a price of its own: The most effective way to hold down health-care costs is to limit the availability of care. Some other developed countries ration care directly. Some spend less on facilities, technology, or physician incomes, leading to long waits for care. Such trade-offs are not inherently bad, and not all health care is of equal value, though that would seem to be a determination most appropriately made by patients rather than the government. But the fact remains that no health care system anywhere in the world provides everyone with unlimited care. Moreover, foreign health-care systems rely heavily on the U.S. system to drive medical innovation and technology. There’s a reason why more than half of all new drugs are patented in the United States, and why 80 percent of non-pharmaceutical medical breakthroughs, from transplants to MRIs, were introduced first here. If the U.S. were to reduce its investment in such innovation in order to bring costs into line with international norms, would other countries pick up the slack, or would the next revolutionary cancer drug simply never be developed? In the end, there is still no free lunch. American single-payer advocates simply ignore these trade-offs. They know that their fellow citizens instinctively resist rationing imposed from outside, so they promise “unlimited” care for all, which is about as realistic as promising personal unicorns for all. In the process, they also ignore the fact that many of the systems they admire are neither single-payer nor free to patients. Above and beyond the exorbitant taxes that must almost always be levied to fund their single-payer schemes, many of these countries impose other costs on patients. There are frequently co-payments, deductibles, and other cost-sharing requirements. In fact, in countries such as Australia, Germany, Japan, the Netherlands, and Switzerland, consumers cover a greater portion of health-care spending out-of-pocket than do Americans. But American single-payer proposals eliminate most or all such cost-sharing. Adopting a single-payer system would crush the American economy, lowering wages, destroying jobs, and throwing millions into poverty. The Tax Foundation, for instance, estimated that Sanders's plan would have reduced the U.S. GDP by 9.5 percent and after-tax income for all Americans by an average of 12.8 percent in the long run. That is, simply put, not going to happen. So Americans are likely to end up with a lot less health care and than they have been promised

Single-payer would destroy the economy through tax hikes and revenue disruption

Pipes 16 (Sally, CEO of the Pacific Research Institute and contributor @ CNBC, “The Ugly Reality of Single-Payer,” 1/31/16, <https://www.usnews.com/debate-club/is-single-payer-health-care-a-good-idea/the-ugly-reality-of-single-payer>, DOA 6/20/17 NCC)

Medicare For All Master File

This is complete nonsense. Every other single-payer system around the world delivers subpar care at astronomical cost. Worse still, the multitrillion-dollar tax hikes – that's "trillion," with a "t" – that Sanders has proposed to finance his single-payer monstrosity would decimate the American economy. Voters in need of a definitive reason to dismiss Vermont's "democratic socialist" as a legitimate candidate now have one. Sanders's "Medicare-for-All" proposal would require \$14 trillion in new public spending over the next decade and would expand the size of the federal government by over 50 percent. He plans to cover those costs by ratcheting up taxes on virtually everyone. He wants to hike income tax rates by 2.2 percentage points and levy a new 6.2 percent payroll tax on employers. He'd also dramatically crank up income tax rates for families making over \$250,000 year. And he'd set the estate tax at 65 percent. These new taxes would slow our economy to a halt. They'd rob businesses of capital to invest in expansion and job creation. The returns on entrepreneurship would dwindle. Corporations would direct investments to friendlier environs abroad. Sanders ought to be intimately familiar with the eye-popping costs of single-payer. They just prevented leaders in his home state from implementing a single-payer scheme within their borders. Four years ago, the Vermont legislature approved a plan to create a state-level single-payer system with basically all the features of Sanders's "Medicare-for-All." But last month, Gov. Peter Shumlin announced that he'd be killing the project, specifically because the requisite tax increases on individual earners and businesses "might hurt our economy." The Sanders "Medicare-for-All" plan is specific about how much lucre it'll extract from the American public, but short on the details about how it would actually be administered. How will physicians' compensation be determined? Who will they work for? For those that refuse to leave private employment, what will the punishment be? Who will own hospitals? The list of unanswered questions goes on and on. Sanders and his ilk are pushing for single-payer in the United States in large part because they admire socialized health care systems in other countries like the United Kingdom and Canada. In their romanticized view, single-payer is more efficient, more egalitarian, more humane and less costly. But the facts don't fit that portrayal. Single-payer systems typically use price controls to control the cost of health care goods and services. Those price controls cause the purveyors of health care goods and services to limit the supply that they'll deliver. Limited supply meets unlimited patient demand – after all, health care appears "free" – and shortages result.

Single Payer breaks the bank – Colorado made this mistake already

Morrissey 16 (Edward, Columnist who's worked for several news outlet, including the New York Sun and American Spectator, Blogger with the Heritage Policy Blog, "Here's Proof that a Single Payer Health System Could Break the Bank," 9/11/16, <http://www.thefiscaltimes.com/Columns/2016/08/11/Here-s-Proof-Single-Payer-Health-System-Could-Break-Bank>, DOA 6/9/17 NCC)

In short, the individual markets keep marching closer and closer to collapse. Whether or not the imposition of a single-payer system on all Americans in a crisis was the secret plan all along for ACA advocates, the existential crisis for this market is nearly upon us. This is the time to spring socialized medicine in the US, right? Wrong, concludes the Colorado Health Institute. Colorado voters will decide whether to approve ColoradoCare, a single-payer system in November, and its advocates made some of the same arguments as Obamacare advocates did six years ago. A single-payer system would make health care more efficient, less costly, and generate budget surpluses from its inception. A government-run system would guarantee the end of uninsured Coloradans – a goal that Obamacare was supposed to accomplish. CHI's study found exactly the opposite on almost every point. Colorado spends \$37 billion in its status quo, the CHI study notes, and ColoradoCare would only reduce those costs to \$36.3 billion in its first year – a savings of less than two percent. Revenues would drop by a billion dollars, "resulting in a first-year deficit of \$253 million," a deficit that "would grow every year." Revenues projected for ColoradoCare "wouldn't be able to keep up with increasing health care costs, resulting in red ink each year of its first decade." Keep in mind that this is not just Colorado's problem, either. The economic model of ColoradoCare relies on continuing federal payments to keep from sinking to the bottom of a red-ink ocean, which means that it will cost every American to operate ColoradoCare. Colorado would apply for waivers to Medicaid and Obamacare, and have Washington pay them directly for those programs. Even with that, though, CHI estimated that the state would get \$4 billion less from waivers than ColoradoCare

advocates estimated. All in all, the single-payer system will create a massive budget deficit at the end of a decade. “The resulting deficit in 2028, after all other revenues and savings are taken into account, would be \$7.8 billion,” the study concludes. The new system would not constrain health-care costs, and the disparity “would cause ColoradoCare’s bottom line to worsen every year.” In a monopolistic government-run system, what options would Colorado residents have to fix these problems? CHI offers three ways to keep ColoradoCare from collapsing. The government-run system “could ask its members to approve tax increases,” (emphasis mine), which would erode buying power across the board and have a negative effect on the economy. Failing that, the government could choose to provide fewer benefits or stiff providers with lower payments. These are precisely the options left when the government takes over a private-sector function. It operates from a scarcity model, choosing to ration and tax where a healthy market would provide opportunities for price signaling, competition, and increased production. None of the potential solutions to the fiscal crisis that would result from ColoradoCare add to the choices or options consumers would have in the market; it either restricts their buying power, their choices, or their providers. After all, how many doctors will choose to work and live in Colorado in a system where the government restricts what they can make from their work, and keeps reducing their pay?

Presume against single-payer – it’s impossible to accurately predict its impact and could wreck the economy

Snell and Tankersley 09 (Kelsey and Jim, D.C. Reporters with the WaPo, “The many mysteries surrounding Bernie Sanders’s single-payer health care plan,” 3/15/16, https://www.washingtonpost.com/news/powerpost/wp/2016/03/15/the-many-mysteries-surrounding-bernie-sanders-health-plan/?utm_term=.1894499842ab, DOA 6/20/17 NCC)

“It is not just a problem of the politics,” said Sherry Glied, dean of the Wagner School of Public Service at New York University. “The devil truly is in the details in designing single payer – you have to define what you are going to give up, the trade offs, and once you do that [single payer] isn’t a simple elegant thing anymore.” Experts say Sanders’ plan might decimate the health-insurance industry and force hundreds of thousands of Americans to find new jobs, or it might simply force insurers and their employees to cater more to the rich. It might bust the federal budget and stall economic growth, or it might supercharge the economy. It might give Americans the best, most affordable health care in the world, or it might sentence them to long waits, substandard care and a system that works much better for the wealthy than everyone else. The plan’s likely effects on the federal budget are just as murky. Analysts at the Congressional Budget Office started but never released an estimate in 2009 when Democrats were pushing for a single payer option to be considered alongside the Affordable Care Act. The details of that report are confidential, but it is generally very hard to know with any certainty what a policy upheaval like socializing health care would actually do to the government’s bottom line, said former CBO director Doug Elmendorf.

Single-payer will cost much more than whatever their ev says

Blevins 03 (Sue, President of the Institute for Health and Freedom, “Universal Health Care Won’t Work — Witness Medicare,” 4/11/03, <https://www.cato.org/publications/commentary/universal-health-care-wont-work-witness-medicare>, DOA 6/20/17 NCC)

If history is any indication, any single-payer initiative will end up costing much more than advocates claim. That, in turn, will lead to higher taxes and/or rationing under which the government will determine which medical treatments will and will not be covered. How do we know this will happen? Because single-payer health care has already been empirically tested on seniors in the United States. Many people may not realize it, but the Medicare program is one of the largest single payers of health care in the U.S. and in the world. An examination of Medicare’s 38-year-old track record provides evidence of what happens when the government controls the financing of health services for millions of U.S. citizens. Consider the following facts. When Medicare was debated in 1965 (the year it was signed into law), business and taxpayer groups were concerned that program expenditures might grow out of control. However, single-payer

advocates assured them that all seniors could easily be covered under Medicare with only a small increase in workers' payroll taxes. The federal government's lead actuary in 1965 projected that the hospital program (Medicare Part A) would grow to only \$9 billion by 1990. The program ended up costing more than \$66 billion that year.

Unemployment

Medicare for All will increase employment

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

Medicare for All should support job creation. Medicare for All will support higher levels of spending on relatively labor-intensive activities. This is because net health care costs will fall for small- and medium-sized businesses. The operations of these businesses tend to be more labor-intensive than those for larger-scale businesses.

Medicare for All causes unemployment

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

The implementation of Medicare for All will produce significant job losses for workers now employed in the private health insurance industry as well as administrative support staffers devoted to health insurance matters within the health care services industry

Right to Health Care Answers

Health care is not a right

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

This rhetoric presents a false choice. Health care is neither a right for the many nor a privilege for the few. It's a good and a service, just like everything else in our market economy. SCARCITY CAN'T BE WISHED AWAY Scarcity is one of the fundamental concepts of economics. Societies have limited resources. They have to be apportioned somehow. Tradeoffs are inevitable. Establishing a right to health care creates the prospect of infinite demand for care. But health care goods and services are necessarily scarce. There's no way to create an unlimited supply to meet that potential demand. Northwestern University professor Craig Garthwaite points out that health care is not a public good whose consumption the government can regulate, like parks or clean air. "If I consume health care services, someone else can't," he said in an interview with Vox.⁶ By dressing health care up in the language of rights, single-payer advocates are really calling for health care to be free at the point of access. Dr. Adam Gaffney, the president of Physicians for a National Health Program, has said that making people pay for health care "is just a way of punishing the sick and the poor." He points to the United Kingdom's National Health Service as proof that free health care is not simply "pie-in-the-sky and unrealistic."⁷ Economics is not a concern for those who maintain that there's an individual right to health care.

No way to determine what people are entitled to

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

criteria for positive rights, on the other hand, is tricky. What does a right to health care guarantee? Is it just a right to free medical care? Perhaps it's a right to quality medical care, or efficient medical care. If so, which tradeoffs are we willing to make? The government can provide shoddy medical care to a lot of people quickly and cheaply. But that's probably not what single-payer advocates have in mind. Look at how many questions arise as we try to establish a baseline for what we mean by a right to health care. These difficulties are in part why we don't claim to have a "right" to other basic necessities. Imagine the debate that would ensue over a "right to food." Does that mean a right not to go hungry? Maybe it's a right to consume the necessary number of calories each day. If so, does it matter where those calories come from? It's easier and cheaper to consume 2,000 calories at McDonald's than at a farmer's market. But that isn't the healthiest option. The questions and complications are overwhelming and don't come with easy answers. Similarly, rights presuppose a level of equality that cannot be achieved in health care. We can't pay for a speedier trial or freer exercise of religion. Does a right to health care entitle everyone to seek treatment from the best doctors or at the best hospitals? And to ensure equal protection of that right to health care, would the government have to ban people from paying extra for better treatment? Perhaps top-notch facilities would be prevented from offering innovative procedures—and instead compelled to offer a suite of government-sanctioned services. This puts the government in a bind as well. If there's a \$100,000 pill that can cure a group of patients, but the government can only afford to give it to half of them, what do we do? In countries with single-payer programs, equality often

takes precedence over health. Nobody would get that pill. Pipes, Sally . False Premise, False Promise (p. 8). Encounter Books. Kindle Edition.

Right to health care undermines the rights of others

Sally Pipes, 2020, *False Promise: The Disastrous Reality of Medicare for All*, Pipes is the President & CEO, Pacific Research Institute .

The right to health care may also push up against the rights of others. Negative rights basically require people to “live and let live.” Positive rights are more invasive. If everyone has a right to health care, the government could end up infringing on the rights of health care professionals. Can the government compel hospitals to take on more patients than they have beds to meet increased demand? Can it force doctors to log longer hours, work in subpar hospitals, or perform operations that go against their better judgment? The right to health care would also impose duties on every citizen. The U.S. Supreme Court famously found that the right to free speech “would not protect a man in falsely shouting fire in a theatre and causing a panic.”¹² Similarly, just because everyone has a right to travel does not mean they can careen down the interstate after consuming an entire bottle of scotch.¹³ If I have a right to health care, do I also have a duty to keep myself healthy? Do I waive my right to health care if I’m a smoker or if I’m obese? Would we be comfortable with the measures that officials in the United Kingdom have implemented to prohibit certain patients from having surgery unless they lose weight or quit smoking?¹⁴ Once the government is responsible for guaranteeing a right to health care, it has a plausible claim to micromanage what we eat, how much we exercise, and how we generally comport ourselves. Pipes, Sally . False Premise, False Promise (p. 9). Encounter Books. Kindle Edition.

Health care as a human right leads to rationing

Chris Jacobs, 2019, writer @ The Federalist, *The Case Against Single Payer*, Kindle Book

To make health care a human right, as Sen. Bernie Sanders frequently claims a single-payer system will do, the federal government will have to define that right. And by defining what health care individuals will receive, a single-payer system—especially one that prohibits private insurance outside the government system, as the House and Senate bills do—will also define what care individuals will not receive. As we have seen, by making health care a “human right,” a single-payer system will lead to large increases in people using health care. The combination of 1) more insured patients, 2) more covered services, and 3) the abolition of cost-sharing for all health care services will cause demand to soar. How, then, can government accommodate all this new demand? In a word, it won’t. Instead, government bureaucrats will attempt to contain health care costs by restricting the supply of care provided. That rationing will take on several forms. In some cases, physicians will quit, or never enter medical school in the first place, reducing the available supply of care. In other cases, the global budget model introduced in the House’s single-payer bill will encourage hospitals to stint on care to meet their government-set spending targets. In other cases, the government could outright deny treatments federal bureaucrats deem too expensive. In all cases, however, the limits on access to care will have very real consequences for patients, particularly elderly seniors with multiple chronic conditions. When coupled with the bill’s provisions on abortion, which allow for taxpayer-funded abortion-on-demand, single payer will end up abandoning some of our society’s most vulnerable individuals. Even single-payer

supporters admit their legislation will ration health care.¹ When the Mercatus Center released its study questioning the costs of a single-payer system, a writer for the socialist magazine Jacobin responded: [The study] assumes utilization of health services will increase by 11 percent, but aggregate health service utilization is ultimately dependent on the capacity to provide services, meaning utilization could hit a hard limit below the level [the study] projects.² This socialist commentator knows of which he speaks. Both the liberal Urban Institute and Rand Corporation assume that demand for health care will increase under a single-payer system, raising health-care spending—but that constraints on supply will prevent many people from accessing all the additional care they seek.³ Jacobs, Chris. The Case Against Single Payer . Republic Book Publishers. Kindle Edition.

Medicare for All doesn't guarantee health care as a right

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

It seems little surprise, then, that Sanders's rhetoric about single payer notwithstanding, neither the House nor the Senate single-payer bills actually make health care a right.⁴ Instead of guaranteeing the right to receive health care, they only guarantee the right to have that care paid for if Americans can find someone to provide it in the first place—a major catch Sanders never mentions.⁵

Conceptualizing health care as a right forces so much spending that it trades-off with other social responsibilities

Finally, we also regard health as a social good. It is not in our nation's own best interest to have a populace wracked and consumed by disease. From even the most cynical view, sick people do little to contribute to economic production and income taxes. A healthy workforce can produce more than a sick workforce. From a more generous point of view, few of us would disagree with the statement that suffering is bad and health is good. But when regarded as a social good, the question is not simply how much health care is in the best interests of the individual (that was our first moral perspective). Rather, the question becomes how much health care is in the best interests of society, given our limited resources and the welter of other good and services that are of value. For example, how much should we spend on health as opposed to education? As opposed to public housing? As opposed to law enforcement? As opposed to our physical infrastructure-roads, utilities, etc.?... A health care reform program that satisfies our rhetoric of health care as a moral right of the individual would presumably cover the Lakeberg twins. It would pay for liver and pancreas transplants. But such a program would devastate the economy and draw much needed funds away from other social goods such as schools, housing, roads, defense and job opportunities.

Health care is not a human right.

Barlow, Consultant Neurosurgeon, 1999 (Philip, "Health Care Is Not a Human Right", *British Medical Journal*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1126951/>, DOA 8/18/2017, DVOG * WAVE ONE*)

A human right is a moral right of paramount importance applicable to every human being. There are several reasons why health care should not be considered a human right.

Firstly, health care is difficult to define. It clearly encompasses preventive care (for example, immunisation), public health measures, health promotion, and medical and surgical treatment of established illness. Is the so called human right to health care a right to basic provision of clean water and adequate food, or does everyone in the world have a right to organ transplantation, cosmetic surgery, infertility treatment, and the most expensive medicine? For something to count as a human right the minimum requirement should surely be that the right in question is capable of definition.

Secondly, all rights possessed by an individual imply a duty on the part of others. Thus the right to a fair trial imposes a duty on the prosecuting authority to be fair. On whom does the duty to provide health care to all the world's citizens fall? Is it a duty on individual doctors, or hospital authorities, or governments, or only rich governments? It is difficult to see how any provision of benefits can be termed a human right (as opposed to a legal entitlement) when to meet such a requirement would impose an intolerable burden on others.

Thirdly, the philosophical basis of all human rights has always been shaky. Liberalism and humanism, the dominant philosophies of Western democracies, require human rights. Religion requires a God, but this is not in itself evidence of God's existence. Most people can see some advantage in maintaining the concept of civil and political rights, but it is difficult to find any rational or utilitarian basis for viewing health care in the same way.

To propose that health care be considered a human right is not only wrong headed, it is unhelpful. Mature debate on the rationing and sharing of limited resources can hardly take place when citizens start from the premise that health care is their right, like a fair trial or the right to vote. I suspect that the proponents of the notion think that to claim health care as a human right adds some kind of weight or authority to the idea that health care, and by extension healthcare professionals, is important. A more humble approach would achieve more in the long run.

The right to health care is the right of access to health care, not the right to insurance coverage—health care is a commodity similar to food or clothing; people should have the right to purchase it at market cost.

Stark, Center for Health Care Policy Analyst, 2017 (Roger, MD, policy analyst for Washington Policy Center's Center for Health Care, April 30, "Health Care Is Not a Right", *The Washington Times*, <http://www.washingtontimes.com/news/2017/apr/30/health-care-is-not-a-right/>, DOA 8/19/2017, DVOG * WAVE ONE*)

"We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness." These words in the Declaration of Independence define the "rights" of American citizens. They do not include health care. Yet for over 100 years, some Americans have believed that health care is not only a right, but that the government should provide it and taxpayers should pay for it. If medical treatment is a right, then what exactly does that mean? Does it mean that your neighbors, through the government, are obligated to provide all health care for you? Does it mean that anyone can demand the government to pay for hospitalization, for prescription drugs, and for specialty treatments such as organ transplants? Does it mean that every American has a right to the skill and knowledge of all physicians

and providers? These questions lead to other questions. How does society pay for health care for all? Who gets to decide who should receive health care and how much? Who gets to decide what the health care budget should be? Who should have the power to make health care decisions for us? Or rather than confront these issues, do proponents of health care as a right mean everyone should have health insurance? The problem with this belief is that simply having health insurance does not guarantee timely access to actual medical care. Every citizen of Canada has government-paid health insurance, but the long wait times for treatment, most notably for specialty care, would be unacceptable for Americans. Everyone can agree that health care is a necessity of life. So are food, shelter, and clothing. Yet no one is demanding universal “food care” or universal government housing. The critical issue is that people expect access to food, shelter, and clothing. Americans expect choices and competition when they shop for these necessities of life. The government exists to guarantee free-markets for Americans when they seek access to virtually any product, but especially access to food, shelter, and clothing. No one would expect society, through government, to pay for these necessities of life for everyone. If “food care” was controlled, paid for, and regulated by the government, we would have overutilization, fewer choices, and a limited supply. The private system of grocery stores and supermarkets guarantees access, choice, and competitive prices for everyone. The free-market system is efficient, voluntary, and fair. The critical point is utilizing the best mechanism to allow the greatest number of Americans access to health care. The Canadian single-payer system does not guarantee timely access. The American experience with the Veterans Administration hospital system, a comprehensive government-controlled, single-payer health care program, reveals unacceptable wait times and huge inefficiencies. Fundamentally, these systems ration health care by waiting lists and limited money. The quality of care can be variable. Because of budgetary constraints, the demand for health care is much greater than the supply in virtually every county with a government-controlled health care system. Even Medicare, essentially a single-payer plan, is not financially sustainable. Just like in all other economic activities, the free-market offers the best solution to provide the greatest access to health care and to control costs. People freely making their own health care decisions and using their own health care dollars would give Americans the best chance to utilize their “right” to access health care, with safety-net health programs provided for those who can’t afford it. At the end of the day, health care is an economic activity like any other, albeit with the most personal of interactions between patient and provider. Society should work toward putting patients in charge of their health care, reducing the role of government, and focusing on access, not health care as a supposed “right.”

Answers to Health Care as A Social Good

If we conceive of health care as a social good, intensive care will not be funded

Mark Waymack, 1993, Ethical Issues in Health Care Reform,
<http://ageconsearch.umn.edu/bitstream/17147/1/ar930131.pdf>

A program that regards health care simply as a social good would inevitably reduce patient choice (something the Clinton committee seeks to preserve), not only in terms of physicians, but also in terms of what services they may receive, e.g., health as a social good would most certainly not fund the Lakebergs, nor would it fund most of the intensive care unit care delivered in our nation's hospitals.

This means the poor and the uninsured will never be protected

Mark Waymack, 1993, Ethical Issues in Health Care Reform,
<http://ageconsearch.umn.edu/bitstream/17147/1/ar930131.pdf>

A program that treated health as simply an economic good and/or service would do nothing to extend coverage to the uninsured. And in the cold calculations of the marketplace, the suffering of economically marginal people will not be heard.

Answers to: Racism

The ACA is increasing access and quality

Glied et al 5/8 (Sherry A. Glied, Dean, Robert F. Wagner Graduate School of Public Service¹ New York University, Stephanie Ma, analyst for Village Health, a strategic business initiative of DaVita Kidney Care., MPA from NYU Wagner Graduate School of Public Service, specializing in healthcare finance, Anaïs Borja, junior researcher at the Robert F. Wagner Graduate School of Public Service of New York University, "Effect of the Affordable Care Act on Health Care Access" <http://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-aca-health-care-access>)

¶ One of the main goals of health reform like the Affordable Care Act (ACA) is to expand insurance coverage and, ultimately, to increase access to care. Among its reforms, the ACA expanded Medicaid coverage in participating states to all nonelderly adults with incomes below 133 percent of the federal poverty level (FPL), about \$16,000 for an individual or \$33,500 for a family of four, and provided subsidized insurance through the health care marketplaces for small businesses and individuals without access to employment-based insurance. Since the ACA's first open enrollment period in the fall of 2013, the number of uninsured Americans has fallen from 41 million to 27 million.¹ ¶ Many prior studies have examined the relationship between insurance coverage and access to care. Virtually all have found that people with health insurance, whether Medicaid or private coverage, have better access to services. However, studies that compare people with and without coverage can be biased; people who choose to participate in coverage may differ from those who do not.² For instance, people in poorer health may be more likely to sign up for care than healthy people.¶ ¶ A few studies have examined how access to care at the population level has improved since ACA implementation.^{3,4} One study, using the Gallup-Healthways Well-Being Index, found that by the end of the second enrollment period in 2015, the proportion of Americans without a personal doctor decreased by 3.5 percentage points and the proportion reporting an inability to afford care decreased by 5.5 percentage points.⁵ These improvements were more pronounced in states that expanded Medicaid. Another study, using data from the Health Reform Monitoring Survey (HRMS), examined how various measures of access and affordability changed between the first and second open enrollment periods.⁶ Among all income groups, there were significant improvements, including increases in the proportion reporting a regular source of care and in those reporting decreases in unmet needs because of cost of care. A recent Commonwealth Fund survey found that 72 percent of those enrolled in a marketplace plan or in Medicaid had used their insurance to visit a doctor, hospital, or other health care provider. More than half said they would not have been able to access or afford care before getting coverage through the ACA.⁷ There is also evidence to suggest that the ACA has significantly reduced health disparities between racial and ethnic groups.⁸ ¶ While these studies avoid the problems of selection in the prior literature, they do not fully disentangle improvements in access resulting from the ACA and those resulting from other contemporaneous changes, such as slower growth in health care costs and an improving economy.¶ ¶ In this study, we used two datasets—the National Health Interview Survey (NHIS) restricted use data and the Behavioral Risk Factor Surveillance System (BRFSS)—to directly estimate the effect of the ACA's first open enrollment on health care access. The initial rollout of the ACA varied across states during that period, depending on how well state websites and enrollment processes operated in the early months of 2014, as well as whether states chose to participate in the Medicaid expansion. We use this variation to more accurately identify the effects of new coverage and capture the impact of the ACA. We measured access to medical care in the past year and access to a personal doctor or usual place of care.¶ ¶ Findings¶ ¶ Effect of Increases in Marketplace Enrollment on Access to Care on a Population-Wide Basis¶ Before implementation of the ACA's coverage expansions, many Americans had inadequate access to care. A substantial share of the nonelderly population—from 9 percent to 19 percent, depending on the question asked—went without care because of cost in the period before the ACA expansions were implemented. The percentage was somewhat higher among those in the income range that is eligible for marketplace subsidies and much higher among those with incomes in the Medicaid-eligible range (Exhibit 1). Many adults reported that they had no usual place of care.¶ ¶ ¶ We examined how increases in marketplace enrollment affected how people in a state accessed care, controlling for states' decisions to expand Medicaid. In the NHIS data, we found that for each additional 1 percent of the nonelderly population enrolled in the marketplace, 0.23 percent fewer were likely to report not getting medical care because of cost. On average, 2.5 percent of the U.S. population was enrolled in the marketplaces in 2014. These data imply that enrollment in the marketplaces decreased the national rate of not getting medical care because of costs by 0.57 percentage points. Relative to the baseline level in Exhibit 1, this estimate suggests that marketplace enrollment in 2014 alone reduced the number of people facing cost-related barriers to access by 6 percent.¶ ¶ Similarly, for every 1 percent increase in the number of nonelderly people enrolled in the marketplaces, 0.51 percent more report having a usual place to get medical care (Exhibit 2). Given the national

marketplace enrollment in 2014, this translates into a 1.3 percentage point increase in the rate of nonelderly adults who report a usual place to access medical care. The effects are larger in the BRFSS data. These estimates imply that enrollment in the marketplaces increased the rate of nonelderly population with a usual place of care by 2 percentage points.^{¶ ¶ Effects of Marketplace and Medicaid Coverage on Enrollees' Access to Care¶ ¶} The population-level effects described above show how access to care changed across a state's population. On an individual basis, gaining insurance coverage through the ACA decreases the probability that a person will report not receiving medical care because of costs by 20.9 percent (Exhibit 3), according to the NHIS data. In the BRFSS data, insurance coverage is associated with a 25 percent decrease in the probability of not receiving medical care because of cost. To put this figure in context, prior to implementation of the insurance expansions, about 47 percent of uninsured people reported that they were unable to access care because of cost. Gaining coverage cut that figure by half. Getting coverage through the ACA is also associated with very substantial increases in the probability of having a usual place of care—by 47.1 percent according to the NHIS data and 86.5 percent in the BRFSS data.⁹ These figures imply that people who gained coverage through the ACA's expansions were just as likely to have a usual source of care as were those who had held insurance prior to the coverage expansions.^{¶ ¶ Discussion¶ ¶} When the ACA was first introduced and debated, some opponents of the law argued that it was not needed because uninsured people already had adequate access to care.¹⁰ Since its passage, others have argued that the insurance coverage provided to people under the ACA provides insufficient protection against high costs or offers such limited networks that the newly insured cannot find care.^{11,12} These arguments imply that the ACA would not generate improvements in access to care.^{¶ ¶} Our analysis provides strong evidence that this implication is false. Expanding Medicaid coverage and establishing state marketplaces have not only decreased the number of Americans who are uninsured but has substantially improved access to care for those who gained coverage. People who are newly insured through the ACA are much less likely than uninsured people to report that they are unable to get care or delayed getting care because of cost. They are just as likely as those who have always been covered to report that they now have a usual place of care.

Framing lack of access to health care through the lens of inequality is anti-black whitewashing of gratuitous violence that makes black violence fungible

Broeck 2016 – Prof. Dr. Sabine Broeck teaches American Studies, Gender Studies and Transatlantic Black Diaspora Studies at the University of Bremen ("Inequality or (Social) Death," *Rhizomes* Issue 29) bhb

[2] This radically aggravated deprivation of the Black urban poor has received only very select attention, as suggested by the response of my German colleague. One immediate reason for his "not having heard" might lie in the eclipse of the so-called "water crisis" by the media spectacle of the immediately lethal, anti-Black violence of street killings that has, due to the public impact of Black social media activism, captivated global attention in the last several years, and has subsequently been turned into a pornotroping spectacle of death by international white press attention. I am using the term "crisis" here by way of citation of the—however spare and scattered -white US media coverage. The scattered reports about Detroit have repeatedly framed those particular substantiations of ongoing structural anti-Black social policy, which could be spotlighted for their apparent excessiveness, as a "crisis."

[3] Thus, the reason for the widespread lack of awareness, I suspect, lies in the pervasive human disinterest, brokered by transnational media and political, social and cultural institutions, in the imminent killing and devastation—in this case by purposeful water withdrawal—of Black being: a disinterest that renders Black being dispensable to and by human society. This human disinterest in Black life has created a kind of proactive, aggressive ethical void, which keeps attracting the spectacularization of Black suffering and death. This concerted pattern of Black absence and Black hypervisibility is a factor of anti-blackness that Black resistance has had to come up against in the long afterlife of slavery—in full awareness of the fact that Black resistance, in forms of spectacular threats to what is considered human life, has acquired its own kind of media fungibility. [4] In pitting "human" against "Black being" here, I am asserting the theoretical urgency to attend to the structural antagonism between human civil society, the "world as we know it," as Fanon had it, and racialised Blackness. In the aftermath of enslavement's thingification of the enslaved beings, Black life has been always already split off from humanness and its post-Enlightenment entitlements, rights, and social claims. With this analysis, I am drawing on decades of Black interventions against white slavist modernity (see Broeck, 2015) and, more specifically, on recent Afro-pessimist radical critiques of the split between white life and Black social death to which this issue is

dedicated. Thus, the purpose of this paper is to join the recently revivified debate about social inequality in times of rampant neo-liberalism from an antagonistic and quite an agonizing angle. (For this debate, see paradigmatically Brueggemann (2015), David Grusky and Szonja Szelenyi (2011), Hurst (re-edited 8th edition: 2015), Caliendo (2014), and Brubaker (2015)). Addressing the so-called "water crisis," in one of the oldest, post-industrial, post-modern and socially precarious urban zones in the United States, demands putting these (post)-classical leftist-social Democratic and even Marxist repertoires of reading a late capitalist politics of decay—in which the term and concept of inequality originates and resonates—into sharp critical relief. Any work on the purposeful production of, as Saidiya Hartman called it with a palpable sense of desperation and ire, "collateral damage" (Hartman 2007, 31), Black lives need to be grounded in Black radical intellectual labor. This needs to be stated explicitly, since the theoretical absorption of Black suffering into analogies with other disadvantaged and discriminated against social constituencies has blatantly disregarded the large body of epistemic work pointing towards the impossibility of that analogy. Black being has been singularly contained in and overdetermined by its ongoing abjection from civil and social life, by its aggressively being evacuated and excluded from even the possible status of claimancy to rights and entitlements (Sexton, Wilderson). Only this reorientation of critique could then lead to a new kind of extensive empiricist attention, which cannot be realized in the space of this limited textual intervention, to the longue durée historical contours of Black urban populations' suffering "gratuitous violence," in Frank Wilderson's term (Wilderson). Wilderson's term lends itself urgently, in my opinion, to articulate both the ongoing proliferation of white terrorist violence and, as its flipside, state and federal abandonment of Black life. [5] Wilderson's work, most prominently, has clearly marked a break with theories of various provenances that see Black life staked by economic oppression, political underrepresentation, and social deprivation, even though on the level of experience, so his argument goes, all these facets impact on Black life. In contrast, and pushing Fanon's and Hartman's points, his focus is on the deep structure of anti-Blackness and its function for the very existence of the human. His argument takes off where Fanon left it: the human is because the Black is not. To him, anti-Blackness is anchored in the human's very sense of self; it is motorized by and within a libidinal economy (his term) that needs Black non-existence to be able to count itself as human, that needs the relegation of Black being to the realm of non-human sentience, in order to even envisage, revise, fight over, rewrite and recast the human's humanity. To Wilderson, the Black being is made to suffer, not because of anything that he or she does, or because of any kind of recognizable claim that could be made in a conflict among humans, as in gender struggle or class struggle; Black being is made to suffer as a structural prerequisite to the human-beingness of white humans. Just because. [6] For my intervention, I acknowledge specifically the trajectory of Black, post-enslavist epistemic work without which such a paper would not have been thinkable. Of course, the agony referred to before harks back to Fanon's notion of "zones of being, and of non-being," which do, respectively, contain human life and never-human Black life forms (a term I owe to Rinaldo Walcott, see Broeck 2015). It has passed through Césaire's indictment of Europe and, by extension, the Western reign of capital and its repeating ideologies, as "rotten to the core"; it has learned from Sylvia Wynter's theoretical critical advances on post-Enlightenment philosophical and political theorems, including Marxism and Feminism, which she sees defined, still and again, within the parameters of the "human's" regime, which has relegated post-enslavist Black populations the world over to a kind of non-existence (Wynter). Obviously, the deployment of "social death" as a term goes back to Orlando Patterson's work which, by now, has gained such currency that one actually needs to defend the pertinence of this term to analyzing Black (post) enslavement against free-floating analogizing. Without Saidiya Hartman's break-through arguments, first, against enslavement's Black subjection as spectacle, and second, against the white production of Black being as fungibility and accumulation under enslavement and its afterlife (Hartman 1997), something like the so-called Detroit water crisis would remain obscure to analysis, a point that is also true for the still and again pertinent urgency of Hortense Spillers' crucial points about enslavement's legacies. To Spillers, white society, by way of and after the rupture of the Middle Passage, has denied Black being any coherence as subjectivity, any generative capacity of claims tied to specific markers of human-ness, like gender (Spillers). Instead, Black being has remained perceptible to human—that is white—society only as usable "flesh." Accordingly, violence against Blackness cannot be conceptualized as a transgression, I conclude from these arguments, but as the underlying premise of human functioning, including the struggle around rights, social improvement, justice and freedom, and basic material guarantees of life, like water, electricity, access to public health and other services. [7] This point is driven home in the ostentatious routine legality and juridical legitimacy of the policies of aggressive water denial—as a state response to unpaid bills—by the city government of Detroit, who acts in clear view of the fact that mass Black poverty and non-enfranchisement figures as the existential norm for those Detroit communities, and not an exception which exceeds the social contract. The Detroit case also shores up the implication of the US federal government in the maintenance of this violent naturalization of deprivation: obviously local and state policies in this case did not cause alarm which might have led to federal intervention. This seems all the more scandalous given both the massive local struggle for affordable access to running water for the poor Black residents of Detroit and the devastating indictment of the Human Rights Watch Committee's report which, however, received only massive public agnotologic, that is, willfully ignorant (See Proctor, and Mills) neglect. Reading up on the

activists' detailed and intimate reports of suffering and struggle, as documented on numerous websites, most prominently the work of the Detroit Water Brigade, makes visible the enormous duress that those grassroots initiatives have been facing as they navigate between drumming up financial and other support for their activist practices, including the creation of alternative mobile water supplies, and avoiding the trap of repeating the anti-Black use of Black communities' systematic deprivation as fodder for a local greedy white sensationalism that has had neither material nor political interest in changing the situation. This rather limited localized press attention, veering from liberal sentiment in parts of the mainstream press to excessive fascist racist propaganda videos on websites (which I will not cite here!), has been matched with an overall absence of theoretical analysis and critical response. [8] To restate my point, the reason for this absence seems to me to lie, on the one hand, in a kind of white supremacist indifference towards the specific empiricism of Black suffering, reigned by the theoretical innocence of an assumption that liberal and leftist theory knows all about how the underclass has been oppressed and dispossessed. On the other hand, this active indifference is being mobilized and confirmed over and again by the leftist framework of inequality, which actually disables any astute analysis of a "crisis" like the one unfolding in Detroit. Thus, in order to understand the overall silence around this issue, both in the US itself and also across the Atlantic, one needs to examine a paradigmatic array of white liberal and leftist commentary on this and similar "events" of urban deterioration, for which the terms "inequality" on the one hand, and "decay" on the other hand have been instrumental. [9] For example, texts such as The Inequality Reader, Social Inequality. Forms, Causes, Consequences, and the recent Social Inequality and Social Stratification in U.S. Society, even though they favor the explanatory power of structural causes over and against the assignment of blame to afflicted communities, and even though they address the "continuing significance of race" and are aware of anti-Blackness as a factor (Feagin 2011), maintain as their conceptual reference for inequality research the key terms of "discrimination," "racial hierarchy," unjust and unfair "distribution," the "stratification" of wealth and poverty, the "racialisation of poverty," "social status" distinctions around "white privilege," and the impact of "race relations" (Doob). In Inequality in America: Race, Poverty and Fulfilling Democracy (Caliendo) from 2014, terms of a similar register are assembled: the concepts of "disadvantage," "discrimination," "disparities of access," "frame the debate, moving the discussion towards "The Space between Power and Powerlessness" (a significant chapter title), and towards possible "amelioration." In all these investigations, an insistence on differentiation across a human scale is their arguments' mobilizing machine, creating a repertoire of proactive significations which keep analyses tied to questions of human society's contingencies of class reproduction and obscuring the structural non-existence of Black life forms as human within that social and political frame. [10] Contrary to these analytic evasions, I suggest that the recurring mobilization of these terms has served to obscure the paradigmatically afrocidal core of Detroit's water politics. I propose this term to stress my point that the "collateral damage" of Black life has obviously not been seen by white actors, including leftist and liberal intellectuals, as the violent destruction and dispensation of a US national group. If it had been, a term like mine, referring to the established use of the term genocide, would be applied to white supremacists' willful practices and structures of letting Black life perish. According to standard definitions, genocide does not necessarily mean the immediate destruction of a nation, except when accomplished by mass killings of all members of a nation. It is intended rather to signify a coordinated plan of different actions aimed at the destruction of essential foundations of the life of national groups, with the aim of annihilating the groups themselves (See e.g. Lemkin). If human society refuses to recognize anti-Blackness as genocidal, a neologism is inevitably called for to enable conceptual analysis. Therefore I situate my paper as a critique of the recently rekindled academic currency of the term "inequality" as an analytics that cannot grasp the lethal character of anti-Blackness. With due respect to Black epistemic labor, "enslavism"—as a condensed concept contracting the insights gained from the study of Black scholars' work—is thus my own term for that circum-Atlantic modern to postmodern regime, which has abjected Black existence from the world of human subjectivity and sociability. For Black life, enslavism entailed a purposeful absence and denial of interpellation by post-Enlightenment prerogatives of "freedom" and "equality," which have successfully pre-ordained the status of human-ness for subjects to be able to circulate within conflicting civil and democratic claims at all. Within the framework of this paper, then, the particular angle given by the heuristics of enslavism demands a critique of a concept like inequality, based as it has been in an anti-capitalist conceptual rhetoric, which has not examined its own anti- Blackness. White power's containment of Black being in abjection, fleshiness, usability/disposability and a state of non-humanness, has overdetermined what Hartman calls the "afterlife" of enslavement.

Using insurance to ameliorate white guilt for structural injustice entrenches anti-blackness by codifying black patients as risk-prone and pathological.

Hinkson and Ehlers 2017 – Leslie R. Hinkson is Assistant Professor of Sociology at Georgetown University and Nadine Ehlers, PhD, is an academic staff member of the School of Social and Political Science at The University of Sydney (“Conclusion: Freedom from Debt,” Subprime Health: Debt and Race in U.S. Medicine pp 183-186) bhb

Through framing race as biological and as the underlying cause of health disparities, architects of race-based medicine have laid the groundwork for a tripartite system of health care delivery biomedical practice, and biomedical research that has simultaneously racialized disease and illness and rationed access to and quality of care along racial lines. This system has created a space for health disparities- rooted in slavery, settler colonialism, Jim Crow, and residential segregation-to grow, and for health-related costs and debt to accumulate to its victims. Such debts, as the chapters collected here explore, impose a financial toll in addition to emotional, psychological, and social costs. Several contributions in this volume have illustrated how race-based medicine has created monetary debts for minority subjects through limited access to affordable care and through a history of social and medical abuse and neglect that created health disparities. These disparities are costly to address-in pure monetary terms-and such costs are often squarely placed on the shoulders of racial minorities themselves. Additionally, race-based medicine has, in recent decades, augmented the creation of debt through the formulation of race-targeted treatments that are associated with larger price tags than those used to treat nonminority subjects with similar ailments.

Are the terms of repayment any less onerous when the debt is conceived as a moral as opposed to a monetary one? In other words, does the United States as a whole suffer emotionally, financially, psychologically, and socially as a result of the moral or ethical debt burden associated with its historical role in helping to both create and maintain disparities in the health profiles of racial minorities compared with their White counterparts? The contributions of this volume suggest that it does. As many authors in this volume argue, race-based medicine today is often positioned as an attempt to redeem the nation's less than virtuous past: it is framed as a means through which we might redress past injuries and repay this accumulated debt. However, race-based medicine often fails to address the conditions that created this debt in the first place, and rather than serving to defray that debt and alleviate attendant suffering, it often functions to maintain the status quo and thus entrench past injury.

An enduring question that remains is, what are the problematics of framing race-based medicine as an adequate or even appropriate form of redress? Rather than ensuring that all people have access to affordable healthy food, for example, we provide them with race-targeted pharmaceutical treatments for hypertension and diabetes. Rather than pouring more resources into studying the social and environmental determinants of breast cancer, we invest more heavily in the search for race-specific genetic factors to explain the increased likelihood of African American women dying from the disease than their White counterparts. Rather than investing in increasing the supply of affordable, quality health care in minority communities, particularly where the inhabitants are lower income, we expand Medicaid coverage. But what use is health insurance if the health providers you are able to access view your coverage as inferior to other forms and so won't accept it? Or, what if those providers don't offer quality care, or are too few in number to serve everyone in the community requiring their services?

Ultimately, such approaches all come with significant monetary costs, and all attempt to address health disparities in some way. Some have even been specifically crafted as a means of social redress for the existence of these disparities. However, none truly focuses on eliminating them. Thus, race-based medicine can be seen as a racial project that, in our contemporary era, is greatly influenced by the tenets of neoliberalism: it extends a meaning of race based in biology-which is used to rationalize the organization and distribution of both medical services and medical knowledge-without disrupting profit margins or

shareholder value.¹ Indeed, it yields the future promise of both better health outcomes for those who fall under the racialized biomedical gaze and greater wealth to those invested in its many forms of expansion. To date, however, wealth associated with race-based medicine has only accrued to a select few, and as the cost of health care rises, minorities continue to experience excessive rates of morbidity and mortality. Thus, the specter of guilt recursively haunts the conscience of the nation, and that guilt continues to keep the United States a nation divided.

In examining race-based medicine through the lens of debt, the chapters in this volume return again and again to its main limitation: its rationalization and practice reveal a poor theorization of race. That race should be conceptualized as a biological reality, or even an admittedly crude-yet necessary stand-in for genetic variation, reveals an underdeveloped and ahistorical understanding of the concept's past and present as a sociopolitical category. In a form of teleological reasoning, race becomes an explanatory variable—the supposed cause of racial health disparities—without much attention being placed on what race is or the casual [sic] mechanisms and pathways through which race operates as a predictor of health profiles. Such reasoning is indicative of a disturbing trend in biomedicine that may well disseminate across the rest of society: the reentrenchment of race as a biological “truth” in a field that is esteemed as a hard science, whose assumptions are in many ways seen as inviolable by many other academic disciplines and by the public, may serve to not only provide biological explanations for health and other racial disparities found in our society but to provide justification for them as well.

The reentrenchment of the idea that race is biological makes for poor science. To be clear, it is to be expected that medical practitioners and researchers should focus on the body, on the biological roots of disease, and on the biological responses to external stimuli. The problem with race-based medicine, particularly as it relates to ethnopharmacology, is not that it focuses on the biological but in that it treats race as a possible biological determinant or root cause/trigger of disease as opposed to thinking of race as predicting the amount of exposure to a series of external stimuli that invoke certain biological responses. For example, African Americans are more likely to be diagnosed with nitric oxide deficiency than Whites. This condition can be caused by obesity, stress, diet, and lack of exercise, among other factors. In other words, the primary causes are external to the individual. Yet scores of scientific and medical journals recommend, given the higher probability of nitric oxide deficiency in this population, that beta-blockers are not an effective alternative pharmaceutical option when considering treatment for hypertension or congestive heart failure. If this deficiency is what explains the lack of effectiveness of the drug in individuals, why not simply test all patients with hypertension or congestive heart failure for nitric oxide deficiency in order to determine the best course of treatment? Why simply use race—whether self-identified or assumed by the health care professional—as a proxy for a specific biological process? In focusing on the racial category as opposed to low levels of nitric oxide, the former becomes the focus of treatment, the deficiency to be overcome. Biomedicine, we would suggest, needs to focus more on what is broken in bodies and the pathologies to be found in biological processes, rather than biologizing what is broken and pathological in our society.

Insurance doesn't mean care—racial biases in medicine mean that black people might get treatment, but never quality care Hoberman 12

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Over the past 25 years. The most prestigious American medical journals have produced massive evidence confirming that racially biased diagnosis and treatments are a fact of life in American medicine. These analyses document racially biased behaviors and if prompted one official investigation and no disciplinary proceedings. Other professionals serving the public, such as policemen or professors, are not

granted such immunity from scrutiny of their professional conduct. The racially motivated habits whose effects are presented in the medical literature and statistical data are so ingrained that some doctors do not deviate from them even when they know their interactions with black patients are being recorded for observation. Their personal eccentricities and the specific harms they cause their patients remain anonymous, buried in the statistics that make it into print. Concealed behind the sterile terminology will racial "disparities" and "cultural differences" are an unknown number of biased behaviors that in other social venues might be regarded as negligence or violations of the law. What evidence do we have the doctors employee racially motivated thinking when dealing with patients of color? The abundant data that indicate differential diagnosis and treatment for a wide range of diseases and disorders are one type of evidence. Their crucial disadvantage is that they portray collective behavior rather than the more detailed scenarios of private professional conduct that do not appear in the medical literature. The motives for some physician behaviors can be deduced on the basis of what is known about the history of racist thinking by physicians. Deductions of this kind are indispensable to understanding racially motivated medical thinking and behavior, given the dearth of current survey data about physicians racial thoughts and fantasies. But they are open to the objection that what we know about doctors racial complexes from the overt medical racism of the past may not apply to modern practitioners who have supposedly absorbed socially sanctioned disapproval of racist speech and behaviors and conduct themselves accordingly. This book's methodology is based on the premise that, to the contrary, significant aspects of the medical racial folklore of the pre-civil rights have persisted and adapted to modern circumstances, to a greater extent than many have assumed possible in an age of officially mandated racial equality and racially civil public discourse. There is, in fact, no reason to assume that medical students and doctors are less likely to absorb and act upon the racial fantasies that still suffuse modern societies. In 2001, for example, 3 white medical students at the University of Alabama at Birmingham were exposed by the news media. After they were black face to a Halloween party. One was dressed as Stevie Wonder, the 2nd is a character from the Fat Albert cartoon show, and the 3rd as a black woman. The medical school officials who handled this case, with whom I communicated, resolve this matter by accepting public apologies and devoting a data racial sensitivity training. The idea that this behavior demonstrated character defects that might make these individuals unfit to practice medicine apparently did not figure in the process that finally certified them fit to treat black patients. This incident also raises the question of where cultural stereotyping ends and biological race fantasies begin. Blackface signifies a fantasy of racial transformation, just as cross-dressing signifies a fantasy of gender transformation. These medical students found gratification in taking on the identities of a blind singer, a comical cartoon image, and the generic black female who is traditionally ranked at the bottom of our racial hierarchy. These future positions regarded playing with distorted versions of the black body is a kind of entertainment. One can only wonder what the experience of public humiliation and a day of racial sensitivity training may have done to temper or redirect their fantasies about black bodies in ways that might serve the interests of the African-American patients who will someday consult them for medical treatment. The most thoroughly documented racial disparities concerning the diagnosis and treatment of heart disease, the leading cause of death in the United States among Blacks as well as whites. This book argues that the medical folklore about Blacks and cardiovascular diseases that was so evident throughout the 20th century has distorted some doctors responses to heart disease in black patients. The absence of this historical perspective. In the current medical literature illustrates the naïveté of medical authors who regard racially differential diagnosis and treatment of heart disease is a mysterious phenomenon whose causes have somehow eluded our understanding. Reading our way back to the relevant medical publications and coronary disease will help to clarify the mystery. At this point. Let us survey. The findings about racially disparate treatment of patients requiring therapy for heart disease, that appeared since the late 1980s. As of 1989 white patients were undergoing one 3rd more coronary catheterizations and more than twice as many coronary angioplasties as black patients. In 1993. Researchers confirmed that white patients consistently underwent invasive cardiac procedures more often than black patients. In a 1996 editorial in the new England journal of medicine, H. Jack Geiger expressed deep concern about the unequal treatment of heart disease: "perhaps most consistent-and most disturbing-are the repeated findings that Blacks with ischemic heart disease, even those enrolled in Medicare or free care systems are much less likely to undergo in geographically, angioplasty, or coronary artery bypass grafting." A 1997 report came to similar conclusions regarding bypass surgery; the author called this finding "disturbing, because we also found that they were not due to differences in the severity of disease or to coexisting illnesses." A 2000 report confirmed that "medical therapies are currently underused in the treatment of black, female, and poor patients" who have suffered acute myocardial infarction. "This variation was not explained by severity of illness, physician specialty, hospital, and geographic characteristics"-- possible confounding factors. The study ruled out, leaving physician bias as the most probable explanation for why black patients were offered fewer therapeutic procedures. A 2005 survey of racial differences in the management of acute myocardial infarction covering between 1994 and 2002 found that racial differences and care had persisted rather than diminished during this period. Racially differential practices have also been found to affect the treatment of early-stage lung cancer. One research team wrote the following in 1999: "our analyses suggest that the lower survival rate among black patients with early stage, non-small cell lung cancer, as compared with white patients, is largely explained by the lower rate of surgical treatment among Blacks." The same conclusion was reiterated in 2006: "black patients obtain surgery for lung cancer less often than whites, even after access to care has been demonstrated. They are likely not to have surgery recommended, and more likely to refuse surgery." It is historically conditioned fear that causes some black patients to refuse surgery even when it would be in their best interest to consent. The medical literature refers to these decisions as examples of "patient preferences" as though these decisions to reject surgery were free and autonomous acts on the part of empowered medical consumers. In fact, black spheres of surgery persist because the medical profession is never address the consequences of its racist history and weight that might reassure African-Americans who feel strain from the medical system. Heart and cancer surgeries are generally regarded as desirable procedures that benefit patients, and that is why racially differential access to them is unjust. There are other kinds of surgery that are undesirable when better alternatives exist, and here too black patients have borne an extra burden of suffering. The effects of a hysterectomy, for example, are likely to be more of an ordeal.

for a black woman than for her white counterpart, since “black women are more likely to get the more invasive kind of hysterectomy,” which doesn’t require a large incision. The vaginal operation is more expensive and harder, and studies have shown it is used more and women higher on the social economic scale.” It was reported in 1996 and 1998 that black patients with diabetes and circulatory problems were less likely than whites to have legs during surgery and are more likely to undergo the amputation of these limbs. Yet, precisely the reverse was true of the more beneficial type of operation, since Blacks were less than half as likely as whites to get hip replacements. Here, too, “patient preferences” dissuade some black patients from undergoing hip or knee surgeries because they “report less confidence in the efficacy” of such operations. Accepting such “patient preferences” as autonomous decisions is mistaken, since the black patients lack of confidence in the procedures is an expression of mistrust rooted in a group history of traumatic experiences involving the medical profession.

Insurance and Care are intrinsically tied to each other and defined in opposition to blackness—Care is coded through the middle passage, where a slave masters on the ship named Care threw hundreds of slaves overboard, insuring white care by providing black death.

Sharpe 2016 – Christina Sharpe is Associate Professor of English at Tufts University (*In the Wake: On Blackness and Being* pp 101-118) bhb

Twenty years after Phillis, the ship and the girl, arrive in Boston, Massachusetts, the Zong achieves notoriety through the binding and throwing overboard of 132 (or 140 or 142) Africans in order to collect insurance.¹⁹ The text of the 1783 court case Gregson v. Gilbert tells us that this was not a case of murder, tells us that “it has been decided, whether wisely or unwisely is not now the question, that a portion of our fellow creatures may become property.

This, therefore, was a throwing overboard of goods, and of part to save the residue” (quoted in Philip 2008, 211). Originally named the Zorg (or Zorgue), which translates from the Dutch into English as “care,” the ship becomes the Zong after it was captured in war and bought by a

Liverpool slave company and an error was made in the repainting of the name. We should pause for at least a moment on the fact of a slave ship named Care (care registering, here, as the provision of “what is necessary for the health, welfare, maintenance, and protection of someone or something,” as support and protection but also as grief) before, and as, we attempt to understand that single word Ship attached to that small Black female body in the aftermath of the Haitian earthquake in 2010. Is Ship a proper name? A destination? An imperative? A signifier of the im/possibility of Black life under the conditions of what, Stephanie Smallwood tells us, “would become an enduring project in the modern Western world [of] probing the limits up to which it is possible to discipline the body without extinguishing the life within” (Smallwood 2008, 35–36)? Is Ship a reminder and/or remainder of the Middle Passage, of the difference between life and death?

Of those other Haitians in crisis sometimes called boat people? Or is Ship a reminder and/or remainder of the ongoing migrant and refugee crises unfolding in the Mediterranean Sea and the Indian and Atlantic Oceans? Given how visual and literary culture evoke and invoke the Middle Passage with such deliberate and reflexive dysgraphic unseeing, I cannot help but extrapolate.

Compare that image to the 1992 photograph of another Haitian girl child (figure 2.6). She is also seven or eight years old, ten at most, and she is holding a ship. That photograph is taken during the height of the forced exodus of Haitian refugees—those people adrift, sometimes picked up and incarcerated, and other times, most often, turned back by the US Coast Guard and other nations. As Kaiama Glover (2011) reminds us, the “ship” indexes the “floating detention centers controlled by government agencies of the United States and the United Kingdom . . . where ‘ghost prisoners’—individuals denied protective anchoring to a sovereign homeland—languish in the international waters of the Indian Ocean . . . [as well as those] 20th and 21st century Haitians . . . shipwrecked and lost at sea or turned away from hostile beaches in Jamaica, the Bahamas, Florida . . .” We know, too, that “the United States has intercepted thousands of Haitian refugees at sea and forcibly returned them” (Deloughrey 2010, 708). The Haitian girl child in this photograph stands in front of a desk and before a man and a woman seated behind and to the side of the desk. Their backs are to the camera. They are taking down her information, checking boxes, in a ledger of some sort. The woman is wearing gold earrings; there appear to be an epaulet on the shoulder of the man’s shirt. The little girl stands in front of them, in front of the desk on which a model ship rests (a model Coast Guard cutter?), and her hands are on the ship. No one appears to be with her there. Her face is serious, her look concentrated. What is the look in her eyes? What do I do with it? Where was her mother? Her father? Whom did she turn to when scared? The ledger that renders us illegible as human returns and repeats, as does the ship. In the 1992 photograph we see a ship and we see a little girl; we see a little girl holding a ship and know that a ship will hold this girl, precariously. The photograph is captioned “Haitian Boat People” and the accompanying description reads: “A small child waits while her personal information is written down in preparation for the voyage from Haiti to the United States. US President Bill Clinton offered temporary asylum to fleeing Haitians who have abandoned the poverty and corruption of their homeland. Thousands of refugees head for the shores of Florida, attempting the 500 kilometer journey in rickety boats made from their former homes.” The phrase boat people, applied to those Haitians leaving the country under force, reflects, enacts, and attempts to erase its particular and brutal violences, and this ship and this girl enact a prior and ongoing instance of eponymy.²⁰ “A boat, even a wrecked and wretched boat still has all the possibilities of moving” (Brand 2002, 92).

Of course, after the initial obliterating shock of seeing the 2010 photograph, one searches for clues to help understand, perhaps explain, the violence of someone placing the word Ship on the forehead of a young Black girl. One pulls back so that the other details I described become visible: the gown, the leaf, those big brown eyes with their impossibly long eyelashes and an uncovered wound under the right one, the stretcher and the cold pack. In addition to indexing all that Glover cautions us to keep in mind, we might allow that the label Ship is expedient, that the people who put it there are trying to help, that it’s a signifier of medical necessity in the midst of disaster and the disorder that follows. Someone wanted to mark this girl child for evacuation, wanted to make sure she got on that ship. But an allowance for intention aside, one of the larger questions that arises from the image is how does one mark someone for a space—the ship—who is already marked by it?

In *Beloved* (Morrison 1987, 61), Sethe asks her mother, “Mark me, too. Mark the mark on me too” (the mark being the brand under her breast that she shows Sethe so that her daughter might identify her if her face is destroyed in the event that their revolt is unsuccessful). The mark was burned into Sethe’s mother’s flesh on the littoral before she was stowed in the hold of the ship. But it is also more than that. It is a mark consistent with the branding that would turn those Africans into property and with a Kongo cosmogram that marks the bearer of it as an initiate. In the latter case, it connects the living and the dead, and it signifies that the bearer “understands the meaning of life

as a process shared with the dead below the river or the sea" (Stuckey 1992, 103; see also Thompson 1984). The mark in *Beloved* is connected to the ship on which Sethe's mother is forced to cross into slavery and to what was before and what comes in its wake. The mother's

response to Sethe's request that she "mark the mark on me too" is a slap because she knows what that mark means and she knows, and Sethe will come to know, that she is already marked. The mother also knows that to live in the wake, Sethe will have to remake the meaning of the mark, as she too will come to "understand the meaning of life as a process shared with the dead below the river or the sea" (Bolster 1998, 65). We must ask, again, with Spillers (2003b, 207), whether "this phenomenon of marking and branding actually 'transfers' from one generation to another, finding its various symbolic substitutions in an efficacy of meanings that repeat the initiating moments."

To return to the image of the little girl with the word Ship on her forehead, it also strikes me that of the forty-two photographs in the online image gallery of the aftermath of the 2010 earthquake where I first found this one, this is the only one in which the caption does not label the person photographed as male or female, boy or girl.²¹ And this seems to me to be significant in a culture so intent on that marking.²² When I look at this photograph I see a young girl, to quote Jordan on Phillis Wheatley, "a delicate body, a young, surely terrified face" (Jordan 2003, 176)! And I wonder if it is the word Ship that has confused the photographer and the caption writers. A synchronicity (a singularity) of thought emerges here. And it occurs to me that the person who affixed that word Ship to her forehead emerges as another kind of underwriter, here, whose naming operates within the logics and arithmetics that would also render her a meager child, as in one who occupies less space in the hold of a ship (figure 2.7).

To be clear, the optic that registers this girl only as "child" is one that indexes at least a certain inability to see, but what is at stake here is not a correction of that vision, not an expansion of that category of "girl" to include this child. Rather, what I am indexing here arrives by way of Spillers's "Mama's Baby, Papa's Maybe" (2003b, 208), that "our task [is to make] a place for this different social subject." We should remember not only that the "death rate on the trans-Atlantic voyage to the New World was staggeringly high" but also that slave ships "were more than floating tombs. They were floating laboratories, offering researchers a chance to examine the course of diseases in fairly controlled, quarantined environments. Doctors and medical researchers could take advantage of high mortality rates to identify a bewildering number of symptoms, classify them into diseases and hypothesize about their causes" (Glover 2011). We should remember, too, those in the present, seen and still abandoned at sea—like those on board what has come to be called "the left-to-die boat."²³ And remembering this, we should pause, again, on the name and provenance of the ship that that little girl is destined for—a US military medical ship named Comfort. "US," "military," "comfort," and "allopathic medicine"—each and together being terms whose connection in the lives and on the bodies of Black people everywhere and anywhere on the globe—warrant at least a deep suspicion if not outright alarm: from those experiments on board the floating laboratory of the slave (and migrant) ship, to J. Marion Sims's surgical experiments conducted without anesthesia on enslaved women; to the outbreaks of cholera in Haiti introduced by UN troops; to experiments with mustard gas on US Black soldiers in World War II to produce an "ideal chemical soldier"; to the Tuskegee and Guatemala syphilis experiments and their ripple effects; to the dubious origins and responses to the crisis of Ebola; to the ongoing practice of forced sterilization; to recent studies that show again and again that Black people in the United States receive inferior health care because they are believed to feel less pain.²⁴ We might pause, too, because that ship named Comfort is too close in name to another one originally named Care, the Zorgue renamed the Zong. But in this particular 2010 un-naming, in this marking of a quantity known only as "child," we glimpse that oceanic ungendering that Spillers theorized in "Mama's Baby, Papa's Maybe" (2003b, 214) as "those African persons in 'Middle Passage' . . . literally suspended in the oceanic, if we think of the latter . . . as an analogy on undifferentiated identity." We continue with Spillers (2003a, 206), "Under these conditions we lose at least gender difference in the outcome, and the female body and the male body become a territory of cultural and political maneuver, not at all gender-related, gender-specific."

The question for theory is how to live in the wake of slavery, in slavery's afterlives, the afterlife of property, how, in short, to inhabit and rupture this episteme with their, with our, knowable lives. "What else is there to know" now? In excess of: "Hers is the same fate of every other Black Venus" (Hartman 2008, 2)?

I didn't want to leave her (this girl child with the word Ship affixed to her forehead) as I found her in an archive of hurt and death and destruction that reveals neither her name nor her sex nor any other details of her life. One AP caption tells us: "An injured child waits to be flown for treatment on the USNS Comfort."²⁵ The second AP caption reads, "Port-Au-Prince, Haiti—January 21: A child waits to be medevaced by US Army soldiers from the 82nd Airborne to the USNS Comfort on January 21, 2010 in Port-au-Prince, Haiti. Planeloads of rescuers and relief supplies headed to Haiti as governments and aid agencies launched a massive relief operation after a powerful earthquake that may have killed thousands. Many buildings were reduced to rubble by the 7.0-strong quake on January 12."²⁶ But a "voice interrupts: says she" (McKittrick 2014, 17).

And so this Girl from the archives of disaster of the first month of the second decade of the twenty-first century is evocative of another two girls on board that slave ship Recovery in the midst of the long disaster of Atlantic slavery whose effects are still unfolding and whose stories Hartman tells by untelling in "Venus in Two Acts." And they are evocative of other contemporary girls, as they, too, are mis/seen and all too often un/accounted for.

A meager story is not a failure. "We are not only known to ourselves and to each other through and by that force" (Sharpe 2012a, 828). And I was not drawn to this young girl's image to enact more violence. If I could help it, I did not want to resubject her in those ways. Echoing the poet Claire Harris (1984, 38) in "Policeman Cleared in Jaywalking Case," I think, "Look you, child, I signify . . . the child was black and female . . . and therefore mine, Listen." What happens when we look at and listen to these and other Black girls across time? What is made in our encounters with them? This looking makes ethical demands on the viewer; demands to imagine otherwise; to reckon with the fact that the archive, too, is invention. Harris's poem takes its title from a news item that appeared in the Edmonton Journal in 1983. The girl is fifteen and Black and she is stopped by the police for jaywalking. She is "terrified" (a bystander recalls) and unable to produce identification with a photo on it that will satisfy their gaze, their rules, and so she is arrested, "stripped/spread/searched" (Harris 1984, 36). The second girl in the poem is the poet, who at fifteen is daydreaming when she steps, thoughtless, into a busy street in Trinidad. "I was released with a smile/with sympathy sent on in the warm green morning/Twenty years later to lift a newspaper and see my fifteen year old self/still dumb/now in a police car/still shivering as the morning rolls past but here/sick in the face of such vicious intent" (Harris 1984, 36). In the face of the Canadian state's "vicious intent" Harris is moved to imagine across time and space to retrieve the incident from her childhood in order to place it alongside the contemporary one, and to speak and write to and from an imagined and lived otherwise. So when Hartman in "Venus in Two Acts" concludes: "So it was better to leave them as I had found them" and then two pages later asks, "In the end, was it better to leave them as I found them?" the statement and the question perform an epanalepsis: "the repetition of a word or

words after an intervening word or words, whether for emphasis or clarity, as to resume a construction after a lengthy parenthesis"; a "liaison between words and sentences."²⁷ Between the statement and the interrogative is the interregnum; and in that interval the "something—anything—else" can and does appear.

In the 2010 photograph of a Haitian girl child marked with Ship, we lose whatever attempt at a first name Phyllis granted Phyllis Wheatley, lose something like gender and individuation. "Yet a voice interrupts: says she" (McKittrick 2014, 17). Recall that in the archives Spillers, Philip, Hartman, and others most often encounter not individuals, but columns in which subjects have been transformed into cargo marked in the ledger with the notation "negro man, ditto, negro woman, ditto." "There were," on the Zong's and other ships' manifestos, Philip tells us, "no names—the lists of slaves in the book were simply identified as 'Negro man' or 'Negro woman' at the top of the ledger and the account book followed by 'ditto' all down the page, with the exception of one gloss, 'meagre,' allowed with reference to 'negro girl'—'negro girl meagre.'" She continues, "And just in that one word . . . I halted when I saw the word, and I thought, there is a whole story in that word, 'meagre'" (Saunders 2008a, 77).

Phyllis Wheatley, daughter of a "bitterly anonymous man and a woman" (Jordan 2003, 176), was "meager" (a meager, sickly child according to some accounts), never really a girl; at least not "girl" in any way that operates as a meaningful signifier in Euro-Western cultures; no such persons recognizable as "girl" being inspected, sold, and purchased at auction in the "New World." Likewise, to some, Phyllis was never really a poet. Most famously not to Thomas Jefferson, who wrote in Query XIV of Notes on the State of Virginia ([1785] 1998, 147), "Misery is often the parent of the most affecting touches in poetry.—Among the blacks is misery, God knows, but no poetry. . . . Religion indeed has produced a Phyllis Whately; but it could not produce a poet. The compositions published under her name are below the dignity of criticism."

In that 2010 photo the meager child is not Phyllis, but Ship; that is, she is not a particular ship/girl named Phyllis but any ship/child/girl; the part for the whole. And, while this is the only photograph like this that I have found, my experience of photographs of disasters that happen in Black spaces and to Black people is that they usually feature groups of Black people, to quote Elizabeth Alexander, in "pain for public consumption" (Alexander 1995, 92) whether those Black people are in Los Angeles, New Orleans, Sierra Leone, the Dominican Republic, Lampedusa, Liberia, or Haiti (figures 2.9–2.13).

Philip in Zong! and Fred D'Augier in Feeding the Ghosts tell us that there were on board that slave ship Zong many meager girls. So, on the one hand, we can imagine this photographer pulling back the shot to reveal not one Black girl child but row after row after row of Black girls, boys, men, and women with the word Ship affixed to their foreheads. Alternatively, given the ways Black suffering forms the backdrop against which another kind of "human drama" (capital H) is staged, we might also realize that pulling back the shot may reveal that she is the only one so labeled for evacuation. Marked as the Ship/the child (like The Phyllis); saved (?) in order to be subjected yet again, because we are only usually singular, only the one, in an extraordinariness that, from one point of view obscures suffering in order to produce a "miracle Phyllis," and rarely "singular" or "one" in our putatively visible suffering or vulnerability despite that being, for some, all that there is to be seen. It was not better to leave her as I found her. In my reading and praxis of wake work, I have tried to position myself with her, in the wake.

October 3, 2013. A ship filled with 500 African migrants caught fire, capsized, and sank one half-mile off the coast of the Italian island of Lampedusa. Like the Zong, which was built to carry at most 200 people but was packed with over 440 captive Africans, this unnamed ship was meant to hold fewer than half the number of people on it. Over 300 of the men, women, and children on board were killed. "Deep sea divers 'unpacked a wall of people' from the hull of a smuggler's trawler on the seafloor near this Italian island on Monday, gingerly untangling the dead would-be migrants in the latest and most painstaking phase of a recovery operation following the ship's fiery capsizing."²⁸ Two hundred thirty years after the crew on board the slave ship Zong threw overboard those living Africans, that word cargo repeats, and so do the horrors of the holding, the throwing, and the beating. African migrants are exposed "to inhuman levels of violence," stabbed and thrown overboard, shot and thrown overboard, migrants shut in the "dark and suffocating hold," while others are packed on deck—standing on the door to the hold; the perils are not now, and never have been, evenly distributed. As newspapers report on these present disasters and the migrants' states of distress, are we to imagine that some kind of repair is done with the contemporary newspapers recognition of their physical and psychic distress and the addition of the adjective human to the noun cargo? The addition of the word human to cargo does nothing, here, to ameliorate the ghosting these ships do of transatlantic slavery or the afterlives of slavery or the afterlives of property. "Pastness . . . is a position. Thus, in no way can we identify the past as past" (Trouillot 1997, 15).

The aff traps black people into a racist system-- Implementing NHI through an anti-black grammar leads to race-specific medical interventions – it creates racist disease surveillance that contains and securitizes black spaces because of structural factors that make their inhabitants predisposed to illness

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Second, and related to our first point, these biomedical targeting operations extract the conditions of black health and illness from the broader contexts of structural racism. Biomedical targeting generally fails to recognize the social conditions in which poor health emerges and, in the case of black subjects, how poor health, institutional racism, and the epistemology of anti-blackness are ontologically enmeshed. The targeting

of black populations—specifically the two cases we explore here—does not simply direct resources to black subjects. Instead, in such operations, race is objectified as that to be targeted, meaning that race itself is not undone: That is, race as a stratifying mechanism that orders the social—a social order characterized by anti-blackness—is not called into question. Both BiDil and medical hot spotting demarcate populations, with supposedly distinct bodies, and name them as a political problem in need of specific health governance; black bodies and racialized spaces are targeted in order to manage the life of the population. Accordingly, BiDil might be seen to ontologize blackness as a corporeal truth for market accumulation, while medical hot spotting can be said to spatially ontologize structural racism in order to secure cost efficiencies of the health care system. BiDil is predicated on financial extraction; medical hot spotting is predicated on threat containment.

These biomedical targeting technologies reveal how health interventions do not necessarily support or achieve a better future for African Americans. Instead, they advance the epistemological violence of anti-blackness by concentrating the “problem” of black life in the U.S. at the scales of: (1) the racialized body (BiDil) and (2) space (hot spots), which both become objects of ever more heightened administration, financial exploitation, and securitization. BiDil positions African Americans as “problem bodies” that must take on responsibility for their own racialized embodied risk through the act of buying and consuming race-based medicine; here, anti-blackness operates through the black responsibilization of risk. Medical hot spotting tracks, maps, and fixes high-cost health care users in “problem spaces” that are positioned outside the populace; hot spotting locates and reifies the structural position of anti-blackness in space for the purposes of surveillance, anticipation of risk, and containment.

Third, contemporary biomedical targeting technologies are an endangering form of health administration exacerbated by the logics of neoliberalism. Under neoliberal conditions, populations previously excluded from the vital politics of the nation are now ostensibly being addressed. However, the two biomedical targeting technologies that we explore reveal a predatory power to demarcate race for purposes spanning financial extraction to threat containment—even as such “targeting” is advocated as the means for addressing the embodied and spatial effects of racial inequality. In neoliberal times, the color line no longer operates as a clear and obvious modality of exclusion, as Du Bois would have it (Goldberg, 2008). The neoliberal biopolitics of health increasingly emphasizes customizing health, the body, and life itself through biomedical practices (Clarke et al., 2003: 181–182). Our two case studies reveal how customizing health seems to be an operation of inclusion (directly or indirectly by race) within biomedicine: BiDil is a customized drug that attends to black health; it targets racial minorities supposedly to extend life. Medical hot spotting is also a form of customization through care delivery: It delineates “problem spaces”—where high utilizers of health care are located—in order to direct resources and generate efficiencies in health provisions. “Customizing” works in the first case through “color awareness” and marketing within biomedicine (i.e. the racialized spectacle of the body), and paradoxically in the second, through invisibilizing race at the level of “location”/space according to the so-called colorblind agency of the free market and cost–benefit analysis (O’Boyle, 2007). While both targeting technologies may attempt to alleviate racial health disparities, they simultaneously augment racial difference and exacerbate racial inequalities—but they do so in very different ways: thus emphasizing the importance of tracing out the empirically distinct means through which each technology resecures the epistemology of anti-blackness. BiDil highlights the neoliberal refusal to acknowledge the social production of risk, by casting health as an individual—not social—enterprise. Medical hot spotting disavows the historical and spatial processes of racial formation that structure the present and simultaneously shows that certain (racialized) subjects are positioned—in advance—as risk failures within the paradoxically “race-neutral future” of the nation. To begin exploring these ideas, we turn to the case of BiDil, the oft-disputed first pharmaceutical with a race-specific indication.

England proves that anti-black structural racism makes for worse health outcomes for black bodies in their NHI Matthews 15

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Matthews D (2015) Sociology in nursing 4: the impact of ethnicity on health inequalities. Nursing Times; 111: 44, 18-20.

The extent of racial prejudice **in Britain** is difficult to quantify, primarily because people may be unwilling to admit to it. However, the British social attitudes survey in 2013 showed that 30% of the British population described themselves as racially prejudiced (National Centre for Social Research, 2014). Direct experience of racial prejudice, or awareness that such attitudes exist, can have significant negative consequences for individuals' health, particularly their mental health (Annandale, 2014; Barry and Yuill, 2011). Karlsen et al (2005) argued that experiencing racial prejudice increases the risk of anxiety disorders and depression, as it has among Caribbean, Indian, Pakistani and Irish minorities. Similarly, racially prejudiced attitudes can be embedded in how society operates, causing social structures and institutions to function in a racist manner. Rather than just focusing on the actions of individuals, we need to look at social structures and institutions that may operate in a discriminatory manner and influence the actions and attitudes of those within them.

Institutional and structural discrimination can be found in health and other **government services in the health sector**; for example, it has been argued that the institutional attitudes and practices of mental health services and the criminal justice system have contributed to some of the ethnic disparities identified. **The reasons for the over-representation of black individuals, especially young men, in mental health settings** are hotly contested (Annandale, 2014) but one underlying reason **is how mental health services and associated institutions respond to them** (Rogers and Pilgrim, 2014). The likelihood of individuals being labelled as mentally ill increases in proportion to the cultural gap between those who are labelled and those who are labelling (Horwitz, 1983). **Young Afro-Caribbean men** are far more likely to come into contact with mental health services than other groups, especially via the criminal justice system; it is claimed this is because society - the wider public and criminal justice institutions - perceives them as a social threat (Barry and Yuill, 2011). As a result, the criminal justice system is more likely to interpret their behaviour negatively and, as that behaviour is more likely to be "visible" to criminal institutions working in collaboration with the health system, the individuals **are more likely to be labelled as having a mental illness**. In this respect **mental health services can be viewed as institutions of social control** (Rogers and Pilgrim, 2014), based on dominant perceptions of young Afro-Caribbean men exhibiting behaviour seen as a social threat. This is supported by research from the last three decades, which shows this group is more likely than its ethnic majority counterpart to be compulsorily admitted to mental health institutions and placed in locked wards (Rogers and Pilgrim, 2014). Suggestions of discrimination in **the institutional practices of health services** are contentious (Bradby, 2012). The purpose here is not to claim that those working in these services are racially prejudiced, but to suggest that the manner in which these services and institutions operate may **discriminate against minority ethnic groups due to embedded norms, values and practices that impact on how their health status is understood**.

Any imagination of reformism is a libidinal, political, and economic investment in an antiblack institution that should be rejected

Rogers 17

(Melvin Rogers, Scott Waugh Chair in the Division of the Social Sciences and Associate Professor of Political Science and African American Studies, "White Supremacy, Fear and the Crises of Legitimation," January 1, 2017, <http://www.publicseminar.org/2017/01/white-supremacy-fear-and-the-crises-of-legitimation/#.WIJhVLYrK1s>)

These two seemingly disparate moments – Slager's mistrial and Trump's win – both call into question the legitimacy of the political and legal institutions that define the American polity. The first crisis of legitimacy relates to categorical insecurity, while the second is tied to the presumption of power by white Americans, which was perceived to be under assault, leading to the reactionary politics that produced Trump. **But the two legitimization crises** are not of the same character and, in fact, **are at cross-purposes with each other, generating an impasse that is not readily overcome**. **In the wake of similar high-profile police shootings where wrongdoing seems so clear, but goes unpunished, the Slager trial crystallizes what many believe – that police officers can kill black Americans with impunity**. The greatest obstacle to freedom and equality thus appears to be a society in which citizens are habituated to recognize some among themselves as worthy of care, concern, and justice, while believing they can withhold these important moral goods from others. **Black Americans** thus **find themselves living in a society in which they are**

asked to follow the law, and yet, are simultaneously unprotected by political and legal institutions. **The direction of loyalty goes from black Americans to the state, but not the other way.** This condition is the quintessential expression of a **legitimation crisis** — what philosopher Jürgen Habermas described in 1973 as **an inability of the state to secure institutionally and morally the goods for which it was established**, thus **destroying any faith the citizenry would** otherwise **place in its institutions**. The ascendancy of Black Lives Matter is not merely the result of trying to properly align one aspect of American society — in this case, the criminal justice system — to the appropriate values that define our political and social life. Rather, the movement is a claim that **the way we order our collective lives and dispense justice benefits only one group**. And yet, the **Trump victory makes clear** that **a sizeable segment of the population rejects** an American future that is more diverse, more inclusive, and potentially more equal. It rejects, in other words, **precisely the vision to which Black Lives Matter gave expression**. The “**whitelash**” to which Jones points **should be read as an attempt by white Americans to address what they too perceive as a legitimation crisis: they can no longer trust their racial identity to secure** for them the **entitlements** (including economic ones) that it previously had. Both of these crises of legitimacy are **fueled by** the workings of **white supremacy**, but they are in obvious and inescapable conflict. The first crisis — namely, **that non-white lives are valued less than white lives — cannot be addressed without intensifying the second**. And addressing the second, as **through the ascendancy of Trump, involves doubling down on the politics of domination and arbitrary violence that generate the first**. III When we treat white supremacy as the operating logic that ties these two moments together, we are faced inexorably with white supremacy’s other operating feature — namely, fear. In police shootings of unarmed black people, the police officer is often found saying that he “feared for his life,” or in the case of Slager, felt “total fear.” **White supremacy creates a condition wherein the “natural” or “normal” status of black people easily mingles with traits of criminality in the minds of observing citizens** and conditions their behavior toward black people, regardless of any observable nonthreatening conduct on display. After all, in the case of Michael Scott, he was running away. **White supremacy thus creates a social epistemic context that renders the status of blacks** — the lives they lead and the activities they undertake — **uncertain, subject to arbitrary domination** at best **and death** at worst. But such dangers are unable to come into view precisely because of the normalization and legitimization of the claims of fear often provided by police officers specifically, and white Americans generally. **Just as the logic of white supremacy involves valuing white lives more than others, it leads to the presumption that white Americans are thus (a) accurate when they describe the context in which they engage nonwhites as threatening and (b) are therefore legitimate in their display of force to extinguish the source of fear.** This is because **the security of white lives is to be affirmed at all costs**, even when it renders non-white lives disposable. Black Americans are not unique in suffering as a result of this logic, even if they are the most obvious victims of it. This leads to a deeper problem. **The avoidance of a legitimation crisis for white Americans not only involves** legal and political institutions channeling the supremacy of whiteness, **but also protecting whites from the existential fear that is the hallmark of non-white lives.** **This involves a constitutive distortion of democracy.** As John Dewey made clear in his 1927 work, *The Public and Its Problems*, **democracy involves treating public life as an open sphere — a network across which** problems and concerns get communicated by different groups seeking relief, and in our coordinated effort to address such concerns, **we build a shared life** together founded on the principle of equal regard. **In contrast, white supremacy involves a distortion of democracy by treating the concerns of white Americans as the true and legitimate concerns of the polity** and therefore the only concerns in need of redress. If democracy opens the space of power by preventing any one group from claiming exclusive authority to use it, white supremacy renders public life static by tethering it to whiteness. The result is to render the concerns of non-whites as either of less importance or unworthy of any consideration if such consideration involves a diminution of whiteness. This is something about which African-Americans have long been aware, from the nineteenth century to the present century, even as they debated whether to see this distortion as partial or total. But we know that black Americans are not unique in suffering as a result of this logic if we focus on Donald J. Trump’s campaign for the presidency. “*Make America Great Again*,” the mantra of his campaign, was consistently wedded to the proposition that America is no longer great because “illegal” immigrants are stealing jobs from white people — largely white men — because Muslim-Americans are threatening to supplant the values of American democracy, and because America is in danger of being effeminated by both the disabled and the LGBTQ community. **Similar to the treatment of black Americans, Trump demonized or pathologized all other groups.** As Charles Blow rightly

observed in August: “Make America Great Again’ is in fact an inverted admission of loss – lost primacy, lost privilege, lost prestige.” But these loses take on the force that they do because they generate the perception of uncertainty regarding one’s status, and, correspondingly, fear of falling to a level that would make white Americans merely equal to their non-white counterparts. The legitimization crisis for white Americans is thus a legitimization crisis of whiteness and the security their identity otherwise provided them. And yet, it is precisely the institutionalization of whiteness that various groups such as African-Americans often see as the culprit for their ill treatment. But herein lies the rub and the source of the impasse: who among us would readily give up such security, even for the noble values of equality, freedom, and justice? The troubling issue that we must grapple with is the possibility that white supremacy generates far too many psychological, libidinal, cultural, political, and economic goods to be sufficiently destabilized or decentered. And the goods, although not few in number, that seemingly come from a racially inclusive society that affirm the equal dignity of persons appear far too weak to create an ethical society that can find institutional and cultural support. Overcoming this impasse suggests, at a minimum, that tinkering within the existing structures of the United States or imagining that those structures would permit a radical transformation of values would simply not match the gravity of the problem.

Increasing access to NHI is the extension of anti-black eugenics. Appeals to a liberal ethic of care is the appropriation of black suffering for the benefit of the biopolitical state.

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In Beloved, Morrison departs from and transforms the slave narrative convention of juxtaposing the degradation of slaves with that of animals in order to draw our attention not to the violence of dehumanization but rather to the violence of humanization. More specifically, Beloved suggests that animalization and humanization of the slave’s personhood are not mutually exclusive but mutually constitutive. In other words, the slave’s humanity (the heart, the mind, the soul, and the body) is not denied or excluded but manipulated and prefigured as animal, whereby black(ed) humanity is understood, paradigmatically, as a state of human animality, or “the animal within the human.” Morrison’s text recalls rhetorical strategies employed by Frederick Douglass, arguably the nineteenth century’s most iconic slave, that diagnose racialization and animalization as mutually constitutive violence under slavery. Douglass’s iconicity is perhaps precisely owed to his dexterous navigation of competing liberal humanist rhetorical modes and affective registers, in particular, sentimentality and religio-scientific hierarchy. While Douglass undoubtedly radically calls into question the biopolitical logics and practices of slavery with respect to both humans and animals, he does so in a manner that reveals the seemingly near-inescapable paradoxes of liberal humanist recognition to the extent that one is conscripted by its terms—appeals to discourses of sentiment and Self. Yet, both sentiment and the sovereign “I” return us to racialized, gendered master narratives of identity and feeling, which the rooster’s gaze in Beloved productively de-stabilizes.⁵ Mister’s gaze, or the exchange of glances between Mister and Paul D, offers a much-needed critical alternative to sentimental ethics—sympathy, compassion, protection, stewardship, care, and the humane—which has historically been conceived within the terms of a racialized, heteropatriarchal economy of sensibility. In what follows I examine how we might read Morrison as productively problematizing sentimentality as well as gendered appeals to discourses of the Self rooted in religio-scientific hierarchy, as both discourses have historically recognized black humanity and included black people in their conceptualization of “the human” but in the dissimulating terms of an imperial racial hierarchy. Re-constellating the slave narrative genre, Morrison opens up a new way to interpret the genre, not as one that exposes slavery’s de-humanization but rather as one that details the violence of liberal humanism’s attempts at humanization. Unsettling reified interpretations of history and literary slave narratives, Beloved identifies the violation of slavery not in an unnatural ordering of man and beast but in its transmogrification of human form and personality, as an

experiment in plasticity and its limits therein. To put it differently, New World slavery established a field of demand that tyrannically presumed, as if by will alone, that **the enslaved, in their humanity, could function as infinitely malleable lexical and biological matter, at once sub/super/human. What appear as alternating, or serialized, discrete modes of (mis)recognition**—sub/super/humanization, animalization/humanization, privation/superfluity—are in fact **varying dimensions of a racializing demand that the slave be all dimensions at once, a simultaneous actualization of the seemingly discontinuous and incompatible.**

NHI produces a form of biological citizenship which attaches itself to the inmates debt to society – the debt is paid through acquiesce to a eugenic project in which black and brown people are medicated and sterilized in the name of disease and crime prevention

Pollock 14 [Anne, “On the Suspended Sentences of the Scott Sisters: Mass Incarceration, Kidney Donation, and the Biopolitics of Race in the United States,” *Science, Technology, & Human Values*, Volume: 40 issue: 2, page(s): 250-271,
<http://journals.sagepub.com/doi/full/10.1177/0162243914539569>]

In Discipline and Punish ([1975] 1995) theorized that prison’s obvious failure to rehabilitate is actually part of its function, playing a key role in constituting the delinquency it purports to seek to correct. In the profoundly racialized US prison system, the role of prisons in constituting a class of society that is excluded from society is particularly blatant (Alexander 2010). Indeed, in the post-Jim Crow era, as Loic Wacquant (2002, 55) argues, the “carceral institution...has been elevated to the rank of the main machine for ‘race making.’” No other country has an incarceration rate as high as the United States, and our prison system is rooted in our history of slavery (Davis 1998; Blackmon 2008). I refer to the US prison system as “our” prison system, at the risk of sounding parochial to non-American readers, to underscore the responsibility that I and others writing from this critical location must take for this moral emergency. In the wake of the fall of Reconstruction, the swelling prison system in the South did more than appropriate labor; incarceration and a prison record also became a mode of denying citizenship rights more broadly (Davis 1998). The Scott Sisters have themselves put their experience into this larger context of the social role of criminal justice in perpetuating racial inequality, for example, by participating in a town hall meeting at a Jackson church on the topic “Saving Black Boys from the Cradle to Prison Pipeline to Help Ourselves” (Thomas-Tisdale 2012).

The Scott Sisters’ case is also embedded within the larger problematic of the public health consequences of mass incarceration (see Freudenberg 2002; Rich et al. 2012). In 1991, much earlier in the growth of mass incarceration, the American Public Health Association (1991) issued a statement decrying mass imprisonment on the grounds that “prisons disproportionately confine sick people...and...prisoners are subject to further morbidity and mortality in these institutions,” noting that **this burden falls particularly heavily on poor people and people of color.** More recently, amid scholarship showing that black/white health disparities are smaller among prison populations than amid the general population, Dumont et al. (2013, 85) point out that much of the impact on the social determinants of health appears after prisoners are released, creating “a perverse relationship between public health and incarceration: even as correctional facilities appear to provide a venue for addressing health disparities by accessing a high-need, medicallyunderserved, largely non-White population, incarceration itself ultimately perpetuates those disparities in the community.” Barbour’s notion of prison release as a way of saving money points to the peculiar character of the right to health care in the United States. As sociologist Tony Hatch (2010) has pointed out, in the United States, the only people with a Constitutional right to health care are prisoners: any state is perfectly within the law to disregard the health of any ordinary citizen. This peculiar structuring of the right to health care—such that **deprivation of liberty and access to a right to health care are explicitly intertwined—is part of how biological citizenship is negotiated in the United States.** The US Supreme Court has ruled that failures to provide adequate medical care to prisoners is considered “cruel and unusual punishment” under the eighth amendment: Mississippi is not legally allowed to disregard the health of a person in its custody in prison. In the 1976 ruling *Estelle v. Gamble*, the Supreme Court liberally cites a still-active provision of the Civil Rights Act of 1871, which provides federal recourse for those whose constitutional rights are being violated by a state (42 U.S.C. § 1983). The Supreme Court’s invocation of a Reconstruction-era law hints at the state and federal racial politics at stake in requiring states to care for their prisoners. By making the state’s release of the Scott Sisters conditional upon the state’s release from any obligation toward them at all, **a perverse form of freedom is constituted.** Mississippi officials have explicitly articulated medical release of prisoners as a means of shifting costs from state to federal obligation, pointing out that if released prisoners qualify for Medicaid, the state’s financial burden for their care is lowered to 25 percent, and if released prisoners qualify for Medicare, the financial burden is completely shifted to the federal government (Bakeman 2012).

And in this particular case, the sisters were allowed to move to Florida, where their mother, children, and grandchildren were living, an unusual privilege for people on parole that is both quite correct and effectively diminishes still further any contribution by the state of Mississippi to their care. Any Medicaid or other state contribution for the Scott Sisters’ care will be paid for by the state of Florida, not by the state of Mississippi. Of course, **even though prison confers a right to health care, in practice, prisoners are often very poorly cared for.** That Jamie Scott is in such poor health—after spending essentially her whole adult life in the custody of the prison—points to the inadequacy of that care. **The structurally racist criminal justice system is the context of both the organ failure and of its donation,** in a way that resonates with Sherine Hamdy’s account of dialysis and kidney donation in Egypt. There, Hamdy posits that “**disease processes**” of kidney failure and survival are “already political,” and “**contest the very opposition between the biological and the political**” (Hamdy 2008, 563). Both Jamie Scott’s organ failure and Gladys Scott’s promise of organ donation have what Hamdy would flag as a “political etiology.” **Dialysis** itself provokes comparisons with incarceration among nonincarcerated people with end-stage renal disease, who describe themselves as “doing time” (Russ, Shim, and Kaufman 2005). In this sense, Jamie Scott’s kidney failure is its own life sentence. Even the prospect of a kidney transplant, from her sister or

otherwise, would not free her from the obligations of disease management but would trade one intensive medical regime for a less onerous one. Prison is a particularly stark setting for what Alondra Nelson has characterized as a central tension in the health inequality of African Americans: poor black communities have long been “both underserved by and overexposed to the medical system” (Nelson 2011, 20). The Scott Sisters’ case becomes an individualized instantiation of this problematic: the medical system that cares so poorly for Jamie also demands bodily sacrifice from Gladys. After their release, the sisters cared for their ailing mother (since deceased), while striving to get themselves healthy enough for transplant surgery, for which they lack the necessary financial resources (Ma’at 2012b). Insurance (presumably Medicaid) would pay for Jamie’s surgery but not for Gladys’s. The inadequacy of health care for prisoners is in this sense continuous with the inadequacy of health care for racially stratified American publics.

The plan’s leads to biocitizenship. Results in racial mapping for the growth of new markets through the creation of patents.

Roberts 10 [Dorothy, George A. Weiss University Professor of Law and Sociology and the Raymond Pace and Sadie Tanner Mossell Alexander Professor of Civil Rights @ Penn Law, “Race and the New Biocitizen,” in What’s the Use of Race? Modern Governance and the Biology of Difference, pp.259-64]

Amy Harmon of the New York Times won a 2008 Pulitzer Prize for a prominent series of articles called “The DNA Age,” about the many ways genetic discoveries are influencing our lives. One of these articles, titled “Gene Map Becomes a Luxury Item,” quoted a millionaire, saying, “I’d rather spend my money on my genome than a Bentley” (Harmon 2008a, F1). Sequencing your genome can be quite pricey. Knome, in Cambridge, Massachusetts, charged private clients \$350,000 to read their entire genome and provide a face-to-face, customized analysis of what it tells about them. Scientists predict that, in the near future, they will be able to map everyone’s personal genetic code at a more reasonable cost, allowing doctors to make more accurate predictions about our health and prescribe medications designed specifically to match each person’s individual DNA profile. In fact, several biotech companies already offer to genotype DNA sent to them by customers and provide personalized reports about their ancestry and risk for various conditions. Using the tag line “genetics just got personal,” the Silicon Valley company 23andMe is an online service that sends customers an at-home kit to collect a saliva sample and, based on a genetic scan, gives them quantitative estimates of their risk for certain diseases and traits based on research that has found genetic associations. The company also uses genotyping to “compare your genetic information to that of people from around the globe.” 23andMe markets itself as a tool not only for gathering personal information, but also for creating social connections. Its Web site prominently displays “sharing and community” as a chief service, noting, “Seeing your own genetics is just the beginning of the 23andMe experience. Our features also give you the ability to share and compare yourself to family, friends and people around the world.” In September 2008, the New York Times style section carried a colorful splash about the celebrity “spit party,” hosted by Barry Diller, Rupert Murdoch, and Harvey Weinstein, at which the glitterati spit into test tubes so their DNA could be analyzed (Salikin 2008). Co-founder of 23andMe Anne Wojcicki explained that the company helps people use their genomes as a platform for social networking: “If you want to have a community around us, we’d like to be able to allow you to form a pisorias-specific community” (Salikin 2008, ST1). But her

vision of this new citizenship based on DNA is even grander: “We envision a new type of community where people will come together around specific geno-types, and these artificial barriers of country and race will start to break down” (Weiss 2008, A1).

Sharing

one’s DNA is becoming a civic duty as well as a basis for civil engagement. In October 2008, Harvard genetics professor George Church launched the Personal Genome Project (PGP), which will build the only public DNA database that links genes to diseases, physical traits, and abilities (Harmon 2008b). In exchange for having their genomes inventoried, PGP participants agree to make it all public, along with personal information about their health, ancestries, and habits. Ten people, called the PGP-10, initially volunteered, and Church appealed to 99,990 more of his fellow citizens to join him in donating their genetic material as part of the new civic responsibility to aid scientists in their mission to advance personal genomics. “We’re all at risk for everything to some extent,” Church said, “and so we need to have a rich set of data and we need to be sharing that data until we get a much deeper understanding of what all the risk factors are, environmental and genetic” (Nakashima 2008, A1). A key component of 23andMe’s services is similarly to put customers’ genetic information in a database for research. As the company explains on its Web site, “Because we believe 23andMe’s mission extends to the advancement of science, we intend to give you the opportunity to participate in research that could improve understanding of how genetics influences our lives.”³ The expansion of genetic research and technologies has helped us cross a threshold into a new type of biopolitics concerned with our capacity to control and manipulate human life. As British sociologist Nicholas Rose (2007) has shown, so-called biological citizenship is grounded in the unprecedented authority wielded by individuals over their well-being at the molecular level. According to Rose (2007, 40), “our very biological life itself has entered the domain of decision and choice.” Biological citizenship entails both individuals’ autonomy over personal welfare and a biosociality that links people together around their common genetic traits (Rabinow 1996). Genetic information enables individuals not only to manage their own health, but also to unite with others around their common health conditions, as revealed by DNA testing. Rose (2007, 4) and others celebrate biocitizenship because it enhances human agency, as patients “become active and responsible consumers of medical services and products ranging from pharmaceuticals to reproductive technologies and genetic tests,” and as they are empowered to form alliances with physicians, scientists, and clinicians to advocate for their interests (Franklin and Roberts 2006). The relationship between citizenship and biology entails far more than organizing around shared health concerns. Genetics becomes the basis for political relationships that extend beyond the family and that include a broad range of ties among citizens and with the state. Genetics provides novel means for reinterpreting existing political identities and creating new ones, for forming communities, for participating in civic life, and for imposing civic duties. We could describe the emerging category of biological citizenship without regard to race. Indeed, biological citizenship is supposed to transcend race. But I have been struck by the way race is fundamental to the new biocitizen. Race is treated as a key—even essential—classification in the genetic research and testing that informs biocitizens. Race is at the cutting edge of technologies that empower biocitizens. Race is integral to the public discourse about genetics that promotes biocitizenship. Why? Why is race, a category invented in premodern times, so central to the most modern scientific advances? What is the use of race in constructing the biocitizen and in promoting biocitizenship as the prevailing relationship among individuals, the market, and the state? I want to take up Rose’s (2007, 167) admonition to “locate the current debates over race and genomics firmly within the transformed biopolitics of the 21st century.” But just as we cannot apply the same old sociocritiques or paste the same label of eugenics on contemporary biopolitics, nor can we uncritically assume that the new biocitizenship necessarily fosters individual life and choice and necessarily intervenes on the consequences of inequality, rather than legitimizing inequality. By placing race at the foundation of biocitizenship, race appears more significant at the molecular level, precisely as it appears less significant in society. On one hand, scientists have recently claimed genetic confirmation of classical racial categories; pharmacogenomic researchers use race as a proxy for genetic difference in studies of disparities in health and drug response; and biotech companies market a variety of products that treat race as a biological grouping. On the other hand, the U.S. Supreme Court has affirmed a color-blind approach to social policy that rejects race consciousness as a tool for addressing inequality, while many pundits have declared the Obama presidency to be evidence of a postracial America. Scientists, politicians, and corporations are constructing biocitizenship in a way that not only obscures the continuing social significance of race, but helps to promote post-civil rights mechanisms for preserving the racial inequality. The expansion of Race-Based Biotechnology The emergence of biocitizenship is occurring at the same time as we are witnessing a resurgence in scientific and commercial interest in genetic differences among “races.” (Duster 2005). After World War II, the rejection of eugenics, which had supported sterilization laws and other destructive

programs in the United States, generated a compelling critique of the biological basis of race. The classification of human beings into distinct biological races is a system of governance that arose out of European conquest, enslavement, and colonization of people in Africa and Asia. Biocitizenship did not really originate in the twenty-first century. Race has always been a form of biocitizenship: its function is to include or exclude residents from full citizenship according to their assignment to a political hierarchy based on invented biological demarcations and justifications. Social scientists' conclusion that race is socially, politically, and legally constructed was confirmed by genomic studies of human variation, including the Human Genome Project. These studies showed high levels of genetic similarity within the human species. Genetic differences among human beings are "clinically distributed"—they appear gradually across geographic space; they do not fall into sharply demarcated groupings (Bolnick 2008, 72). On June 26, 2000, when President Bill Clinton unveiled the results of the Human Genome Project, he proclaimed that "human beings, regardless of race, are 99.9 percent the same." Most genetic variation occurs within populations, not between them. Some scholars believed that the science of human genetic diversity would replace race as the preeminent means of grouping people for scientific purposes. In his manifesto against racial thinking, Against Race, sociologist Paul Gilroy (2000, 37) predicted that advances in genomic research would eventually discredit the idea of "specifically racial differences" by rendering race a useless way of classifying people. Similarly, Aravinda Chakravarti (2009, 380) wrote, in a recent issue of Nature, that "each of us has around 6.7 billion relatives. . . . The global picture of relatedness that is emerging from DNA studies stands to shatter many of our beliefs about ourselves." Chakravarti is hopeful that by shifting the focus of genomewide studies from populations to individuals, "we could test once and for all whether genetic race is a credible concept" (Chakravarti 2009, 381). Reports of the demise of race as biological fact were premature. Attention quickly shifted from the 99.9 percent genetic similarity to the 0.1 percent genetic difference, and that difference was presumed to encompass race. One of the first sites for resuscitating race was also an important aspect of biological citizenship: personalized medicine. By prescribing therapeutics that match each individual's genetic predisposition to disease and response to drugs, scientists will enable people to manage and advocate for their own health more effectively. Key to the National Institutes of Health Pharmacogenetics Research Network, which studies how genes affect people's response to drugs, is the belief that "it is important to understand the 0.1 percent difference because it can help explain why one person is more susceptible to a disease or responds differently to a drug or an environmental factor than another person" (National Human Genome Resource Institute 2005). Some researchers see race as a critical first step to producing personalized medicine because it can serve as a proxy for individual genetic difference (Tate and Goldstein 2004). The Raw Materials of Pharmacogenomic Research in her ethnographic study of two pharmaceutical labs, medical anthropologist Duana Fullwiley (2008) discovered that race served as an unquestioned organizing principle for the collection, analysis, and reporting of genetic data. During a six-month fieldwork stay at the University of California, San Francisco, Department of Biopharmaceutical Sciences, Fullwiley interviewed researchers investigating the pharmacogenetics of cell membrane transporters, molecules that are vital to drug delivery. The human genomic DNA that provided the raw material for their research entered the lab already classified by race. The researchers purchased DNA from the Coriell Institute for Medical Research Cell Repository, which identified samples according to self-reported race. Unsatisfied, they also sought a grant to build a genetic database specifically for their project that collected more "racially pure" DNA by "excluding anyone who reported racial mixing in their genealogies for the past three generations" (Fullwiley 2008, 159). The researchers not only assumed that African American and Caucasian DNA samples would have significantly different haplotype frequencies, but they also perceived each as the other's "opposite race" (Fullwiley 2008, 162). When researchers found results that were inconsistent with their perception of racial categorization, instead of rethinking their presumptions about racial sameness and difference, they usually reacted against the data. So when African American genetic frequencies were too similar to Caucasian ones, the scientist concluded that the racially labeled samples must have been contaminated.

The organizing principle of race has marked the very raw materials that go into creating the new biocitizen and shape the scientific conclusions researchers draw from them. Race at the Frontier of Personalized Medicine The promise of personalized medicine, matching drugs to each individual's unique genome, hinges on race. Until pharmacogenomics can live up to this promise, race stands in as a surrogate for individual genetic variation. In June 2005, the Food and Drug Administration (FDA) approved the first race-based pharmaceutical, BiDil, to treat heart failure specifically in African American patients. BiDil was not designed only for black people. Jay Cohn, the University of Minnesota cardiologist who patented BiDil, combined two generic drugs that have been prescribed to patients regardless of race for decades and originally intended to market it to all suitable patients. Cohn and the biotech start-up firm Nitromed repackaged BiDil as a race-specific drug as a way to get marketing approval from the FDA and to extend the patent (Kahn 2004). What is more, the clinical trial that tested BiDil involved only African Americans. Because there was no comparison group, the researchers never showed that BiDil functions only or even better in black patients than in others. Yet the FDA permitted Nitromed to market BiDil as a drug for black people.

Why do heart patients need a race-specific therapy? One theory supporting this need is that the reason for higher mortality rates among black heart patients lies in their genetic difference, either in the reason for getting heart disease or the reason for responding differently to medications for it. In its March 2001 press releases, Nitromed explained that BiDil's efficacy stemmed from "a pathophysiology found primarily in black patients." "Observed racial disparities in mortality and therapeutic response rates in black patients may be due in part to ethnic differences in the underlying pathophysiology of heart failure," the company asserted (Kahn 2003, 474). The FDA similarly explained its decision to approve BiDil specifically for African American patients in a January 2007 article in Annals of Internal Medicine. "We hope that further research elucidates the genetic or other factors that predict the usefulness of hydralazine hydrochloride-isosorbide dinitrate [the ingredients in BiDil]," the authors wrote. "Until then, we

are pleased that one defined group has access to a dramatically life-prolonging therapy" (Temple and Stockbridge 2007, 61). In the past, the FDA has had no problem generalizing clinical trials involving white people to approve drugs for everyone. White bodies function like human bodies. But with BiDil, a clinical trial involving all African Americans could only serve as proof of how the drug works in blacks. By approving BiDil only for use in black patients, the FDA emphasized the supposed distinctive—and substandard—quality of black bodies (Bowser 2004). BiDil is only one example of the growing trend toward what law professor Jonathan Kahn (2006, 1349) calls "the strategic use of race as a genetic category to obtain patent protection and drug approval." The emergence of race-based biomedicine means that the pharmaceutical and biotech industries see blacks and other racialized groups as profitable markets and test populations, as companies are searching for new money-making drugs and as the expansion of biotechnologies increases demand for human subjects and sources of human tissue. Race is a key channel through which scientists and corporations convert biomedical research into biocapital. In this way, powerful market forces help to construct the new biocitizen along racial lines.

Impact – property relations are founded on and sustained by the violent erasure of black bodies

Leong (Diana, Assistant Professor of English & Environmental Humanities Graduate Program at Utah University) 2017 (The Salt Bones: Zong! and an Ecology of Thirst, Published January 4th 2016, Isle Journal, Volume 23 Issue 4, November 2016, C.A.)

The "Zong" case played a pivotal role in enabling British commercial law and modern finance capital to ensure/insure the fungibility of the slave. Scholars of its legal proceedings have pointed to the "general average" as the

fundamental principle at stake in the appeal. Under the terms of this insurance precept, claims could be made for cargo that was deliberately destroyed if the act was absolutely necessary to secure the success of the larger enterprise. In these instances, all contracted parties (i.e., insurers and the insured) agreed to share in the loss and recompense of jettisoned cargo. In the case of "Zong," the ship's owners and crew invoked this clause to make a claim for the average value of the jettisoned slaves by speculating about the value they would have generated in their imagined exchange. But as Ian Baucom skillfully argues, the general average is also the "practice by which finance capital insures not only its objects, but, more importantly, its capacity to value (and to guarantee the value) of objects regardless of either their thingly existence or their actual market place exchange" (29). The "Zong" case is singular therefore not in the fact that it treated slaves as commodities, but because it formalized practices of speculative finance that successfully freed value from the material existence of the object. Value, in other words, no longer depended on the exchange and use values of objects, or even on the actualization of an imagined loss, but was instead conferred in the acts of insurance and speculation. "Insurances," Baucom writes, "set the money-form of value free from the life of things" (30–31). What this means for our understanding of racial slavery is that the edifice of modern finance is built on a violent erasure of black bodies that is not only condoned but anticipated, producing "an economy in which blackness circulates precisely as a form of disappearance, a spectral blackness" (Sexton, "Captivity" 78). This circulation of blackness as money-form (i.e., currency) and spectral remainder occurs alongside and through the extraction of labor from the slave's flesh, but is not necessarily bound to it. In this regard, the slave's flesh is marked as excessive, which, as Philip reminds us, provides the generative locus for a certain legal order.

Certain legal order. In "Zong! #2" of the "Os" section, we encounter the following clusters of words: the throw in circumstance the weight in want in sustenance for underwriters the loss the order to destroy the that fact the it was the were negroes after rains Wafor Yao Siyolo Bolade Kibibi Kamau (Philip 5) In the context of the "Zong" case, "the loss" belongs to "the underwriters" of the ship's insurance company for whom the systematic murder of slaves represented a contractual obligation. Within this framework, any recognition of the slaves' former bearings, as sons, daughters, friends, and partners, is foreclosed. However, Philip declares "the Africans on board the 'Zong' must be named. They will be ghostly footnotes floating below the text ... [the] idea at [the] heart of the footnotes in general is acknowledgement—someone else was here before—in Zong! footnote equals the footprint" (200). All twenty-six poems in "Os" contain a set of African names separated from the formal text by a thin line—footprints of a type of loss that cannot be accounted for within the confines of the law. In her analysis of "Zong! #2," Shockley argues that we should read these names as additional "underwriters" of the text to counter the calculations of value necessary to speculative finance. The word cluster "the weight in want/in sustenance" also draws attention to one homophone that repeats throughout the collection: "want," meaning "to desire or need," and "wont," meaning "one's customary behavior in a situation" or "given to." The word "weight" invokes, first and foremost, the heaviness of those black bodies cast into the sea and the value guaranteed by their deaths. The footnotes at the bottom of the page also bear the weight of lost kinship in want of recognition. In light of the absences that saturate "Zong! #2," and the bar of the law that separates the lost from "the loss," the phrase "weight in want," or the "value in custom," refers to captivity itself. Within the system of "Zong" as both text and historical instance, the "wont" or "custom" that provides "sustenance" for the "underwriters" of slavery is the eradication of black bodies. Acts of violence that verified the slaves' material existence as excessive to the production of abstract value consequently begat an "order" that comes in and as "destroy." Even though the treatment of the slaves as subjects of capital was assumed and uncontested, the court still ruled in favor of ordering another trial and overturned the initial awarding of compensation to "Zong's" owners. According to the proceedings of Gregson v. Gilbert, "Zong's" slaves were allegedly thrown overboard after the crew concluded that "a sufficient quantity of water did not remain on board ... for preserving the lives of the master and mariners ... and of the negro slaves" (Philip 210). However, during the appeals process, it was discovered that slaves were thrown overboard in groups over the course of several days. During this time, rainfall had re-supplied the ship with enough drinking water so as to make the further killing of slaves unnecessary. Nevertheless, slaves were still thrown overboard after the rains had fallen, begging the question of what, well beyond the captain's morbid fiduciary self-interest, motivated the additional murders? The case was clearly never about the ethical significance or legality of these deaths or about the treatment of slaves as commodities. In fact, as Jeremy Krikler proposes, the Chief Justice, Lord Mansfield, may have deliberately "ignored [those] aspects of the law," which contested the legality of the massacres because he was "fixed firmly on the questions of absolute necessity and the general average which he believed might now be weakened if the humanity of the slaves was introduced" (43). Mansfield's well-documented ambition to rid British commercial law of ambiguity certainly guided his decision to safeguard its clarity. Once it became clear that the ship's owners failed to meet the standards of absolute necessity, Mansfield's refusal to consider the slaves' humanity enabled him to shift focus toward the crew and away from the murders themselves. In so doing, the laws of absolute necessity and the general average were left intact, another paramount example of the "order in destroy" found in "Zong! #2" (Philip 5). Mansfield's resolve to treat the "unnecessary" murders as nothing more than evidence of crew error works retroactively to confirm the slaves' status as "empty bearers" of an abstract, theoretical, but entirely real

quantum of value" (Baucom 31). As such, **both the law and the systems of speculative finance it scaffolds treat the slave as if she were already dead; until, as Mansfield's anxieties suggest, they resurrect her to fortify the boundaries of the "human."**

Impact – Racial battle fatigue causes chronic and mental illnesses, and increased rates of infant mortality.

Sullivan (Shannon, Chair and Professor of Philosophy at the University of North Carolina at Charlotte. She teaches and writes on feminist philosophy, critical philosophy of race, American pragmatism, and continental philosophy) **2017** (Setting Aside Hope: A Pragmatist Approach to Racial Justice, Chapter 13 in Pragmatism and Justice, Pragmatism and Justice Edited by SUSAN DIELEMAN, DAVID RONDEL, AND CHRISTOPHER VOPARIL OXFORD UNIVERSITY, https://www.academia.edu/27794394/Setting_Aside_Hope_A_Pragmatist_Approach_to_Racial_Justice_2017_, WAKE AD

While Warren's argument against the politics of hope primarily targets its metaphysical nature, **the destruction of black bodies that he analyzes is no mere abstraction**. Neither, of course, are the intractable racial in- equalities described by Bell. In both cases, **antiblackness involves "the literal destruction of black bodies that provide the psychic, economic, and philosophical resources for modernity to objectify, forget, and ultimately obliterate Being** (nonmetaphysical Being" (Warren 2015, 327). This occurred initially through the transatlantic transformation of human beings into things (slaves) and then subsequently through other social, legal, and extralegal ways of annihilating black people and communities, including political tactics such as poll taxes, literacy tests, and the convict leasing system (2015, 216). **Recent developments in the medical health sciences reveal another material way to see how the metaphysical, legal, and economic destruction of black people via hope is both literal and physical**. A concrete connection between hope and poor health and death exists for black Americans, and I now turn to that connection to bodily situate Bell's and Warren's accounts. Psychologists and other social scientists in the United States recently have focused on how African Americans cope with so-called mundane racism: not the big-booted racism of chattel slavery, lynching, or even legalized segregation, but rather the more mundane and subtle or 'invisible' racial attacks that increasingly are being documented in post—Jim Crow America. Examples include the student who rolls his eyes in class when he realizes that the black woman at the front of the room will be his professor or the black person checking out at the grocery store who gets hassled to show several forms of identification to cash her check when the white person in front of her did not. In many ways, microaggressions such as these are minor in comparison to the major assaults that African Americans historically have experienced and still do experience. At mini- mum, racial microaggressions are not spectacularly horrific in the way that the overt violence of shootings and chokeholds is. **But just because we tend not to notice the destructiveness of racial microaggressions does not mean they are trivial. Racial microaggressions can be deadly, although we** (especially white people) **often don't recognize or want to acknowledge their violent effects.** De facto white class privilege in the form of racial microaggressions contributes to people of color's **"racial battle fatigue,"** which entails "the constant use or redirection of energy for coping against mundane racism which depletes psychological and physiological resources needed in other important, creative, and productive areas of life" (Smith, Hung, and Franklin 2012, 40). Racial battle fatigue has been **linked empirically to depression, tension, and generalized anxiety disorder in African Americans, and the stress associated with all of these psychological problems also contributes to physiological weathering that harms black health, contributing to high rates of hypertension, cardiovascular disease, pre-term birth rates, and infant mortality to name a few** (Smith, Hung and Franklin 2012, 37, 40; D. Smith 2012). **The effects of white racism literally get inside and help constitute the bodies of black people in harmful ways. They wear down the body's various systems by creating a high allostatic load via stressors that accumulate over time.** The results are health problems such as disproportionately high rates of pre-term birth, infant mortality, cardio- vascular disease, diabetes, and accelerated physiological aging (Blitstein 2009). **Racism hurts—literally—and it also kills in ways that are subtler but no less deadly than the lyncher's noose or the neighbor's bullet** (Drexler 2007). **These effects, moreover, can be transgenerational, physiologically passed onto subsequent generations through various epigenetic changes** (Sullivan 2013).

Antiblackness is a controlling impact. Increase in access cannot solve racial health disparities. The plan de-politicizes the conditions that produce these effects.

Sullivan (Shannon, Chair and Professor of Philosophy at the University of North Carolina at Charlotte. She teaches and writes on feminist philosophy, critical philosophy of race, American pragmatism, and continental philosophy) **2017** (*Inheriting Racist Disparities in Health: Epigenetics and the Transgenerational Effects of White Racism, Critical Philosophy of Race*, Volume 1, Issue 2, 2013, pp. 190-218 (Article) Published by Penn State University Press, WAKE AD)

A major health disparity between black and white Americans is found in preterm birth rates, and because of the extensive and often severe consequences of preterm birth, I focus on it here. Preterm birth, **which occurs when a baby is born at least three weeks before full term** (forty weeks), is **a leading cause of infant death and mortality. It also is associated with** numerous, subsequent health problems in both childhood and adulthood, such as **respiratory and heart problems** (including cardiovascular disease and related maladies), **cerebral palsy, intellectual disabilities, vision and hearing complications, and feeding and digestive problems** (Lu and Chen 2004, 692; Centers for Disease Control 2012; Mayo Clinic 2011; Kuzawa and Sweet 2009, 3). **African American women are 1.6 times more likely than white American women to give birth prematurely** (thirty-seven weeks or earlier), **and 2.9 times more likely to give birth very prematurely** (thirty-two weeks or earlier) (Lu and Chen 2004, 692; Mayo Clinic 2011). **An African American baby is more than twice as likely to die in the first year of his or her life than a white American baby** (Lu and Halfon 2003, 13). **This gap has not improved since the civil rights movement and the end of Jim Crow, despite efforts to increase African American women's access to prenatal health care** (Lu et. al. 2010, 62). In fact, **it only has widened in the past fifty years: from 1.6 to 2.3 times a greater risk of mortality** for African American children than white American children in the first year of their lives (David and Collins 2007, 1191). As one neonatologist has put it, **"There's something about growing up as a black female in the United States that's not good for your childbearing health.** I don't know how else to summarize it" (California Newsreel 2008, 1). What is this "something" that is so damaging to African American women's health? The official if somewhat unhelpful answer provided by **the U.S. Centers for Disease Control** (2012) is that "the reasons for the differences between [the preterm birth rates of] black and white women remain unknown and are an area of intense research." A significant portion of this research **is searching for a "preterm birth gene" specific to African Americans** (David and Collins 2007, 1191–92). Besides tending to work with an essentialist concept of race, **this line of research is troubling because it "problematically conflates observed biological variation with inferred genetic contributions, and ignores evidence that social factors can have durable life course and transgenerational effects on health**" (Kuzawa and Sweet 2009, 9). It wrongly assumes that "predisposition" means "genetic," that is, that the fact that people are born with predispositions for particular health conditions demonstrates that those conditions must be genetic (Francis 2011, 55). The misguided assumption made by the quest for a preterm birth gene is that biology is both synonymous with genetics and antithetical to all things social.

The alternative is a refusal to affirm.

Ehlers & Krupar (Nadine, University of Sydney & Shiloh, Georgetown University) **2017** (*Biofutures: Race and the governance of health, Environment and Planning D: Society and Space* 2017, Vol. 35, (2), p.222–240, Wake AD)

The Du Boisian vision of alleviating the racial "cut" in the governance of life has yet to be realized. **In the era of neoliberal biopolitics, black lives are especially imperiled in the very same moment that life is ostensibly affirmed. Biomedical targeting technologies are predicated on the laudable pursuit of attending to vulnerable populations and alleviating racial disparities of health.** These technologies potentially address specific conditions that affect black life, in accord with Du Bois' call to attend to the color line. In the contemporary era, **race-based pharmaceuticals and medical hot spotting bring black subjects into the fold of the vital politics of life through customizing care at different scales of existence**—the individual body and the environment of certain populations. Yet **in doing so, as we have shown, these practices continue to ontologize those bodies and**

spaces as a problem. Thus, while they may not explicitly fortify the color line in the Du Boisian sense, they more ominously resecure anti-blackness through the supposed fostering of life. The targeting of specific bodies or spaces extracts them from broader relations of structural racism and customizes medical resources in ways that objectify race or racialized space as that which should be secured against. Ultimately such biomedical targeting recursively protects the reality that health optimization is an exclusionary anti-black project. Our main intervention has been to examine the epistemological underpinnings of antiblackness with respect to new health governance along the lines of race. Our two examples of BiDil and medical hot spotting show that biomedical targeting anticipates risk and failure and performs death-expectant interventions that ultimately expel African Americans from optimal health but do so in different ways. BiDil extols black responsibility of risk, enlisting African Americans in self-care for lived and embodied conditions of anti-blackness, that is, for violence against blacks and for historically accumulated disadvantage and ill-health from the positioning of African Americans outside of the category of Human. Medical hot spotting further demonstrates antiblackness as the structural positioning of African Americans outside the rest of the populace as demarcated “problem spaces” inhabited by “problem bodies.” The practice orchestrates violence through spatial abstraction and data-based mapping operations that contain and surveil race as a threat, and, like BiDil, it calls for individualized responsibility. In short, these biomedical targeting technologies fail to cultivate black futures. Instead, they ontologically secure blackness as nonfuturity. Futurity lies at the heart of biopolitical governance and practices, which intervene into life in order to control but also improve the prospects of the population. In a Foucauldian understanding, **biopolitics exerts a positive influence over life, “that endeavors to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations”** (Foucault, 1978: 137). Yet, **if health, as we have shown, is an exclusionary antiblack achievement, it seems imperative to work to abolish race as an operation that biopolitically adjudicates. To this end, biomedical efforts that seek to organize reparative justice must work against reestablishing race as an ontology at the very same moment that we labor toward alleviating those very real social disparities predicated on race.** As such, **a just politics would need to address the epistemology of anti-blackness as the basis for health. Essentially, such a politics would refuse this world, precisely because it is structured through anti-blackness and “looks like no future at all”** (Bliss, 2015: 93)

Answers to: Self-Interest

It is not in everyone's self-interest to have health care

Wade L. Robison Ezra A. Hale Professor in Applied Ethics Rochester Institute of Technology Rochester, 2012

When we look at the various reasons that have been offered for universal health care, we find that they cover the field. It might seem that an appeal to self-interest would suffice. After all, each of us with health care is at risk of losing it (by being laid off, for instance, or finding the premiums suddenly significantly higher than we can afford), and those without health care are at risk at any time of illness or of harm (in a traffic accident, say). Unfortunately, an argument from self-interest is an argument for prudence, and individuals make radically different evaluations of what is prudent and what is not. Some are risk-averse; others are high fliers. Otherwise, we would not see people texting while driving or tailgating so closely that they must hit the vehicle in front should it have to stop suddenly. In addition, those without health care know they will be treated even if they lack health care insurance. So arguments from self-interest fail because, it may be claimed, it is not in everyone's self-interest to have health-care. "R. Paul Olson Ph.D. MD.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 102-105). AuthorHouse. Kindle Edition.

Answers to: Costs Too High

A lack of universal care fragments the funding system

R. Paul Olson, 2012, PhD, MDiv, Moral Arguments for Universal Health Care, Kindle edition, page number at end of card

There is also a growing awareness among some health policy analysts that . . . one of the major barriers to controlling health care costs is exactly this lack of universal coverage. This is not only because it is difficult for poor and sick people to seek preventive care, but also because it fragments the financing system, requiring the existence of an expensive safety net as well as aggravating the problem of cost-shifting. (Anderson, Rice, & Kominski, 2007, p. xxxiii) "R. Paul Olson Ph.D. MDiv.". Moral Arguments for Universal Health Care: A Vision for Health Care Reform (Kindle Locations 287-292). AuthorHouse. Kindle Edition.

Equality Answers

Equality of opportunity just means a person should have a fair shot to access natural talents and abilities. Providing health care is not necessary for that

Han Hennenberger, Connecticut College, 201, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

Jacobs argues that Daniels' approach fails. Differences in health among individuals do not always reflect arbitrary social circumstances but arbitrary natural circumstances. Daniels differs from Rawls in his interpretation of fair equality of opportunity as he requires that it minimize both social and natural circumstances. According to Jacobs, however, this interpretation is misguided. The principle of fair equality of opportunity accepts that natural differences among people are fair. After all, it requires that people have an equal shot at developing and utilizing their natural talents and ambitions, not that everyone have equal natural talents and ambitions. Therefore, Jacobs concludes, universal access to healthcare is not a requirement of fair equality of opportunity and the minimalist egalitarian strategy fails.

Rivate Heath Insurance Turn

Medicare for All bans private health insurance, undermining care

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

Unlike the health plans funded by the Canadian and British governments, the single-payer system proposed by Sanders and Rep. Pramila Jayapal presumes to provide every possible service to every American, and at no out-of-pocket cost to them, giving the sponsors their justification to ban private health insurance. But over and above the philosophical issues associated with banning private health insurance—Why shouldn't individuals be able to buy supplemental or private coverage if they want it?—comes an important logistical question: Can a government-run system cope on its own? The examples of countries like Canada and Britain suggest that a system that banned private health insurance entirely would face two complementary problems. Would the government system have the money, and the capacity, to fund all medical procedures for all individuals? One American health care expert wrote that he didn't understand the need for private insurance in Britain, until an NHS manager explained that private care provides a pressure-relief valve for the government-run system: All the people using the private system have already paid their taxes, so they are siphoning volume out of the NHS that the system otherwise would have to manage....The NHS would come to a grinding halt if private practice went away.³⁹ [Emphasis added.] By banning private insurance outright, the single-payer bills would not just infringe on American citizens' freedom to buy the health coverage they desire. That prohibition would also place tremendous financial and capacity pressures on the government-run system, which it likely could not handle.

Freedom is more important than equality

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

Universal health care is part of Canada's national identity. In 2012, a national poll found that 94 percent of Canadians felt their single-payer system was a "source of collective pride." Health care was more popular than hockey, the maple leaf flag, and the Queen.¹⁵ In 2004, Canada's government-run broadcast service held a vote to determine the greatest Canadian. Canadians chose Tommy Douglas—the father of Canada's single-payer system.¹⁶ Americans would never take this much pride in a federal entitlement. There's a reason for this. Historically, Americans have given primacy to freedom over equality. To take just one piece of evidence for this statement, close to 6 in 10 Americans think "allowing everyone to pursue their life's goals without interference from the state" is more important than the state guaranteeing "nobody is in need," according to survey data from the Pew Research Center.¹⁷ This attitude is built into our national mythology and identity. It informed the American Revolution and the settlement of the American frontier. President Herbert Hoover called this attitude "rugged individualism."¹⁸ Rugged individuals will always bristle at the idea of the government telling us what to do. We know that smoking is bad and eating vegetables is good, but we balk at the idea of public officials ordering us to do one and not the other. Single-payer systems necessitate the kind of paternalism

Americans have always rejected. Pipes, Sally . False Premise, False Promise (p. 10). Encounter Books. Kindle Edition.

Doesn't reduce inequality – people pay to be shorten queues

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

PAYING TO AVOID LONG QUEUES Sure, the costs are high and growing, and the taxes are borderline confiscatory. But at least Canadians and Britons get free health care in return, right? Not really. Patients in the two countries are forking over ever-greater sums on their own to actually secure the care their single-payer systems can't—or won't—provide. In Britain, privately financed health care now accounts for more than 22 percent of national health spending, up from 16.5 percent in 2009, according to OECD data.³² Patients are paying out of pocket because they don't want to wait. One patient with prostate cancer told the Daily Mail in 2017 that he'd spent £6,900 for "very urgent" surgery after the NHS had delayed the procedure multiple times.³³ An investigation by that same newspaper found that two-thirds of hospitals let patients pay out of pocket for things like hip and knee replacement and cataract surgeries. At the Royal Free Hospital in North London, patients paid up to £15,000 for a hip replacement. They paid up to £5,125 for cataract surgery at the Darby Teaching Hospitals, the Daily Mail found: "Many hospitals offer all-inclusive packages that work out significantly cheaper than charging separate fees for the operating theatre time, the consultant, and occupying a hospital bed," the paper reported.³⁴ About two-thirds of Canadians carry private insurance to help them with the cost of things their single-payer system doesn't cover, like prescription drugs, vision care, dental care, rehab services, long-term care, and private rooms in hospitals. In many cases, this insurance is provided by U.S. firms like Blue Cross Blue Shield.³⁵ Private insurance and out-of-pocket payments accounted for roughly 30 percent of the nation's health spending.³⁶ A 2016 survey found that 2.5 percent of Canadians—about 731,000 people—had to borrow money to pay for their prescription drugs.³⁷ Canadians would like the ability to pay for medically necessary care on their own. According to a 2018 Ipsos poll, 76 percent of Canadians believed they should be allowed to pay privately when the wait lists get too long.³⁸ That's against the law, of course. So Canadians head abroad to dodge their country's wait lists. Per SecondStreet.org, Canadian medical tourists spent C\$690 million on treatments in 2017.³⁹ That spending doesn't show up on the country's health care ledger.

Turn: Medicare for All subsidizes health care for the wealthy

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

But single payer takes saying "Yes" to impossibly absurd levels. Because the bill bans private insurance, most individuals will have to use the government-run system. And it will take Medicare dollars currently earmarked for seniors to subsidize this health coverage for the affluent. Abolishing the current Medicare program to fund wealthy individuals' health care sounds like the kind of accusatory claim that a socialist like Sanders would level against Republicans. But in reality, his single-payer legislation would do just that. Sanders's socialist utopia would not only further jeopardize the security past generations expected of Medicare, it would also cost all taxpayers more than we can bear.

Single Payer Not Necessary to Fulfill Moral Obligation

Moral obligation can be fulfilled with many different systems

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

The Patient Protection and Affordable Care Act signed into law by Barack

Obama draws in part from all three major systems. Its most important feature, insurance exchanges, are clearly a form of managed competition. Through insurance exchanges and small business health insurance tax credits businesses that wish to do so are able to provide healthcare for their employees. This feature is reminiscent of employment based systems though there is no government mandate requiring such a provision. Medicare and Medicaid are both examples of single payer systems. They are essentially insurance providers set up and funded by the government. A proposed “public option”, a heavily subsidized insurance plan that would be available in insurance exchanges, serves as a third example. The PPACA seems to incorporate features used in healthcare systems around the world. Most important, however, is whether or not it fulfills the conception of justice which I have laid out.

In determining whether or not the healthcare reform to the United States is just it is useful to first explore what sort of system may be favored by Rawls’ account of justice. I have argued that individuals in the original position would be hard pressed to nail down an enduring system of healthcare from behind the veil of ignorance. The system which best fits a given society is determined by many factors including history, wealth, resources, population, and cultural values. By the nature of the veil of ignorance the specifics of the society cannot be known and thus no one system can be favored. Though the specifics elude them there are a few things which it seems the participants can universally agree upon. The

system must provide at least an adequate level of care to all members of society regardless of their individual situations. Preventive, therapeutic, and palliative care should all be available based upon some system of rationing which takes into account the given characteristics and resources of the society. Some distinction between therapy and enhancement must be made to assist in determining which medical interventions are necessary and should be covered and which are superfluous and must be paid for out of pocket. These are the essentials which individuals situated behind the veil of ignorance would likely agree to.

Given the essential components listed it cannot be argued that justice as fairness favors one of the broad systems of healthcare mentioned over another. Managed competition, employment based, single payer, and the Patient Protection and Affordable Care Act all seem to adequately cover the necessary bases. Each system is then applied to a specific society and tweaked further to better suit the given needs and available resources.

The PPACA is no exception. It strives to address the needs of the people of the United States in the most efficient and acceptable way possible. For example it allows for the subsidy of abortion but only in certain “acceptable” cases. The issue of abortion is extremely contentious in the United States and thus it is a reflection of the society that federal funds may not go towards elective cases. Of primary importance is that the PPACA provides the essential features that I have outlined as being necessary for justice. The PPACA thus fulfills the Rawlsian account of justice.

I have argued that by accepting justice as fairness we are morally obligated to provide universal access to healthcare. This set up the question of whether or not the proposed healthcare reform to the United States could stand up to this account of justice and fulfill our moral obligation. Upon examining the Patient Protection and Affordable Care Act I have concluded that it provides the components of a healthcare system which are necessary for justice.

Health Care Cost Answers

Canada and UK have a lot of hidden costs

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

THE HIDDEN COST OF WASTE Far from being models of efficiency, the Canadian and British health care systems are rife with waste. Here's one example: Canada doesn't have enough long-term care facilities, so seniors often end up staying in hospital beds longer than necessary—"bed-blocking"—because there's no place else for them to go.²⁵ As the Edmonton Sun reported in 2017, "At any given time, around 400 hospital beds in Alberta ... are taken up by bed-ridden seniors waiting for placement in long-term care/nursing home/assisted-living facilities."²⁶ That, in turn, creates shortages of hospital beds.²⁷ A 2015 report found that fraud could be costing the NHS more than £5 billion a year.²⁸ Another revealed that hospitals spend millions of pounds a year replacing crutches and wheelchairs taken by patients.²⁹ The NHS is also spending £3.5 million a year on toiletries. Doctors filled more than 470,000 prescriptions for toiletries in 2017, up from just under 80,000 in 2007.³⁰ British taxpayers spent upward of £1.6 million to cover more than 195,000 prescriptions for Aveeno body wash. The NHS also spent more than £220,000 on Neutrogena shampoos for dry and greasy hair.³¹ It's unclear why the organization prescribes these items, which patients could easily buy at their local drugstore. This sort of routine waste shouldn't come as a surprise. In the private sector, a competitive market puts relentless pressure on companies to cut waste and root out fraud. Government bureaucrats don't have the same incentives.

Health spending is sustainable and won't drag down growth

GDP after subtracting healthcare is steadily increasing and sustainable

Graham 16 – John Graham, Director of the Health Technology Forum, MBA from London Business School, Senior Fellow at the National Center for Policy Analysis, Chartered Alternative Investment Analyst, "The U.S. Health System Is Not An Economic Burden", Forbes, 4-20, <https://www.forbes.com/sites/theapothecary/2016/04/20/the-u-s-health-system-is-not-an-economic-burden/#4339025b2832>

Health spending consumes a higher share of output in the United States than in other countries. In 2013, it accounted for 17% of Gross Domestic Product. The next highest country was France, where health spending accounted for 12% of GDP. Critics of U.S. healthcare claim this shows the system is too expensive and a burden on our economy, demanding even more government intervention. This conclusion is misleading and leads to poor policy recommendations, according to new research published by the National Center for Policy Analysis (U.S. Health Spending is Not A Burden on the Economy, NCPA Policy Report No. 383, April 2016).

Discussing health spending in dollars, rather than proportion of GDP, the report notes Americans spent \$9,086 per capita on healthcare in 2013, versus only \$6,325 in Switzerland, the runner-up. (These dollar figures are adjusted for purchasing power parity, which adjusts the exchange rates of currencies for differences in cost of living). This big difference certainly invites us to question whether we are getting

our money's worth. However, it is not clear that this spending is a burden on Americans, given our very high national income.

After subtracting health spending from U.S. GDP, we still had \$44,049 per capita to spend on all other goods and services we value. Only two countries, Norway and Switzerland, beat the United States on this measure. But compared to larger developed countries, Americans have higher income per capita after subtracting healthcare spending. For example, in the United Kingdom, GDP per capita after health spending was only \$34,863 in 2013. So, even though Americans spent significantly more on healthcare than the British, the average American enjoyed \$9,185 more GDP after health spending than his British peer; and just under \$6,000 more than his Canadian neighbor.

Britain socialized its health system shortly after World War II, completing the work by 1948. Canada's healthcare was more gradually socialized by provincial and federal governments during the period 1947 through 1966. Many assert these so-called single-payer systems relieved the burden of private payment from citizens and made the economy more productive.

On the contrary: Since 1960, the U.S. economy has outperformed all comparable developed countries except Norway and Switzerland with respect to economic growth, after subtracting health spending. From 1960 through 2013, the share of U.S. GDP allocated to healthcare more than tripled. However, this had no impact on the ability of the U.S. economy to deliver high GDP per capita, outside healthcare. Adjusted for purchasing power parity, U.S. health spending increased \$8,937, while GDP per capita increased \$50,269, from 1950 through 2013. Thus, GDP per capita available for other goods and services, after spending on health care, increased \$41,332, or \$780 per year.

Over these 53 years, only Norway and Switzerland increased their non-health GDP per capita more than the United States. Norway, which had become a petro-state due to revenue gushing from the North Sea oilfields, increased this amount by \$57,981, which is \$16,649 more than the United States, or \$314 more in non-health spending per year per person.

The report concludes the theory that health spending influences economic growth for better or worse is too simple. In fact, wages, prices and resources allocated to healthcare are a consequence of economic activity in other parts of the economy, as well as health policy.

There's no economic impact to high health spending

RCA 17 (Random Critical Analysis – Economics Blog, “Health care prices do not play the role most believe,” <https://randomcriticalanalysis.wordpress.com/2017/07/27/health-care-prices-do-not-play-the-role-most-believe/>)

The relative differences between the two US PPPs are quite modest. A given amount of US dollars within the US only goes a little further if spent throughout the entire economy (GDP) than if spent on health if we compare the differences in how far these expenditures go throughout the OECD. My eyeball estimate of these figures suggests health is only about 14% more expensive according to the differences in the volumes they derived there. By way of reference the real volumes of GDP per capita was about 37% higher and AIC about 47% higher in the US in 2014 (note: if you look carefully at the plot, figure 4, you might also notice there is a pretty strong correlation between relative price levels and how wealthy these countries are).

Spending will slow

---ACA expansion has been completed

---drug spending declining

---pent up demand will soon be over

Hempstead 17 – Katherine Hempstead, PhD, MA, Senior Adviser to the Executive Vice President, leads Robert Wood Johnson Foundation's Work on Health Insurance Coverage. “Is the Slowdown Slowing Down?,” 4/7/17, <http://www.rwjf.org/en/library/research/2017/04/rate-of-health-care-spending-growth.html>)

Had the American Health Care Act passed into law, it was widely expected that sharp reductions in health care spending growth, due to both coverage losses and reduced-per-enrollee spending, would have occurred. Yet in the absence of the bill becoming law, there is every reason to anticipate a slowdown in health care spending growth, as the sizable coverage expansion of the last three years has largely been completed.

The Altarum Institute's monthly reports have been documenting this trend, and their most recent analysis suggests that this slowdown is unfolding at a more leisurely pace than anticipated. Health care services spending, seemingly on its way down in the final three quarters of 2015, gave way to somewhat stronger growth in 2016. While overall health spending growth in 2016 was lower, at 5.2 percent, than the 5.8 percent reported for 2015, the 2016 quarterly health care services growth rates send a somewhat mixed message—with the Q4 growth rate of 6.1 percent the highest since Q2 2015. Health care services spending growth did not show a markedly downward trend during 2016, suggesting that perhaps spending growth will not return to pre-expansion levels so quickly. For its part, prescription drug spending growth declined steadily throughout the year, and was well below overall trend by the third quarter.

The continued high growth in health care services spending is particularly concentrated in the outpatient setting. Since 2014, growth in spending in physicians' offices has exceeded that in hospitals, and this trend persisted through the first two quarters of 2016. For 2015, and all but one quarter of 2016, physician spending grew by more than 6 percent. Consistent with this trend, health care jobs grew in ambulatory settings the fastest.

From what we can tell, this trend largely reflects continued growth in utilization, since health care services prices seem to have increased relatively little since 2014. This stands to reason—since utilization increases among those who gain coverage—as financial barriers to health care are reduced. Additionally, among some newly insured populations there may be “pent-up demand,” as long deferred health care needs are addressed.

Aside from coverage expansion, there are other factors that may be affecting trends in ambulatory utilization. New forms of ambulatory care have grown in recent years, both new physical settings—like retail and urgent care clinics—and various types of telemedicine. Health systems are investing heavily in both channels, adding urgent care centers and seeking to add telemedicine capacity. Meanwhile consumers are seeking out telemedicine services, sometimes purchasing packages that augment their insurance plan. These recent changes in the availability of new settings for ambulatory care, along with benefit design changes and new payment models that emphasize primary care, have the potential to influence the utilization patterns of the entire population.

A number of studies have suggested that new ambulatory settings are complements rather than substitutes for traditional physician office visits, and may actually increase net utilization. A recent study of MinuteClinic use found that more than half of visits represented new uses of medical services rather than a replacement for a visit. Retail and urgent care were recently estimated to comprise 20 percent of primary care encounters. The Blue Cross Blue Shield Association estimated that retail visits doubled among commercially insured members between 2011 and 2015.

To the extent to which they may serve as an accelerant to overall utilization, the proliferation of these new sites of care may be changing patterns of health care services use in ways that go beyond meeting the needs of the newly covered, and may affect the trend in spending on health care services.

Coverage expansion is without question a very important component of recent health care spending growth, and as this expansion slows and pent-up demand is satisfied, it would be expected that overall rates of utilization growth would begin to slow as well. And it does appear that some softening in growth has occurred. Altarum estimates that the growth rate in utilization fell from 5.1 percent in 2015 to 4.4 percent in 2016. Echoing this trend, job growth in health care declined considerably in 2017, from more than 30,000 new jobs per month in 2015 and 2016 to less than 20,000 in the first few months of 2017.

There is an unfortunate shortage of timely data on ambulatory care use at the population level, but factors other than coverage expansion may be affecting utilization patterns. Going forward, it will be important to better understand these patterns and see what implications they may have for trends in health care services spending.

Shift to preventive care is coming and solves cost

Gruessner, 17 – Breast Health and Healing Foundation department director

[Vera, "Humana, Aetna, Cigna Invest in Value-Based Care Payment Models; National health insurers are continuing to advance value-based care payment models such as accountable care organizations," Health Payer Intelligence, 1-6-17, <https://healthpayerintelligence.com/news/humana-aetna-cigna-invest-in-value-based-care-payment-models>, accessed 9-8-17]

Value-based care payment models are continuing to make headlines among major health insurance companies around the nation. Last month, Humana entered into a value-based care arrangement with the population health management company Fullwell, according to Zacks Equity Research. The Humana and Fullwell partnership is aimed at creating a wellness-focused, population health-based, and patient-centric healthcare delivery system. More than 150 Fullwell healthcare providers under the Colorado Health Neighborhoods Network will be available to Humana's Medicare Advantage members in the Denver area. Humana's value-based care payment model will focus on reimbursing providers for quality of care instead of quantity. Value-based care payment models depend on patient health outcomes and move away from fee-for-service reimbursement structures, which focused on the volume of services instead of preventive care. "Under the terms of this value-based agreement, both FullWell and Humana are supposed to frame strategies to improve the quality of healthcare at a low cost for the Humana members in Colorado," according to the report from Zacks Equity Research. "Together, the companies are striving to find the gaps in care, manage medication adherence, follow up on patients needing PCP visits, and identify high Emergency Room (ER) seekers and at-risk patients to provide them proper treatment before their condition turns severe." Through the partnership with Fullwell, the payer has aimed its sights on better managing healthcare costs while improving the overall health and wellness of its members. From September through November 2016, Humana shares grew 15.01 percent while the general Health Maintenance Organization industry rose by an average of 14.14 percent during the same time period. Humana decreased healthcare spending by 20 percent in 2015 due to the advancement of value-based care payment models. About 63 percent of Humana's 1.8 million Medicare Advantage members are currently treated through value-based care payment models. An additional report from Zacks Equity Research shows that the national health insurance company Aetna has also been heavily invested in transforming its healthcare delivery strategy by expanding value-based care payment models such as accountable care organizations (ACOs). Currently, more than 40 percent of Aetna's healthcare spending is in the form of a value-based care payment model. The payer's goal is to have 75 percent of their spending in a value-based model by 2020. As such, the company has been expanding their ACO

offerings while also growing in international markets, the report states. Aetna has also decreased its operating costs to 18 percent in 2016, which is a drop from the expenses in 2014 and 2015. Cigna is another health insurer that has taken on the task of advancing value-based care payment models. The fragmented and regulatory nature of value-based care has led Cigna to build a new service company called CareAllies and bring on new talent to help provider organizations more closely improve patient outcomes and quality, according to a Cigna press release. CareAllies will be part of bringing on new health IT systems, strategies, and management to support value-based care payment models among providers. The company will offer solutions to ease the administrative burden of risk and quality-based reimbursement arrangements. CareAllies can even assist providers in developing and launching their own health plan, the release stated in June 2016. "Our aim is to enable all of our provider clients to succeed in an extremely competitive and disruptive healthcare environment," said Julian Harris, President of CareAllies, Inc. "Whether a provider's business is focused on commercial, Medicare, or Medicaid patients, the new CareAllies has the know-how and patient health engagement experience to help deliver better quality and financial outcomes as providers navigate the transition to value-based payment." The new company takes assets from Cigna, QualCare Alliance Networks, Inc., and Cigna-HealthSpring's management services in order to support improving value-based care among providers. CareAllies will take on technology, analytics, and advisory services, which are necessary to truly change healthcare delivery among physician practices when they move into a value-based care payment model. "We will meet provider organizations where they are with the services and capabilities they need," Harris continued. "Some will need us to provide or build core capabilities, and we will also work collaboratively with provider clients that already have those capabilities in place to help them achieve greater physician alignment and clinical integration." National health insurance companies like Aetna, Humana, and Cigna have been moving their provider contracts into value-based care payment models and investing in accountable care organizations in order to achieve the Triple Aim of Healthcare. Other health insurance companies may need to follow in their footsteps in order to reduce rising healthcare spending and improve population health outcomes as well as patient satisfaction.

Short term transition links wreck revenue – that outweighs and short circuits long term “cost reduction”

Moffatt, 17 --- Mike, Mike's academic research is in the areas of optimal pricing, taxation, exchange rates and free-market environmental policy. Mike has studied economics at four different universities in three countries and has taught economics at university level. EDUCATION Mike holds Honors B.A. degrees in Political Science and Economics from the University of Western Ontario, a Masters Degree in Economic Theory from the University of Rochester, and has done graduate work at Queen's University at Kingston. Mike has won a number of academic awards, including a gold medal for Political Science and Economics from the University of Western Ontario for being the top graduating student in his class, 2/25, <https://www.thoughtco.com/why-government-deficits-grow-during-recessions-1147890>

That being said, government budgets tend to go from surplus to deficit (or existing deficits become larger) as the economy goes sour. This typically happens as follows: The economy goes into recession, costing many workers their jobs, and at the same time causing corporate profits to decline. This causes less income tax revenue to flow to the government, along with less corporate income tax revenue. Occasionally the flow of income to the government will still grow, but at a slower rate than inflation, meaning that flow of tax revenue has fallen in real terms. Because many workers have lost their jobs, their dependency is increased use of government programs, such as unemployment insurance. Government spending rises as more individuals are calling on government services to help them out through tough times. (Such spending programs are known as automatic stabilizers, since they by their very nature help stabilize economic activity and income over time.) To help push the economy out of

recession and to help those who have lost their jobs, governments often create new social programs during times of recession and depression. FDR's "New Deal" of the 1930s is a prime example of this. Government spending then rises, not just because of increased use of existing programs, but through the creation of new programs. Because of factor one, the government receives less money from taxpayers due to a recession, while factors two and three imply that the government spends more money than it would during better times. Money starts flowing out of the government faster than it comes in, causing the government's budget to go into deficit.

Single Payer Not Necessary to Fulfill Moral Obligation

Moral obligation can be fulfilled with many different systems

Han Hennenberger, Connecticut College, 2011, Health Care and Justice: A Moral Obligation? Philosophy Honors Papers, <http://digitalcommons.conncoll.edu/philhp/1> DOA: 6-16-16

The Patient Protection and Affordable Care Act signed into law by Barack

Obama draws in part from all three major systems. Its most important feature, insurance exchanges, are clearly a form of managed competition. Through insurance exchanges and small business health insurance tax credits businesses that wish to do so are able to provide healthcare for their employees. This feature is reminiscent of employment based systems though there is no government mandate requiring such a provision. Medicare and Medicaid are both examples of single payer systems. They are essentially insurance providers set up and funded by the government. A proposed “public option”, a heavily subsidized insurance plan that would be available in insurance exchanges, serves as a third example. The PPACA seems to incorporate features used in healthcare systems around the world. Most important, however, is whether or not it fulfills the conception of justice which I have laid out.

In determining whether or not the healthcare reform to the United States is just it is useful to first explore what sort of system may be favored by Rawls’ account of justice. I have argued that individuals in the original position would be hard pressed to nail down an enduring system of healthcare from behind the veil of ignorance. The system which best fits a given society is determined by many factors including history, wealth, resources, population, and cultural values. By the nature of the veil of ignorance the specifics of the society cannot be known and thus no one system can be favored. Though the specifics elude them there are a few things which it seems the participants can universally agree upon. The

system must provide at least an adequate level of care to all members of society regardless of their individual situations. Preventive, therapeutic, and palliative care should all be available based upon some system of rationing which takes into account the given characteristics and resources of the society. Some distinction between therapy and enhancement must be made to assist in determining which medical interventions are necessary and should be covered and which are superfluous and must be paid for out of pocket. These are the essentials which individuals situated behind the veil of ignorance would likely agree to.

Given the essential components listed it cannot be argued that justice as fairness favors one of the broad systems of healthcare mentioned over another. Managed competition, employment based, single payer, and the Patient Protection and Affordable Care Act all seem to adequately cover the necessary bases. Each system is then applied to a specific society and tweaked further to better suit the given needs and available resources.

The PPACA is no exception. It strives to address the needs of the people of the United States in the most efficient and acceptable way possible. For example it allows for the subsidy of abortion but only in certain “acceptable” cases. The issue of abortion is extremely contentious in the United States and thus it is a reflection of the society that federal funds may not go towards elective cases. Of primary importance is that the PPACA provides the essential features that I have outlined as being necessary for justice. The PPACA thus fulfills the Rawlsian account of justice.

I have argued that by accepting justice as fairness we are morally obligated to provide universal access to healthcare. This set up the question of whether or not the proposed healthcare reform to the United States could stand up to this account of justice and fulfill our moral obligation. Upon examining the Patient Protection and Affordable Care Act I have concluded that it provides the components of a healthcare system which are necessary for justice.

General Solvency Answers/Turns

General Health Answers

Medicare for All won't Improve health

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

ADDED SPENDING, BUT NOT ADDED VALUE Apart from whether a single-payer system will raise or lower health costs, policy-makers should consider an even more important question: Does the added federal expenditure represent a wise policy choice? Here again, the available evidence casts significant doubt that it does. First, providing services free at the point of service encourages additional health spending, but that spending does not appear to generate additional improvements in health. The famous Rand Health Insurance Experiment, funded by the Department of Health and Human Services beginning in the 1970s, assigned patients to a series of health plans of varying designs. The study found that patients assigned to plans with higher cost-sharing reduced their health spending, but in general, that lower health spending "had no adverse effect on participants' health."⁴⁴ This theory has self-evident limits, as at some point rising cost-sharing will deter patients from obtaining treatments beneficial to their health. But the single-payer bills would make virtually all health care "free," with not so much as even a \$5 or \$10 co-pay. It does not require a PhD in economics to recognize how these altered incentives could easily result in people using more health care than they need. The Rand Health Insurance Experiment demonstrates this increase in spending would also likely not improve Americans' health. Second, many beneficiaries in government-run health plans do not appear to value their current coverage. A study of Medicaid released in 2015 found that participants derive an average of \$0.20 and \$0.40 for every added dollar spent on the program. Other entities—often hospitals treating otherwise-uninsured patients—received a far greater benefit from Medicaid than the beneficiaries themselves, making it a questionable use of scarce taxpayer resources.⁴⁵ Similar evidence about the value of health coverage comes from Obamacare. In the case of Medicaid expansion, able-bodied adults have signed up at a far faster rate than government analysts expected. By the end of 2016, enrollment in 24 states that expanded Medicaid exceeded projections by an average of 110%—meaning enrollment more than doubled states' maximum predictions.⁴⁶ By contrast, as of the first quarter of 2019, only 11.4 million individuals had coverage on the Obamacare exchanges—fewer than half the 24 million enrollees the Congressional Budget Office (CBO) had projected for 2019 enrollment at the time of Obamacare's passage.⁴⁷ Exchange data also suggest a strong correlation between insurance subsidy amounts and enrollment. For instance, one 2016 analysis indicated that four-fifths (81%) of eligible individuals with incomes below 150% of the federal poverty level (\$38,625 for a family of four in 2019), who qualify for the richest premium subsidies and help with co-payments and deductibles, have signed up for coverage.⁴⁸ By contrast, a far smaller fraction (16%) of those with incomes between three and four times the poverty level, who qualify for much smaller premium subsidies and do not receive co-payment assistance, enrolled in an exchange plan.⁴⁹ All the available evidence—higher-than-expected enrollment in Medicaid, lower-than-expected enrollment in the Obamacare exchanges, and a stratification in exchange enrollment by income level—suggests that beneficiaries do not particularly value health insurance, or at least do not particularly value the coverage options Obamacare has provided them. They will sign up for "free" Medicaid coverage, which in most cases charges no premiums, deductibles, or co-payments, and they will sign up for heavily subsidized exchange plans. But when faced with out-of-pocket premium costs of

more than \$50-\$100 per month, many seem content to forgo insurance. This evidence raises obvious questions: Why should the federal government spend the tens of trillions of dollars that single-payer advocates propose to deliver something that many individuals of modest means appear not to value? The study of Medicaid spending that concluded recipients do not highly value their benefits noted how its results provided important evidence “for assessing the social value of providing Medicaid to low-income adults relative to alternative redistributive policies.”⁵⁰

Single Payer won't be any better than squo – your solvency authors are imagining a perfect system that won't survive contact with our actual politics; fiat can't solve this its not plan text that is the problem – it's the millions of small implementation details that will gum everything up

Pollack, professor at the University of Chicago School of Social Service

Administration2015, (Harold, “Medicare for All — If It Were Politically Possible — Would Necessarily Replicate the Defects of Our Current System” Journal of Health Politics, Policy and Law 2015 Volume 40, Number 4: 923-931, published online before print June 29, 2015, doi: 10.1215/03616878-3150172, p926-928, TOG, * WAVE ONE*)

The initial sales pitch would be admirably simple: we will mail a Medicare card to every American. Yet because single payer upends so many things the ACA seeks to leave intact, Medicare for All would raise intricate and divisive transitional issues. The ACA's major sales pitch to the healthy and insured was, “If you like your insurance, you can keep it.” This pledge proved politically damaging when it could not be fully kept for a very small proportion of Americans who do not receive marketplace subsidies and who had previously purchased rather minimal or risk selected plans. Medicare for All would be fundamentally more disruptive for tens of millions of people. As a matter of basic accounting, a huge reform that creates millions of winners creates millions of losers, too: affluent workers receiving generous tax expenditures, too many constituencies to count across the supply side of the medical economy who are likely to be squeezed in a new system, individuals subject to small or large tax increases, to name a few. This list includes some of the most powerful and organized constituencies in American politics. They would have to be accommodated in complex, sometimes unappetizing, ways. It is in the writing of detailed legislation that one confronts the specific issues that must be addressed. To my knowledge, no fully articulated single-payer proposal was ever drafted. This is telling. Medicare for All would require a serious rewrite of state-federal relations, radical surgery to the Employee Retirement Income Security Act (ERISA), the digestion of various Medicaid functions now performed by state governments, and a myriad of other granular details. Then there are the legal and constitutional challenges. Some would argue that Medicare for All avoids the ACA's constitutional minefields exemplified by the individual mandate. It doesn't. The basic issues in National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012), went beyond whether a mandate is a tax or other niceties. The real fight concerned the constitutional propriety of a post-New Deal expansive federal government that seeks to regulate and humanize our national health care market. Medicare for All would stake an even greater claim to contested views of federalism and the reach of national government. At this writing, one awkward sentence of the ACA has produced a specious but dangerous Supreme Court challenge in King v. Burwell (759 F.3d 358 (4th Cir. 2014), cert. granted, 135 S.Ct. 475 (2014)). I'm confident that constitutional conservative advocates and judges would identify more plausible concerns and glitches in any single-payer plan. Many of the most sensitive challenges that now bedevil the ACA would be sensitive challenges to a Medicare for All system, as indeed they long have been within Medicare and Medicaid. Within any financing system, we would require new care models for complex patients. We would face the economic, organizational, and human challenges of end-of-life care. We would make difficult decisions about network adequacy and patient cost sharing and face difficult questions in designing essential health benefit provisions for autism, substance use disorders, and cancer. We would face difficult questions regarding safety net reimbursement rates. We would face our society's tenuous commitment to the well-being of our most disadvantaged citizens. Federalizing care for dual-eligible Medicare-Medicaid recipients might be done in a way that resembles states with the most expansive Medicaid programs. Just as plausibly, national policies could resemble the policies of far less generous states. In all of these matters, Medicare for All cannot offer itself as the replacement of our depressing health politics. It would have to arise as another product of that very same process, passing through the very same legislative choke points, constrained by the very same path dependencies that bedevil the ACA. Any politically feasible single-payer plan would include a dense thicket of provisions for the myriad of protected publics ranging from veterans to public employees to retirees to affluent professors whose health coverage is more generous than a national plan can uniformly provide. Such realities

would render Medicare for All an inferior, more convoluted product to what Seidman (and I) would wish to see. Imagine the national policy debate over abortion, contraception, HIV prevention, immigration policy, and other matters in a national Medicare plan. Imagine liberal discomfort with a single-payer plan with President Mitt Romney's hand on the tiller, acting in partnership with Speaker of the House John Boehner and Senate Majority Leader Mitch McConnell. The same congressional committee chairs will remain in place to bedevil Democratic and Republican administrations with self-interested micromanagement of Medicare procurement and other rent-seeking behavior. The same justices would sit on the Supreme Court.

Literal Medicare for all won't work – Medicare is designed for a specific population and set of problems – absent changes doesn't work for many

Kilgore, political columnist 7/25/17, (Ed, "Why 'Medicare for All' Is a Misleading Term for Single-Payer Health Care", The Daily Intelligencer, <http://nymag.com/daily/intelligencer/2017/07/medicare-for-all-is-a-misleading-term-for-single-payer.html> accessed 8/19/17 TOG, * WAVE ONE*)

But before getting serious about enacting single-payer legislation nationally or in the states, proponents of "Medicare for all" should make it clear not to take the slogan too literally. Including all Americans in the Medicare program as it exists today probably would not work, and might not even be all that popular in practice.

For one thing, Medicare is by design an "acute care" program. It does not cover long-term hospital stays or nursing-home care, and excludes some routine care (e.g., dental and vision care). Presumably a single-payer program designed to replace all or most private insurance would be more comprehensive than Medicare.

Perhaps more importantly, from a political point of view, Medicare is neither free nor easy for beneficiaries.

Medicare Parts A (which covers medically necessary hospital services), B (which covers doctors' fees and some hospital outpatient services), and D (prescription drug benefits) all have sizable deductibles and co-payments. That is why most seniors who can afford it buy supplemental insurance to cover such "cost-sharing measures" (poorer or disabled seniors who also qualify for Medicaid get fuller coverage through that program). Parts B and D also charge monthly premiums, which most seniors pay through automatic deductions from their Social Security checks. Extending this to people who don't qualify for Medicaid, don't want to pay for a "Medigap" policy, or don't receive Social Security benefits would require a very different structure. As is, "Medicare for all" would certainly conflict with the general argument that single-payer health care gets rid of all those nasty out-of-pocket expenses.

The more you look at it, the more "Medicare for all" is, well, misleading. And it is politically perilous to mislead people about sweeping new health-care programs, as Congress learned in 1988 with the Medicare Catastrophic Coverage Act of 1988, a major bipartisan initiative that had to be repealed the next year when seniors figured out it duplicated the Medigap coverage many already had instead of addressing long-term-care needs.

The scant resemblance of most single-payer proposals to the actual Medicare program is just one problem proponents have in making themselves clear. They also need to agree on what single payer itself means, other than something sorta kinda like Medicare except when it's not. Would single payer literally outlaw private insurance, allow it on the margins, or indeed deploy private insurance companies within a framework of government-guaranteed care (as happens now with Medicare Advantage plans or Medicaid managed-care systems)? The many available variations have all sorts of pros and cons. But pretending it's all very simple obscures these options.

Single-payer fails--long waits, reduced quality, funding crises, inequalities, labor strikes, and more

Fleming 6 – M.D., is an internist and geriatrician in the Division of General Internal Medicine at the Mayo Clinic [Kevin C. 2006, "High-Priced Pain: What to Expect from a Single-Payer Health Care System",

Executive Summary Backgrounder by the Heritage Foundation, No. 1973,
<http://research.policyarchive.org/8469.pdf>] AMarb

Adverse Effects. Health care in a **single-payer system** will be rationed by means other than price. This **will have inevitable adverse effects**, including: • **Long waits and reduced quality**. In Britain, **over 800,000 patients are waiting for hospital care**. In Canada, the **average wait between a general practitioner referral and a specialty consultation has been over 17 weeks**. Beyond queuing for care or services, **single-payer systems are often characterized by strict drug formularies, limited treatment options, and discrimination by age** in the provision of care. **Price controls**, a routine feature of such systems, also **result in reduced drug, technology, and medical device research**. • **Funding crises**. Because individuals remain insulated from the direct costs of health care, as in many third-party payment systems, **health care appears to be “free.”** As a result, **demand expands while government officials devise ways to control costs**. The **shortest route is by providing fewer products and services through explicit and implicit rationing**. • **New inequalities**. Beyond favoritism in the provision of care for the politically well-connected, **single-payer health care systems often restrain costs by limiting surgeries for the elderly, restricting dialysis, withholding care from very premature infants, reducing the number of intensive care beds, limiting MRI availability, and restricting access to specialists**. • **Labor strikes and personnel shortages**. In 2004, a **health worker strike** in British Columbia, Canada, **resulted in the cancellation of 5,300 surgeries and numerous MRI examinations, CT scans, and lab tests**. Canada also has a shortage of physicians, and the **recruitment and retention of doctors in Britain has become a chronic problem**. • **Outdated facilities and medical equipment**. Advances in **medical technology are often seen in terms of their costs rather than their benefits, and investment is slower**. For example, an estimated 60 percent of radiological equipment in Canada is technically outdated. • **Politicization and lost liberty**. **Patient autonomy is curtailed in favor of the judgment of an elite few, who dictate** what health care needs and desires ought to be while imposing **social controls over activities deemed undesirable** or at odds with an expanding definition of “public health.” Government officials would claim a compelling interest in many areas now considered personal.

Single-payer has no commitment to care, no equal access, and denies the truly sick

Goodman et al 4 – *libertarian economist, founding chief executive of the free-market thinktank the National Center for Policy Analysis, **President of Economics America, and ***health economist and senior fellow with the National Center for Policy Analysis [John C. Goodman*, Devon M. Herrick**, and Gerald L. Musgrave***, 2004, Introduction, *Lives at Risk: Single-Payer National Health Insurance Around the World*, Google Books] AMarb

The promise of **national health insurance** is that government will make health care available on the basis of need rather than ability to pay. That **implies a government commitment to meet health care needs**. It implies that rich and poor will have **equal access to care**. And it implies that **more serious needs will be given priority over the less serious**. Unfortunately, these **promises have not been kept**. • Wherever national health insurance has been tried, **rationing by waiting is pervasive**—with waits that force patients to **endure pain and sometimes put their lives at risk**. • Not only is **access to health care not equal**, if anything it **tends to correlate with income**—with the middle class getting **more access than the poor** and the rich getting more access than the middle class, especially when income classes are weighted by incidence of illness. • Not only are health care resources not allocated on the basis of need, these **systems tend to overspend on the relatively healthy while denying the truly sick access to specialist care and lifesaving medical technology**. • And far from establishing national priorities that get care first to those who need it most, these **systems leave rationing choices up to local bureaucracies that, for example, fill hospital beds with chronic patients while acute patients wait for care**. It might seem that some of these problems could be easily remedied. **Yet, as the years of failed reform efforts in Britain and Canada have shown, the defects of single-payer systems of**

national health insurance are not easily remedied. The reason: the characteristics described above are not accidental byproducts of government-run health care systems. They are the natural and inevitable consequences of placing the health care market under the control of politicians.¹⁷ It is not true that health care policies in countries with singlepayer health insurance just happen to be what they are. In most cases, they could not be otherwise.

its comparatively worse than quo measures

Goodman et al 4 – *libertarian economist, founding chief executive of the free-market thinktank the National Center for Policy Analysis, **President of Economics America, and ***health economist and senior fellow with the National Center for Policy Analysis [John C. Goodman*, Devon M. Herrick**, and Gerald L. Musgrave***, 2004, Chapter 13: Managed Care, *Lives at Risk: Single-Payer National Health Insurance Around the World*, Google Books] AMarb

American advocates of single-payer health insurance say that such a system would resolve virtually all of the major abuses of managed care.⁵ Would it? Consider the principal patient criticisms of managed care: (1) you may not be able to see a specialist when you want to; (2) you might not obtain expensive tests; (3) you may experience obstacles getting approval for surgery; and (4) you may have difficulty getting approval to enter a hospital. Yet, the problems American HMO enrollees face are minor compared to the hurdles faced by patients in other countries.

Almost all single-payer systems require patients to go through a gatekeeper who decides whether the patient gets a referral to a specialist. They also limit the number of specialists. Access to expensive technology is more difficult in single-payer systems than for patients in any managed care organization in the United States. Expensive technologies are rationed, including equipment necessary for diagnosis and treatment, such as MRIs. Admissions to hospitals are often cancelled or delayed. As we noted in chapter 8, a recent study in the British Medical Journal compared services delivered by the British NHS with that of the California HMO, Kaiser Permanente. The study found the NHS provides far fewer services and less access to diagnostic tests and specialists than Kaiser, for only slightly less money.⁶ To make matters worse, advocates of single-payer insurance would take away an important right that all managed care patients currently have, the right to purchase their own care. Denied access to a specialist, U.S. patients can always go out of network and pay the cost themselves. Denied access to a diagnostic test, patients can pay for the test from their own resources. If the American advocates of single-payer insurance get their way, these private pay options will be outlawed.

And, it increases the costs of care

Pearl 17 -- Robert Pearl, M.D. Contributor Forbes "Why A Government-Run, Single-Payer Healthcare Approach Is Doomed To Fail"
<https://www.forbes.com/sites/robertpearl/2017/03/16/why-a-government-run-single-payer-healthcare-approach-is-doomed-to-fail/print/>

Myth 2: It Would Reduce The Cost of Coverage

The basis for this claim is that other countries spend a lower percentage of GDP on healthcare—and the assumption that if the government takes over healthcare, the same would happen in the U.S. But as we saw in Vermont, the opposite is likely to happen.

The cost of healthcare is a combination of how many services are performed and how much each costs. When the government can set prices, it can decrease what it pays for each service, but that does not mean overall costs decline. Instead, as has happened around the globe, private insurers enter the market. In response to the higher payments offered, doctors and hospitals put these privately insured patients at the front of the line. And those physicians who continue to accept the governmental rates start doing more to make up for the lost income.

We saw this approach fail when the federal government enacted the Balanced Budget Act of 1997. This legislation required healthcare inflation to rise no faster than GDP. To accomplish this, payments to doctors were theoretically reduced proportionately through the Sustainable Growth Rate calculation (SGR). But each year, the reductions were not applied due to the political backlash. By the time the requirement was lifted, the gap between what was paid and what would be required to match inflation exceeded 20%.

Single payer decreases access and quality of care---drawing conclusions based on other single payer success is a fallacy

Kevin Olsen 14. Anesthesiology Resident at Emory University. "IS SINGLE PAYER APPROPRIATE FOR THE UNITED STATES?" 1/26/2014. <https://scholarblogs.emory.edu/sick/2014/01/26/is-single-payer-appropriate-for-the-united-states/>.

There is much debate, especially with the recent passing of the ACA, over the most cost efficient and health efficacious method to deliver healthcare in the United States. While most would agree that our current system is convoluted and expensive, there is no clear consensus as to what would be the most practical solution for healthcare delivery in the United States. Many counties opt for a single payer system, wherein the populace pays taxes to the government and the government is the sole payer to healthcare providers. This sounds good in theory by opening up access to providers to all Americans, maintaining care for the chronically ill, and reducing the confusion in covered services. Yet, when analyzed, a single payer system would dramatically increase the wait times for not only surgical or radiographic intervention, but even simple checks ups. The lower physician salaries would drive many out of the profession into a higher return on investment career. The lower salaries for all medical professionals and corporations would decrease their investment in new technology, ultimately decreasing the quality of care received [1]. It has been shown by Cutler and McClellan that healthcare spending in new technology has significantly increased both quantity and quality of life with certain interventions [2], while some others fall short. This does not mean that investment in technology is inefficient, but rather investment in the right technology is the key rather than investment for investments sake.

Further, the demographics of those countries with single payer systems do not overlap with the demographic reality of the United States, implying that a single payer system may work when most of the population is similar in lifestyle and genetic background, but may fail with such a diverse situation as there is in the United States. Looking at the 34 member countries of the OECD in its newest data from 2011, the vast majority of countries are homogeneous in the nature of their populace[3]. In addition, although many of the member countries score better in overall health and life expectancy than the United States, it can be inferred that this is because of their lifestyle and not necessarily due to their "superior" healthcare system. As evidence, the United States has a disproportionate increase in diabetes and obesity as compared to other OECD nations. This implies a problem prior to entering the healthcare system rather than after. There is also a significant difference between life expectancies of whites and blacks in the United States, further adding to the conclusion that the demographic differences in the United States may contribute to the complexity of successfully caring for our diverse population [3].

According the United States Department of Commerce: "The United States leads the world in the production of medical technologies and is the industry's largest consumer" [4]. As Americans, we expect quick results, the best technology, and access to our healthcare providers. With a single payer system, access actually decreases with increase demand on the remaining providers. In addition, investment in new technology decreases because of less profit to healthcare companies. As a result, the development and implementation of new technologies suffer. The reason the United States leads the world in medical technology is because of the market we provide for its development. This includes both the access to a large marketplace of patients and the higher payments for those services. Although the U.S may lag the world in certain measures of health, that does not mean switching to a single payer system is the answer. Our demand for the best technology, immediate or quick access to services, and demographic diversity all guide us away from both our current system and a single payer system, but toward a unique, yet to be developed system. A mix of open market competition between providers and healthcare systems is sure to be important, with this increasing access and lowering costs. Regulation must be put in place as "rules of the road" but over regulation as is the status quo currently is crippling.

Moral hazard turn---health insurance trades off with the incentive to maintain good health---offsets the gains from insurance

Harold L. Cole 9/1/16, econ prof @ UPenn, Dirk Krueger, assistant econ prof @ UPenn, "Analyzing the Effects of Insuring Health Risks", SSRN, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2848414

This paper quantitatively evaluates the trade-off between the provision of health-related social insurance and the incentives to maintain good health through costly investments. Our study is motivated by recent US legislation that has tightened regulations on wage discrimination against workers with poorer health status (such as the 2008 amendment of the Americans with Disability Act from 1990, the ADAAA) and that prohibits health insurance companies from charging different premiums for workers of different health (a provision in the Patient Protection and Affordable Care Act, PPACA, that went in effect in 2014). To do so we construct and estimate (using PSID and MEPS data) a dynamic model of health investments and health insurance in which the cross-sectional health distribution evolves endogenously and is shaped by labor market and health insurance policies. The static gains from better insurance against poor health induced by these policies are traded off against their adverse dynamic incentive effects on household efforts to lead a healthy life. In our quantitative analysis we find that although the competitive equilibrium features too little consumption insurance and a combination of both policies is effective in providing such insurance period by period, it is suboptimal (from an ex-ante welfare perspective) to introduce both policies jointly since such a policy innovation severely undermines the incentives to lead healthier lives and thus induces a more rapid deterioration of the cohort health distribution over time. This effect more than offsets the static gains from better consumption insurance so that expected discounted lifetime utility is lower under both policies, relative to implementing one policy in isolation

No Savings from Single Payer; Data shows that government healthcare doesn't reduce costs –just slows growth. However U.S. cost growth is not currently bad, it was bad 30 year ago – but that can't be undone, and Single Payer isn't reverse causal

Megan McArdle, columnist Bloomberg 2014, (Megan, "A Single-Payer System Won't Make Health Care Cheap" Bloomberg View April 30, 2014, available at <https://www.bloomberg.com/amp/view/articles/2014-04-30/single-payer-would-make-health-care-worse>)

Even if you look at spending as a fraction of national income, the U.S. is an outlier. The figures above are for 2010; we now spend close to 20 percent of our national income on health care. One in every five dollars earned goes to buy health-care services, while no other nation cracks 15 percent. The implication that many people draw from this is that the U.S. could realize fabulous savings from switching to a government-run health-insurance system. But wait: The U.S. already

has a government health-care system. Actually, it has several: Medicare, Medicaid, Veterans Affairs, military, federal employee benefits, state and local government benefits. And this system already spends more per capita than most other rich-world governments: The numbers get a little better if you look at them as a percentage of gross domestic product. But not much better. We are spending almost as high a percentage of gross domestic product as every other country, just to cover a fraction of our population. How can that be? Well, let's think about the general theories of why government makes health care cheaper. The first idea is that you get big discounts for buying in bulk. Because governments cover a lot of people, they can negotiate the best prices, which can't be matched in America's fragmented market. The problem with this idea is that U.S. health insurers already buy in bulk. They cover more people than many of the countries cited as cost-control models for the U.S.: A more sophisticated version of this argument says that the power comes from setting prices and controlling administrative costs. This is the idea behind a "public option." But we already have a public option. As mentioned, we have several. And Medicare doesn't control costs noticeably better than the private sector does: Medicaid controls costs significantly better. That's because it's a program for poor people who don't vote much, and politicians don't necessarily care if doctors refuse to take it. So states set reimbursement rates that are so low that you could pay more to take your kid to Panera than the government would pay for you to take him to see a general practitioner. On the other hand, seniors vote, and thus, politicians are very reluctant to tinker with reimbursements. Prices are set the way that other governments set them -- by a centralized committee. But they're set high. There are two potential outcomes for a "public option" health insurer: It could set rates high, in which case it wouldn't control costs, or it could jam them down to Medicaid levels, in which case no one but the very healthy or the very desperate would buy that insurance because it will be hard to actually use that coverage. That brings us to the most sophisticated version of the argument: that we can use monopoly power to bring our health-care spending in line with that of other countries. As long as there is private-sector competition, the argument goes, prices will stay high, because doctors can refuse to accept government reimbursement. But if the government is the single provider of health care (or at least, the single price setter), then we can drive down reimbursements and drug prices to something approaching European levels. This idea has a number of problems, starting with its constitutionality. Here's a big one: Most of the time, since the 1980s, growth in government spending has been higher than total growth, not lower. This represents coverage expansion, as well as price growth. What it does not represent is significant cost control. Think that's just because conservative ideologues are preventing the government from doing its job and controlling costs? Well, here's an even bigger problem with the idea that getting government involved is going to bring our costs down: What's the problem? I hear you cry. Well, the problem is what you don't see in that picture. What you don't see is any government cutting health spending by any significant amount. Oh, Germany managed, once. Canada kept it level for a while. But no one has cut by anything like 35 to 40 percent -- which is what we'd need to get our spending in line with Canada's. I've only shown a few countries, to keep the graph easy to read, but these examples aren't cherry picked, except that they're big rich countries like us. When you dig into the Organization for Economic Cooperation and Development data, you don't see any government, anywhere, making sustained cutbacks in the health-care system, except for situations such as in Greece, which cut back substantially in the middle of an economic meltdown and a sustained run on its government debt. Absent the impetus that a whopping financial crisis provides, at best, you see them hold down cost growth. Holding down growth rates is feasible -- give people a smaller bump in what they were expecting. Cutting spending is absurdly difficult, because it means cutting people's incomes. Incomes that they counted on to help make their mortgages and car payments. Maybe you don't feel so bad for expensive surgeons who have to sell the Bimmer, and I don't, either. But America's cost inflation is not just fancy surgeons. It's everything: surgeons, general practitioners, nurses, respiratory technicians, private hospital rooms, MRIs, CT scanners -- and I haven't even gotten to drug prices: It's theoretically possible that we could demand that all those folks take a pay cut. But so far, as the Official Blog Spouse chronicles, the U.S. political system hasn't even been able to get doctors to take a cut in their Medicare reimbursements, much less their whole incomes. Here's the basic electoral math: If you try to cut the incomes of doctors, nurses, radiology techs, phlebotomists, etc., voters may be glad of the price break, but I'd be surprised if 1 percent would go to the polls and vote for you because you're the guy who cut doctor reimbursements by 17 percent. On the other hand, 100 percent of the doctors, nurses, radiology techs and phlebotomists will storm the voting places and make sure that they cast their vote against the jerk who wants to cut their incomes and, oh, by the way, destroy American health care. Here's the advanced electoral math: Americans like and trust their health-care providers far more than they do their politicians or journalists, or, for that matter, practically anybody. So when you try to cut the reimbursements that fund their salaries, and all the providers band together to run ads claiming that cost-cutting, health-hating American politicians are trying to kill you in order to save a few measly dollars, guess who wins that showdown? We might be able to hold down future costs, but there is no evidence that we can cut the costs we already have back down to the level of those European nations that single-payer advocates like to cite. In fact, I'd say there's quite a bit of evidence to the contrary. Well, that's something, isn't it? Let's get a government system in there, get our cost growth down to the level of other OECD countries instead of the insane rates that our inefficient private system produces. Eventually, as the economy grows, health care will shrink relatively, if not absolutely, and the proportion of national income that Americans spend on health care will come to resemble

that of the rest of the world. Here's the problem with that idea: America doesn't have a cost-growth problem. The rate of cost growth in our "insane," "inefficient," "free market" system isn't particularly high by OECD standards. It's the level that's so high. We're growing at a normal rate, but off a much higher starting expenditure -- an expenditure that we've so far proven unable to cut by even a bit. We are not a nation that has a cost-growth problem; we're a nation that used to have a cost-growth problem, in the 1970s and 1980s: Once we pulled away from the other countries, even an average growth rate meant that the gap between our spending as a percentage of GDP, and theirs, would continue to widen -- especially if their GDP grew faster than ours for any length of time. That is why we cannot count on financing single-payer with the fabulous cost savings to be gained by making our system more like Europe's. Europe didn't gain fabulous cost savings by making their systems more like Europe's: Its nations started from a lower base, and held down cost growth, but they did not actually use single-payer systems to cut what they were spending. Once spending is in the system, it's hard to get rid of. I've already covered the political difficulties with using government power to take income away. But those aren't the only problems. For example, in the middle of the last century, the U.S. decided that private or at most two-person rooms were best, because they made it easier to control infection and to let patients rest. For decades, we built hospitals to this standard; when my mother was in the hospital for a complicated appendectomy, there weren't even any semi-private rooms on the surgical ward. Private rooms drive up costs in a lot of ways: They take up more space, you have to duplicate equipment, and because the nurses can't see the patients, you need more monitors and/or staff circulating to make sure no one has stopped breathing. Basic hospital rooms in many other countries look spartan and overcrowded compared with what most Americans are used to, because they have more people and fewer beeping machines. But even if we got a single-payer system tomorrow, we would not be able to do what those other countries have done, which is not build expensive single hospital rooms in the first place. Those hospitals were built over time, as funds became available and as the old buildings wore out. Trying to replace them all at once with semi-private rooms or wards would cost more than just sucking up the extra expense of the hospitals we have.

Single Payer won't lower admin costs

Pearl, MD and Forbes contributor 2017, (Robert, "Why A Government-Run, Single-Payer Healthcare Approach Is Doomed To Fail" Forbes March 16, 2017 available at <https://www.forbes.com/sites/robertpearl/2017/03/16/why-a-government-run-single-payer-healthcare-approach-is-doomed-to-fail/> accessed 8/19/17 TOG, * WAVE ONE*)

Supporters claim a single-payer system would siphon out billions of dollars in administrative overhead. How they reach this conclusion varies by the source but in each case, a deeper analysis reveals oversimplification and fallacious assumptions. One line of reasoning is based on the lower cost of healthcare in other countries with a government-run system. But the reduced costs in other nations reflect other factors—their cheaper drug prices, lower wages and higher number of primary care physicians compared to specialists—rather than lower administrative overhead. A second comparison drawn is between Medicare and commercial insurance in the United States. Here cost is confused with price, and vice versa. The federal government has a unilateral ability to set prices, and often does so at levels below the actual cost of care delivery. When it does this, hospitals and doctors offset the reduced payments they receive from the government by raising prices elsewhere. Published economic analyses indicate that only 90% of cost is reimbursed through Medicare today and that, as a consequence, commercial insurers pay, on average, approximately 120% of the Medicare rates to doctors and hospitals. Finally, some backers of a single-payer system look at the medical loss ratio (percentage of healthcare premium spent on direct patient care) of some of the publicly traded insurance companies and note that, for some, nearly 20% of their revenues are used for administrative purposes. What is left unsaid is that there are already several not-for-profit insurance programs that spend more than 90% of their revenue on patient care—and as such, little savings would be achieved. The idea that a government-run plan could function without incurring major administrative costs is naive, especially if fee-for-service is the method of provider reimbursement. In such a system, doctors and hospitals would still need to complete claims forms. Government employees would, in turn, be required to sort through them, make certain they're appropriate, question coding and pay the providers accordingly. There is little evidence, whether we look at the U.S. Postal Service or the

Department of Motor Vehicles, that the government is particularly efficient at these types of administrative tasks.

Infant Morality Answers

Higher infant mortality not due to a lack of universal health care

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

Let's turn first to infant mortality. Compared to other countries, the United States has a broader definition of what constitutes a "live birth." According to the National Institutes of Health, the United States reports "as live births more low-birth-weight babies who are at risk of dying on the first day, and then register[s] those who die as infant deaths. But in many European countries, an infant needs to meet certain height or weight requirements to be considered a "live" birth. Similarly, many countries classify infants who die within 24 hours of being born as "miscarriages," which are excluded from infant mortality calculations.¹⁰ Because the definition of infant mortality varies across countries, it's hardly an adequate measure of the quality of a health system. One study published by the British Journal of Obstetrics and Gynaecology found that directly adjusting the infant mortality rates of 12 Western European nations to align with a common definition could reduce some of those rates by up to 40 percent—and even change their rank order.¹¹ America's infant mortality is so high in part because the United States has a lot of neonatal care centers dedicated to treating high-risk infants. But in many European countries, an infant needs to meet certain height or weight requirements to be considered a "live" birth. Similarly, many countries classify infants who die within 24 hours of being born as "miscarriages," which are excluded from infant mortality calculations.¹⁰ Because the definition of infant mortality varies across countries, it's hardly an adequate measure of the quality of a health system. One study published by the British Journal of Obstetrics and Gynaecology found that directly adjusting the infant mortality rates of 12 Western European nations to align with a common definition could reduce some of those rates by up to 40 percent—and even change their rank order.¹¹ America's infant mortality is so high in part because the United States has a lot of neonatal care centers dedicated to treating high-risk infants.

Frontline Turns

Medicare for All would collapse the private health care system and replace it with a worse one

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So Medicare for All gives the government a monopoly over the provision of health insurance. And it forbids doctors who participate in the scheme from accepting private payment for any services the government covers. In other words, it nationalizes the U.S. health insurance system. Sanders and Jayapal counter that they'd permit the sale of private insurance for anything not covered by their Medicare for All plans. But the only things their plans don't cover are elective and cosmetic surgeries. It's almost impossible, by definition, to buy insurance for elective procedures. Insurance is designed to help cover unexpected health costs. There's nothing unexpected about a nose job. The level of disruption Medicare for All would unleash on the U.S. health care marketplace is breathtaking. The 181 million Americans who get health benefits through their jobs would be forced off their plans. So would the 52 million people who buy coverage on the individual market. The more than 20 million seniors with privately administered Medicare Advantage plans would lose their coverage.¹³ Tens of millions of people are on managed care plans through Medicaid; they'd lose their coverage, too.¹⁴ Only those enrolled in the Veterans Health Administration and the Indian Health Service would be excluded from the Sanders-Jayapal vision for health reform. Of course, these two programs are pure manifestations of socialized medicine, as the government owns and operates hospitals and clinics directly. Not surprisingly, both are plagued by delays, poor-quality care, and rampant malfeasance. Medicare for All's backers are convinced the public will love free health care so much they won't mind losing their private insurance. However, most people who say they support Medicare for All think they'll be able to keep their insurance.¹⁵ When the public learns that Medicare for All means outlawing private insurance, support collapses. (See vignette at end of chapter.)

Bureaucracy kills single payer solutions

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

PROBLEMS Liberals must also face the flaws exposed in a single-payer system already operating in the United States: The Veterans Health Administration. The waiting times scandal within the VA, which exploded into public view in early 2014, hints at the future the United States could face under a nationwide single-payer system. Veterans who survived battles in far-flung places from Normandy to Vietnam to Iraq could not survive their encounters with a bureaucratic culture that denied patients timely access to care. Some of the ingredients that precipitated the VA scandal closely resemble the problems seen in other single-payer systems worldwide. For one, under-funding and an aging patient population, a problem magnified in the VA's case by an explosion of veterans from conflicts in Iraq and Afghanistan while Vietnam and World War II vets grow older and more infirm. Then there's its bureaucratic culture focused on meeting targets, even if it involves cutting corners to do so, and decades full of warnings that veterans were incurring wait times far longer than those publicly advertised.³⁷ Those factors all culminated in horrific stories like that of Thomas Breen, a 71-year-old Navy veteran. In late September 2013, Breen went to the emergency room at the Phoenix VA hospital with blood in his urine. Despite his symptoms, his prior history of cancer, and notations on the chart marking his case as "urgent," Breen was sent home to wait—and wait—for an appointment with a urologist. Despite the urgency of his case, and his family's regular efforts to get an appointment, not even a VA primary care doctor would see Breen—until he died on November 30, 2013, of Stage IV bladder cancer.³⁸ Breen's children described his agonizing last days, in which he recognized that the VA system established to help veterans like him had let him down in ways that hastened his death: At the end is when he suffered. He screamed. He cried. And that's something I'd never seen him do before, was cry. Never. Never. He cried in the kitchen right here. "Don't let me die....Why is this happening to me? Why won't anybody help me?"³⁹ On December 6, 2013, more than two months after Breen's initial ER visit, his children received a telephone call: The VA finally had an appointment available for their father—who had died a week earlier, thanks in no small part to the agency's neglect.⁴⁰ Breen's case represented a symptom of a larger problem with single-payer systems. As a review ordered by President Obama concluded, the VA had developed a "corrosive culture" that affected morale, one in which VA staffers themselves called the organization's behavior "unethical" and injurious to patients.⁴¹ Scathing as the reviews of the scandal proved, few should find them surprising. When single-payer systems lack adequate funding—and most will lack funding sooner or later because they drive up health spending—the supply of care will not meet available demand, and waiting times will almost inevitably result.

Single payer systems undermine access to care

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

KEY POINTS Single-payer systems have demonstrated records of denying patients access to care to contain costs. Patients in Canada and Britain—two countries with single-payer health systems—have far less access to specialized yet costly treatments like MRI machines and CT scans than do patients in the United States. In Canada, patients needing specialist care must wait an average of five months from an

initial referral until starting treatment; waiting times average nearly ten months for orthopedic surgery. In Britain, the National Institute of Health and Care Excellence (NICE) restricts access to drugs and treatments not deemed cost effective. Single-payer legislation could bring similar practices to the United States. The Veterans Health Administration scandal illustrated the problems inherent in single-payer systems: Lack of funding means the supply of health care cannot meet demand, resulting in waiting times—and efforts by bureaucrats to conceal those waiting times. Because single-payer legislation would make private insurance “unlawful,” American patients, unlike those in Canada and Great Britain, may have little recourse should the federal government deny them access to costly care. Single-payer supporters portray socialized medicine as a utopia in which everyone gets all the health care he or she needs, free of charge. The facts suggest otherwise. In reality, single-payer systems have a proven track record of denying patients prompt access to treatment, and providing low-quality care. In Canada, health officials keep costs low by restricting the supply of care, forcing people to wait months for treatment. Even Canada’s highest court has criticized its health system, noting that access to a waiting list does not represent access to care. In Great Britain, chronic underfunding has created repeated crises in hospitals, as lack of capacity means patients wait for care. Moreover, Britain’s National Health Service (NHS) restricts access to drugs not deemed cost-effective by government bureaucrats, denying British patients life-saving treatments available in other countries.

Overwhelming Demand

Medicare for All would create unlimited demand, not comparable to other systems

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

By making care “free,” Medicare for All would prompt unlimited demand from patients. But there’s a limited supply of doctors, hospitals, and the like. Meeting that increase in demand would be impossible. No other country in the world offers anything like what Sanders and Jayapal are proposing. Canada and the United Kingdom require some cost-sharing. Out-of-pocket costs—usually for things like prescription drugs—account for about 15 percent of national health expenditures The same goes for Denmark, Norway, and Finland, where out-of-pocket spending accounts for 13.7 percent, 14.6 percent, and 20.4 percent of national health spending, respectively.¹¹ Pipes, Sally . False Premise, False Promise (p. 15). Encounter Books. Kindle Edition. Pipes, Sally . False Premise, False Promise (pp. 16-17). Encounter Books. Kindle Edition.

Not enough space

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TOO MANY PATIENTS, NOT ENOUGH SPACE These massive staffing shortages cause more problems than wait times. Nine million patients had hospital appointments canceled in 2017–2018, up from just over 3 million a decade earlier.¹²⁰ In 2018, close to 80,000 elective operations were canceled the day the patient was supposed to have them.¹²¹ Around 10 percent of those patients had not received treatment within 28 days of the cancellation.¹²² Additionally, close to 4,000 urgent operations were canceled at the last minute—150 of those were canceled for the second time or more.¹²³ As the NHS continues to underperform, private health care has grown increasingly popular. The number of people with private coverage grew more than 2 percent in 2015.¹²⁴ That year, just over 10 percent of the population had private coverage—almost 4 million policies total.¹²⁵ To help clear the surgery backlog, in March 2019 the NHS proposed paying for patients who had been on the waitlist for over 26 weeks to receive private care. That’s about 250,000 patients.¹²⁶ Ironically, one study found that the NHS would be able to perform 300,000 more surgeries a year if hospitals simply organized schedules better.¹²⁷ Meanwhile, cost-cutting is making it increasingly had not received treatment within 28 days of the cancellation.¹²² Additionally, close to 4,000 urgent operations were canceled at the last minute—150 of those were canceled for the second time or more.¹²³ As the NHS continues to underperform, private health care has grown increasingly popular. The number of people with private coverage grew more than 2 percent in 2015.¹²⁴ That year, just over 10 percent of the population had private coverage—almost 4 million policies total.¹²⁵ To help clear the surgery backlog, in March 2019 the NHS proposed paying for patients who had been on the waitlist for over 26 weeks to receive private care. That’s about 250,000 patients.¹²⁶ Ironically, one study found that the NHS would be able to perform 300,000 more surgeries a year if hospitals simply organized schedules better.¹²⁷ Meanwhile, cost-cutting is making it increasingly

Reduced appointment length

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According to BMJ, the average appointment with a general practitioner in the United Kingdom lasts just over nine minutes. Appointment length has been increasing by 4.2 seconds per year, meaning the NHS is on track to meet the British Medical Association's recommended 15-minute appointment sometime in 2086.¹³⁶ Some health officials believe that group appointments are a viable "solution" to this problem. Under this model, one general practitioner sees up to 15 patients with the same condition for around 90 minutes.¹³⁷ The NHS claims that group appointments can improve a patient's experience by giving them more time with a doctor and allowing them to meet other people with their According to BMJ, the average appointment with a general practitioner in the United Kingdom lasts just over nine minutes. Appointment length has been increasing by 4.2 seconds per year, meaning the NHS is on track to meet the British Medical Association's recommended 15-minute appointment sometime in 2086.¹³⁶ Some health officials believe that group appointments are a viable "solution" to this problem. Under this model, one general practitioner sees up to 15 patients with the same condition for around 90 minutes.¹³⁷ The NHS claims that group appointments can improve a patient's experience by giving them more time with a doctor and allowing them to meet other people with their

Wait Times

Medicare for all increases wait times

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GET IN LINE Canadians may be known for their kindness and politeness, but even the gentlest Canuck is bound to get sick of my native country's health care system. Its delays for care would be laughable if they didn't leave millions of people in pain and suffering. Since 1993, the Vancouver-based Fraser Institute has published Waiting Your Turn, an annual report examining wait times for health care in Canada. Those waits have headed in one direction over the past quarter-century—up. The report chronicles two types of waits. The first is how long a patient waits between referral by a general practitioner to a specialist and consultation with that specialist. The second is how long the patient waits for treatment after consultation with a specialist. Together, these two metrics constitute "total wait time."¹ Nationwide, the median total wait time was just under 20 weeks in 2018.² That's more than double the wait Canadian patients faced in 1993.³ Patients in New Brunswick, one of the Maritime provinces, fared the worst, waiting a median of 45 weeks between their initial appointments with general practitioners and specialist treatment.⁴ Not far behind was Nova Scotia, where patients waited more than 34 weeks.⁵ In 2018, 72 percent of wait times nationwide exceeded what physicians would deem "reasonable."⁶ Only the sickest patients come close to securing relatively timely care. Cancer patients had the shortest total wait time in 2018—just four weeks. On the flip side, the median wait for orthopedic surgery was 39 weeks.⁷ These waits are particularly hard on elderly Canadians. Thirty percent of patients waited more than six months for hip and knee replacements in 2018.⁸ One in five Canadians 55 and older says they have major issues accessing health care.⁹ In 2019, Vancouver retiree Jenny MacKenzie was told she would have to wait a full year for hip surgery, according to reporting from Canadian think tank SecondStreet.org. She was dealing with more than physical pain. "It really upsets me I can't cuddle my grandchildren or pick them up," MacKenzie said. All told, Canadians were waiting for nearly 1.1 million procedures in 2018. That means nearly 3 percent of the population were on a waiting list, if we assume one patient per procedure.¹¹ Extrapolate those numbers to the United States, and that's the equivalent of more than 9.8 million Americans waiting for care.¹²

Technology

Patients in Canada can't get access to technology

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A WAITING GAME FOR CUTTING-EDGE TECHNOLOGY IN CANADA

Take CT scanners—medical imaging devices used to detect and diagnose a number of conditions, including cancer.¹ In 2017, Canada had less than 16 machines for every million people, according to the Organisation for Economic Co-operation and Development (OECD). The United States had 42 per million people—2.6 times as many.² Less than 15 percent of rural emergency departments, which serve 20 percent of Canadians, had a CT scanner in 2017.³ Each of the country's three northern territories had just one scanner—in total.⁴ It's no wonder the average wait for a CT scan across the country is more than four weeks, according to the Fraser Institute.⁵ Even when Canadians get CT scans, there's almost a one in four chance that the machine being used is over 10 years old.⁶ Canada's 13 provincial and territorial governments choose which hospitals get scanners and which don't. Despite the combination of tax revenue and federal funding they receive, they can't seem to provide scanners to every hospital. As a result, some hospitals have to fend for themselves. It took 10 years for one hospital in Sudbury, Ontario, to raise enough money to buy one. A nearby hospital in Windsor had its machine replaced after less than a year's wait.⁷ MRI machines are just as hard to come by in Canada. There are 366 of them spread throughout the country.⁸ That equates to less than 10 units per million people. The United States has close to 40 MRI units per million people.⁹ Consequently, wait times for MRIs in Canada average over 10 weeks, according to Fraser.¹⁰ More than one in four MRI machines in Canada are at least a decade old.¹¹ According to a study by the Conference Board of Canada, close to 400,000 people are forced to exit the workforce each year as they wait for CT and MRI scans. All told, these “excessive wait times” cost the economy \$3.54 billion in 2017.¹² The story is the same for radiotherapy machines, like X-rays. The United States has four times as many per million people as does Canada, according to OECD figures.¹³ Then there's the discrepancy in mammography machines, which are used to detect breast cancer. Canada has 18 of them per million people; the United States has just under 60 per million.¹⁴

Britain's health care system is low tech

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BRITAIN'S LOW-TECH HEALTH CARE SYSTEM The United Kingdom's National Health Service is even more technologically retrograde than Canada's. The OECD's most recent data on CT scanners in Great Britain come from 2014. In that year, there were a little over nine for every million Britons. That's less than one-fourth the number available to American patients that year.⁵¹ Mammography machines are also sparse in the British Isles. In 2011, the most recent year for which the OECD has data, there were just over 10 mammography machines for every million British residents. That year, there were almost 40 per million people in the United States; today, it's 60 per million.⁵² Want an MRI in Britain? Good luck. The United Kingdom had just seven MRI machines per million residents in 2014—less than one-fifth as many as the United States.⁵³ This is all bad news for those at risk of cancer or heart disease. In 2017, the Royal

College of Radiologists estimated that over 56,000 patients with angina, a type of chest pain, were unable to access a CT scanner due to shortages. A sufficient number of the machines could have prevented thousands of heart attacks a year by empowering doctors to potentially catch patients' heart problems before they became acute.⁵⁴

Doctor Shortage

Medicare for All means not enough doctors

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THE DOCTOR IS OUT The Canadian health care system doesn't have the capacity to meet demand. In 2018, Canada had fewer than three doctors—and fewer than three beds—for every 1,000 residents.²⁵ In 2019, an estimated 175,000 people in Canada's four easternmost provinces were waiting to be matched with a family doctor.²⁶ If current trends continue, Canada will be short 60,000 full-time nurses by 2022, according to the Canadian Nurses Association.²⁷ Canadian officials don't appear particularly interested in narrowing their doctor shortage. One in five newly certified medical and surgical specialists can't find a job in Canada, according to a May 2019 report from the Royal College of Physicians and Surgeons of Canada. Neurosurgeons, radiation oncologists, and orthopedic surgeons are most likely to be unemployed.²⁸ That makes little sense, given that Canadians wait longer for orthopedic surgery than for any other specialty procedure. Provincial governments don't appear to have the money to hire the doctors their residents need—or don't care to find it. “We have unemployed orthopedic surgeons who are dying to meet this need,” said Mark Glazebrook, the head of the Canadian Orthopaedic Association. “The government can't afford it.”²⁹ And because private insurance is illegal under the Canada Health Act, Canadian patients don't have an escape route from single-payer health care. Some people are trying to change that.

Doctors quit

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The paramedic shortage is just the tip of the iceberg. The NHS is plagued by shortages of other key personnel. The reason is simple—people hate working for the NHS. It's easy to see why. Each week, close to 60 percent of its employees work unpaid overtime. Thanks to the stress, 40 percent of NHS employees report feeling “unwell.” Around half want to leave their roles.¹⁰¹ According to the Mirror, each year more than one in four nurses take sick days due to stress.¹⁰² More than 160,000 nurses have quit the NHS since 2011.¹⁰³ Things aren't much better for doctors. One physician told The Guardian that working for the NHS has drained him of his humanity, since his workload made it impossible to have personal interactions with

patients.¹⁰⁴ British physicians aren't paid particularly well for their troubles, either. The average generalist physician in the United Kingdom makes US\$134,671 a year. His counterpart in the United States takes in close to US\$220,000 a year. General practitioners in Germany and Canada are also better paid than their peers in the United Kingdom.¹⁰⁵ This combination of high-stress work and comparatively low pay has made it hard for the NHS to retain people. In 2018, the United Kingdom had just under three doctors and about eight nurses for every 1,000 patients.¹⁰⁶ That's the worst doctor-patient ratio of all EU countries.¹⁰⁷ As of December 2018, the NHS had over 9,000 doctor vacancies and over 39,000 nurse vacancies in England alone.¹⁰⁸ Toss in other staff, and total NHS vacancies rise to just under 95,000.¹⁰⁹ Things are expected to get worse. About 9,000 doctors quit in 2017, according to BMJ.¹¹⁰ A 2019 poll found that 42 percent of general practitioners were planning to quit by 2024.¹¹¹ In

March 2019, three of the United Kingdom's biggest think tanks released a study examining the future of the health care workforce.¹¹² By 2029, there will be a shortage of "108,000 full-time equivalent nurses."¹¹³ The NHS will be short 7,000 general practitioners by 2024, if current trends continue.¹¹⁴ To help combat the doctor shortage, in 2015 the NHS resolved to recruit 2,000 foreign general practitioners by 2020. As of June 2019, they only had 120.¹¹⁵

Single payer will cause doctor shortages

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

The increasing care the United States' aging population needs, coupled with the retiring wave of doctors in the Baby Boom generation, means the nation's health system already faces a major physician shortage. Over the course of the next decade—between now and 2030—the United States faces an estimated shortfall of up to 121,300 physicians nationwide.¹⁷ With the supply of available physicians already not meeting expected demand, single payer would cause demand for health care to explode, even as it constricts physicians' availability. Single payer would exacerbate the forthcoming doctor shortage, reducing the available supply of care by driving physicians out of medicine. For doctors approaching retirement, the rapid changes envisioned by a new system, coupled with the steep pay cuts, would encourage them to hang up their proverbial spurs early. For mid-career physicians, the thought of performing more work for less pay could prompt them to leave the profession. And the prospect of permanently lower wages and high student debt could discourage some interested students from ever entering medical school.

Single payer causes doctors to quit

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

REDUCING PHYSICIAN SUPPLY The claim that moving to a single-payer system will reduce health-care costs comes down to a single premise: That doctors and hospitals will accept less pay to provide more health care to more patients.⁶ If one disagrees with that premise—and logic suggests that most rational individuals would—then single payer will either lead to an explosion of health-care spending, or a reduction in the supply of care provided. The current pricing system suggests the latter outcome will occur—namely, that doctors will decide to stop providing care, and may leave the profession entirely. Analysis from the office of the independent, non-partisan Medicare actuary explains why...The single-payer bills would cut physician payment significantly, by applying Medicare's current reimbursement levels to the entire American population. Medicare does pay physicians more than Medicaid does, meaning physicians who treat large numbers of Medicaid patients might see no change in pay, or even a slight increase. But many more individuals hold private coverage—181 million with employer-sponsored coverage, compared to only about 72 million in Medicaid—meaning that most physicians will see their pay cut under a single-payer system.⁹ And remember: This pay cut will come at a time when demand for medical services will increase—due to the number of newly covered individuals, and the elimination of virtually all deductibles, co-payments, and other forms of cost-sharing. Jacobs, Chris. The Case Against Single Payer . Republic Book Publishers. Kindle Edition.

Cancer Care

National Health Care reduces access to cancer care

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Just as in Canada, health care in the United Kingdom is defined by long waits, shortages of doctors and nurses, few resources, and unhappy patients. As of May 2019, 4.34 million people were waiting for treatment throughout England, a 42 percent increase from 2014.⁵⁴ One of those patients was Susannah Thraves, a journalist who needed surgery on a damaged kidney.⁵⁵ In an August 2019 piece for The Guardian, Thraves wrote, “I can cope with the physical pain. But I really struggle to deal with the distress and anxiety of being on what seems like a never-ending waiting list.”⁵⁶ The National Health Service acknowledges it will keep people waiting. The “maximum waiting time for non-urgent consultant-led treatments” is 18 weeks after an appointment is booked.⁵⁷ The goal is for 92 percent of patients to be on the wait list for less than 18 weeks.⁵⁸ As of May 2019, the NHS hadn’t hit that target in over three years. In fact, the agency fails to stay within most of its own guardrails. In 2019, the Liberal Democrat party alleged the NHS missed its own treatment time guarantees 200 times per day.⁵⁹ Despite having a “zero tolerance” policy for patients waiting more than 52 weeks for care, as of May 2019 more than 1,000 patients had been left waiting for over a year.⁶⁰ Cancer treatment targets are among the most frequently missed. The NHS aims to treat 85 percent of cancer patients within 62 days of a referral from a general practitioner. As of June 2019, the NHS hadn't hit that target since 2013.⁶¹ According to a report released that same month, only 38 percent of NHS trusts met the 62-day treatment standard.⁶² In March 2019, one doctor told the Independent that “more than 127,000 people have waited too long for cancer treatment since the target was first missed five years ago.”

Ovrcrowding

Overcrowding

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A June 2019 British Medical Association investigation found that NHS hospitals frequently relied on “escalation beds,” temporary beds that are usually reserved for emergencies, like a flu outbreak.⁸⁰ According to BMA consultants committee chair Dr. Rob Harwood, “The use of escalation beds is a sign that trusts are at a critical stage and are unable to cope with demand.”⁸¹ Overcrowding of this nature makes it hard to process patients. Consider the NHS’s four-hour wait target for Accident and Emergency departments.⁸² Daily A&E use has increased every year since 2012, and the NHS can’t keep up.⁸³ In 2018, close to 19 percent of people waited more than four hours in A&E departments.⁸⁴ Over 57,000 people waited more than four hours for admission admission in July 2019 alone. More than 400 patients waited longer than 12 hours.⁸⁵ But nothing compares to January 2019. That month, A&E waits were the worst they’d been in 15 years, with close to 330,000 patients waiting longer than they should have.⁸⁶ That month, the NHS proposed scrapping the four-hour wait target altogether.⁸⁷

Drug Shortages

Drug shortages in Canada

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“SORRY, THAT DRUG IS UNAVAILABLE, EH?” The public sector covers less than half of drug spending in Canada.¹⁵ But the government still exercises outsized control over the country’s drug market. Many of the most cutting-edge drugs are in short supply in Canada, if they’re available at all. One analysis of 290 new medicines brought to market between 2011 and 2018 showed that less than half were available in Canada. U.S. patients had access to 89 percent of those new drugs.¹⁶ The numbers are even more dire in specific categories of treatment. Of 21 new treatments for blood disorders introduced between 2011 and 2018, Canadian patients have access to just 14 percent. All 21 were available in the United States.¹⁷ Canadians have access to less than half as many new central nervous system therapies as Americans. Only 59 percent of the 82 new cancer drugs are available in Canada, whereas 96 percent of them were accessible to American patients.¹⁸ Canadians can blame the price controls their government has levied on medicines for their inability to access them. The country’s Patented Medicine Prices Review Board sets a maximum price for each new drug before approving it for sale.¹⁹ Drug manufacturers may respond by refusing to sell their products in Canada at all—or by making only small quantities available. Consequently, scarcity plagues the Canadian drug market. In 2018, there was a mass shortage of EpiPens—and in 2017, a shortage of the common antidepressant Wellbutrin.²⁰ According to a CBC report, Canada experienced 25 drug shortages in a one-week period in September 2018. Critical medications for Parkinson’s disease, schizophrenia, and hepatitis B suddenly became unavailable.²¹ There’s even a government-chartered website listing all the drugs Canada is short on.²² Drug shortages are so rampant that one in four Canadians has been personally affected by them or knows someone who has, according to a survey from the Canadian Pharmacists Association.²³ Even if drug manufacturers assent to the Canadian government’s price controls, they still have to compete to get onto the formularies of provincial health plans. The Common Drug Review process is conducted by the Canadian Agencies for Drugs and Technology in Health (CADTH), which considers the clinical and cost-effectiveness of a drug.²⁴ Then, the Canadian Drug Expert Committee makes a reimbursement recommendation. Each provincial health plan decides, based on the committee’s recommendation, whether to put a drug on its formulary.²⁵ These may sound like reasonable consumer protections—a way to ensure that people get the best prices possible. But what if you need a drug that doesn’t make it onto the formulary? You’re generally out of luck. That’s a particular problem for people with rare diseases. Canada is one of the only developed countries not to have a policy for the development and availability of so-called orphan drugs. Such drugs are expensive to develop, in part because there’s a small market of potential customers for them.²⁶ Only a few provinces have funds set up to cover orphan drugs. Even when they are covered, very few are available, and not for all rare diseases.²⁷

Cost Control Answers

Neither Canada nor the UK have controlled costs

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Neither Canada nor the United Kingdom has been able to keep its health costs under control. From 2005 to 2018, inflation-adjusted national health spending in the United Kingdom climbed 58 percent, according to data from the OECD. In Canada, it increased 50 percent. In the United States, by contrast, national health spending grew 44 percent—a lower rate than either single-payer paradise. In Britain, health spending grew from 6 percent of GDP to just under 10 percent of GDP between 2000 and 2018.⁴ To keep the system from imploding, the British government is pumping more money into the NHS. In June 2018, the then prime minister Theresa May announced that the NHS would get a £20.5 billion spending boost over the next five years as a 70th “birthday present.”⁵ This funding boost comes on top of a £1.8 billion increase it got in 2017.⁶ Critics have denounced May’s plan as insufficient to deal with the NHS’s current money problems, much less improve its quality of care. The Institute for Public Policy Research, a London-based think tank, called the funding boost “generous” but said, “It will not fund significant improvements in care unless the NHS radically increases productivity.”⁷ Canada’s attempts to control costs haven’t been working either. Between 2001 and 2016, health spending by Canada’s provinces shot up 116.4 percent. Health bills now consume anywhere from 34 percent to 43 percent of provincial budgets.⁸ As in the United Kingdom, health spending has been growing much faster than Canada’s overall economy. In 2000, health care accounted for just over 8 percent of Canadian GDP. By 2015, it was more than 10 percent of GDP.⁹ And in 2018, the Canadian Institute for Health Information pegged health spending at 11.3 percent of GDP—more than C\$6,800 per capita.¹⁰ The upward march of health spending in both countries is likely to continue as their populations age.

The only way to contain costs is to reduce care

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

Even though CBO has yet to release a specific cost estimate for the House and Senate single-payer bills, several elements of the legislative proposals include measures likely to increase spending on health care rather than reduce it. Providing more benefits to more people, and providing virtually all those benefits without requiring them to help pay for their care at the time of service, will induce additional demand for care. People will go to the doctor more often if other people will foot the bill. As a result, government will have to contain costs by lowering payments to doctors and hospitals, limiting the care available, or—more likely—some combination of both.

Savings unlikely

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

SAVINGS SOURCES UNCERTAIN AT BEST The fact that the broader benefits a single-payer system promises will likely drive up health spending yields one obvious question: Will other provisions in the

legislation help contain costs? As with other elements of single payer, one cannot quantify the precise effects, but the available data provide some clear reasons for doubt. The federal government could generate significant savings from lowering reimbursements to doctors and hospitals, but that would also generate serious costs. Provisions in the House and the Senate bills suggest that the new single-payer program would use current Medicare rates—far lower than rates paid by private insurance plans—to reimburse doctors and hospitals.³³ As we shall see in future chapters, these lower payment rates could cause doctors and hospitals to lay off millions of health-care workers, prompt physicians to retire early, and even discourage would-be doctors from ever joining the medical profession. When Sanders congratulated the Mercatus Center for its July 2018 analysis, claiming the study proved single payer would reduce overall assumption that single payer would do so by paying hospitals and doctors at Medicare levels.³⁴ However, such lower payment levels would significantly alter health-care markets, and could prove unsustainable. If a single-payer system instead had to pay doctors and hospitals using current reimbursement rates—in other words, it could not save money by paying providers Medicare rates for all patients—the Mercatus paper concluded this one change would raise spending by \$5.4 trillion over a decade, more than wiping out any supposed savings from single payer.³⁵ Second, a single-payer system could achieve savings from lower pharmaceutical spending, either by lowering payments to drug companies outright, encouraging greater use of cheaper generic drugs, or a combination of the two. Yet arbitrarily lowering payments could limit future medical innovation by discouraging investment in the pharmaceutical industry. This payment strategy would potentially result in short-term gain, but long-term pain, for American patients. As for generic pharmaceuticals, such drugs already comprise 87% of prescriptions dispensed by the current Medicare Part D program, making it difficult to increase generic adoption even further.³⁶ Moreover, because both single-payer bills virtually prohibit cost-sharing, the government would have few economic incentives at its disposal to do so.³⁷ Finally, because prescription drugs represented just 9.4% of total health-care spending in 2018, even a sizable reduction in drug spending would yield only a modest reduction in overall health costs.³⁸ Third, single payer could yield administrative savings for both doctors and the government, due to the simplicity of billing one government-run insurer rather than many payers. But just as health information technology has not yielded its promised savings—government edicts have left frustrated emergency room physicians making an average of 4,000 mouse clicks in a single shift—so too could the new regulations required by a single-payer program swamp any potential reduction in billing-related expenses.³⁹ In addition, the continued prevalence of fraud and improper payments within Medicare and Medicaid, as outlined later, suggests that lower administrative expenses for government-run health programs come with their own costly trade-offs. Overall, many estimates suggest that, rather than lowering health spending, a single-payer system will instead increase it. For example: The Rand Corporation estimated spending would increase by a total of 1.8%. However, this estimate assumed a supply constraint equal to 50% of the new demand—in other words, people would seek care under the new system, but could not access it. In the absence of this supply constraint, Rand assumed that overall health spending would rise by nearly 10%.⁴⁰ The Urban Institute estimated that bringing most national health spending into the federal system would raise overall spending by 16.6% over a ten-year period.⁴¹ Like Rand, the Urban researchers assumed that “not all increased demand could be met because provider capacity would be insufficient.”⁴² The Urban analysts did not quantify spending increases absent supply constraints, but it would obviously exceed the 16.6% figure that assumed such constraints. As noted above, the Mercatus study yielded some modest savings—approximately a 3.4% reduction in health spending over the course of a decade—largely because it assumed that single-payer plan would pay

providers at current Medicare rates. If that assumption, or any other highly favorable assumption included in the study, did not materialize, single payer would raise national health spending.⁴³ On balance, then, it appears that the single-payer bills, in addition to costing taxpayers tens of trillions of dollars, would raise health spending in the aggregate by increasing demand for health services. Single payer could reduce health spending only if it held provider rates low enough or imposed other capacity restraints that would limit access to care.

Rivate Heath Insurance Turn

Medicare for All bans private health insurance, undermining care

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

Unlike the health plans funded by the Canadian and British governments, the single-payer system proposed by Sanders and Rep. Pramila Jayapal presumes to provide every possible service to every American, and at no out-of-pocket cost to them, giving the sponsors their justification to ban private health insurance. But over and above the philosophical issues associated with banning private health insurance—Why shouldn't individuals be able to buy supplemental or private coverage if they want it?—comes an important logistical question: Can a government-run system cope on its own? The examples of countries like Canada and Britain suggest that a system that banned private health insurance entirely would face two complementary problems. Would the government system have the money, and the capacity, to fund all medical procedures for all individuals? One American health care expert wrote that he didn't understand the need for private insurance in Britain, until an NHS manager explained that private care provides a pressure-relief valve for the government-run system: All the people using the private system have already paid their taxes, so they are siphoning volume out of the NHS that the system otherwise would have to manage....The NHS would come to a grinding halt if private practice went away.³⁹ [Emphasis added.] By banning private insurance outright, the single-payer bills would not just infringe on American citizens' freedom to buy the health coverage they desire. That prohibition would also place tremendous financial and capacity pressures on the government-run system, which it likely could not handle.

Drug rice Controls Bad

Drug price controls undermine rug development

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

In addition, Jayapal and Sanders plan to impose price controls on pharmaceuticals. Sanders has claimed that price controls on prescription drugs could cut spending by almost one-third, saving up to \$113 billion per year.²⁴ In reality, such controls would hamper drug development. A study published in Forum for Health Economics and Policy found that implementing price controls solely in the existing Medicare Part D drug benefit would reduce “the number of new drug introductions by as much as 25 percent relative to the status quo.”²⁵ Another study, from the AEI-Brookings Joint Center for Regulatory Studies, looked at what would have happened had the country imposed comparatively modest price controls in the 1980s and 1990s. It found that there would have been “198 fewer new drugs brought to the U.S. market over this period.” As a result, the authors concluded price controls “would have caused much more harm than good.” Pipes, Sally . False Premise, False Promise (p. 18). Encounter Books. Kindle Edition.

Medicare for All establishes drug price controls

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

Michigan senator Debbie Stabenow describes her “Medicare at 50” bill as a prudent and cost-effective way to expand affordable coverage. Unlike Medicare for All, she says, it could “be implemented right away … and has a lot of support and enthusiasm in the country.”⁵³ A number of her colleagues agree. Twenty fellow Democrats have signed on as cosponsors.⁵⁴ Stabenow’s plan would let anyone 50 or older purchase Medicare coverage at a government-set premium. Anyone who bought in would receive coverage for hospital care, physician care, and prescription drugs, just like seniors who are currently enrolled. People would even have the option to enroll in privately administered Medicare Advantage plans, which offer a mixture of Medicare’s traditional benefits and some not covered by the legacy program, like vision or dental care. Because enrollees would be responsible for their own premiums, Stabenow says, her plan wouldn’t cost taxpayers a dime. Premiums would go into a Medicare Buy-In Trust Fund, which would supposedly cover the cost of care for these new enrollees. Stabenow’s plan would also let Medicare “negotiate fair prices” for prescription drugs. Negotiations with an actor the size of the federal government are hardly negotiations—they’re price controls by a different name.

Whatever Stabenow claims about the reasonableness of her bill, it’s just another route to single-payer health care. If “Medicare at 50” were to become law, Congress would face immediate pressure to lower the eligibility age. Stabenow herself has already bowed to this pressure. “Medicare at 50” is an updated version of a “Medicare at 55” bill she introduced in 2017.⁵⁵ Since Medicare could rely on price controls to keep its costs down, it would soon be able to underprice all the private plans for sale on the exchanges. Soon, a Medicare plan would be the only “option” left.

No political Support

Medicare for All is not politically popular

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Misleading Polls About Support for Medicare for All Medicare for All's proponents claim they have the public on their side, and the polls seem to confirm as much. A July 2019 Kaiser Family Foundation survey found that 50 percent of people supported "having a national health plan, sometimes called Medicare for All."⁹⁴ Medicare and Medicaid buy-in schemes also poll well. In that same Kaiser survey, more than three-quarters of the public said they supported Medicare at 50, including 69 percent of Republicans. Seventy-five percent said they backed a Medicaid buy-in.⁹⁵ These polls just reveal that people respond favorably when they're offered something valuable for free. But people don't understand what Medicare for All would entail. Seven in 10 Democrats think people with employer-sponsored insurance will be able to keep it under Medicare for All, according to a June 2019 Kaiser Family Foundation poll. Two-thirds of Democrats believe that people who purchase insurance on their own will be able to hold on to it under single-payer plans.⁹⁶ When they learn about what it will take to bring about Medicare for All, or any of its single-payer cousins, their support vanishes. Kaiser found that just 37 percent supported Medicare for All when told it would "eliminate private health insurance companies." Likewise, 37 percent were behind the idea when told it would "require most Americans to pay more in taxes." Tell people that a Medicare for All scheme would "lead to delays in people getting some medical tests and treatments," and support plunges to 26 percent.⁹⁷ Pipes, Sally . False Premise, False Promise (p. 30). Encounter Books. Kindle Edition.

"Flu Season"/COVID DA

National health care can't handle flu season

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

A&E visits spike when flu season is in full swing. Poor responses from the NHS are so common that "winter crisis" has become a catchphrase in the British media.⁸⁸ Even against such a low bar, the 2017–2018 winter was particularly bad. Nearly 23 percent of patients waited more than four hours to be admitted to Accident and Emergency departments, up from just over 6 percent in winter 2010–2011.⁸⁹ Once they were admitted, more than 221,000 people waited more than four hours to receive treatment.⁹⁰ They were the lucky ones. During winter crises, patients in England can spend hours in ambulances before setting foot in a hospital. The number of beds available throughout the NHS has decreased while A&E visits have increased.⁹¹ Ambulances often line up outside overcrowded hospitals, waiting for a space to open up for the patient they're carrying.⁹² The NHS's goal is for patients to be transferred from an ambulance to an A&E department within 15 minutes.⁹³ During the 2017–2018 winter crisis, over 180,000 of these so-called "handovers" took more than a half-hour. Some 42,000 took over an hour.⁹⁴ Between Christmas and New Year's, nearly 17,000 people waited in the back of an ambulance—nearly 5,000 of them for more than an hour, according to The Guardian.⁹⁵ Of course, this is all contingent upon getting an ambulance. From 2017 to 2018, ambulances routinely took more than 24 hours to respond to patient calls. One Welsh patient waited over 62 hours for an ambulance in 2017, according to BBC News.⁹⁶ Hospitals claimed these cases were "less serious" and patients had to wait while ambulances attended to patients with more life-threatening conditions.⁹⁷ Ambulance operators are seriously short-staffed. More than 33,000 ambulance workers quit the NHS between 2010 and 2018.⁹⁸ The Mirror found that the NHS spent over £235 million on private ambulances to offset a paramedic shortage between 2015 and 2018. That's around £215,000 a day.⁹⁹ The paramedic shortage is so bad in parts of England that ambulance providers have proposed recruiting volunteers or enlisting military personnel as drivers.¹⁰⁰

*Britain's' system couldn't handle influenza

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

Britain's government-run NHS suffers from many of the same shortcomings. As with the Canadian system, the NHS attempts to contain costs by limiting the available supply of care. Like Canada, the British system also compares poorly to the United States in access to MRI machines, CT scanners, and radiotherapy equipment.¹¹ Britain also provides fewer hospital beds per 1,000 residents (2.58) than the United States does (2.8).¹² The past several winters have exposed the NHS's capacity problems in stark light. Chronic under-funding, coupled with the onset of influenza season, resulted in escalating crises within the NHS—so much so that the first four days of 2018 saw more mentions of the word "NHS" with the words "winter crisis" than for the entire years 2003 through 2009 combined. When costs rise due to

an aging population and greater use of services, but taxpayer spending fails to keep pace, people must wait longer for services. The percentage of Britons spending more than four hours in the emergency room rose appreciably during the last decade, leading to Jacobs, Chris. *The Case Against Single Payer*. Republic Book Publishers. Kindle Edition.

Economy Advantage Answers

Delayed care undermines the economy

Sally Pipes, 2020, False Promise: The Disastrous Reality of Medicare for All, Pipes is the President & CEO, Pacific Research Institute .

The economic impact of delayed care in Canada is staggering. Many patients can't work while they wait for care; those who can often do so in a distracted or diminished capacity. Delays in care also add up for friends and family, who have to take time out of their lives to care for loved ones. These costs add up.

Waiting for care cost Canadian patients C\$2.1 billion in 2018, according to the Fraser Institute. That shakes out to C\$1,924 per patient—and that's only taking into account the typical 40-hour work week.

Factor in the remaining 16 hours of each weekday along with the weekend, and that number climbs to C\$6.3 billion, or C\$5,860 per patient.⁵²

Insurance Industry Collase Answers

Health insurance fails

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

Facing such uncertainty, people rely on quality signals, brand names, reputation, the experience of others, advertising, even prices. Buying services that literally can be the difference between life and death, higher prices can increase demand because they are signals of quality. Signals steer patients to a small subset of providers who thus have real market power because people believe they provide better care and save lives. Massachusetts General Hospital, New York Presbyterian, Johns Hopkins, Yale New Haven, the Mayo Clinic, the Cleveland Clinic: these institutions do not compete on a level playing field with other hospitals and providers, and they advertise to further enhance their brands.⁵ Their reputation gives them the leverage to raise prices.⁶ The importance of reputation encourages providers to merge with marquee providers—hospitals with a reputation for extraordinary quality Facing such uncertainty, people rely on quality signals, brand names, reputation, the experience of others, advertising, even prices. Buying services that literally can be the difference between life and death, higher prices can increase demand because they are signals of quality. Signals steer patients to a small subset of providers who thus have real market power because people believe they provide better care and save lives. Massachusetts General Hospital, New York Presbyterian, Johns Hopkins, Yale New Haven, the Mayo Clinic, the Cleveland Clinic: these institutions do not compete on a level playing field with other hospitals and providers, and they advertise to further enhance their brands.⁵ Their reputation gives them the leverage to raise prices.⁶ The importance of reputation encourages providers to merge with marquee providers—hospitals with a reputation for extraordinary coverage. They fear “adverse selection,” where people buy insurance because they know that they are more likely to need coverage than the population average, and so will cost more to cover than the insurance company expects. At the extreme is “moral hazard,” where people buy insurance precisely because they intend to use the policy.⁷ Moral hazard and adverse selection lead to destructive insurance company practices, including the creation of an enormous wasteful bureaucracy dedicated to screening subscribers. Companies invest in bureaucrats, underwriters, claims adjusters and investigators, all to police subscribers and to screen for moral hazard and adverse selection. To discourage moral hazard and limit their risk from adverse selection, they limit the value of insurance with provisions for cost-sharing, deductibles, and co-pays, consciously reducing the social welfare gains from insurance. Insurers have also learned that they can profit by screening for certain subscribers. In a process called “cherry picking,” they advertise for those unlikely to use insurance; by “lemon dropping,” they discourage those more likely to need insurance. They have created giant research operations and marketing departments to develop better screening, including multiple plans with alternative benefit structures to steer potential subscribers towards plans more profitable to the insurer, at the expense of providing adequate coverage to the sick and needy.

Friedman , Gerald. The Case for Medicare for All (p. 38). Wiley. Kindle Edition.

Insurers try not to pay out in order to Maximize profits

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

As a society, we want people to receive quality healthcare because it raises productivity when people are healthy and because, as a community, we want people to live long, healthy lives. Most countries, then, treat health insurance like income insurance, with public provision to capture the benefits of insurance while avoiding adverse selection with universal provision and moral hazard through state supervision. The case for social health insurance goes further, beyond efficiency to questions of equity, humanity, and citizenship. Valuing all as equal citizens, we do not want healthcare to be reserved only for those with the most money. Or, even worse, to trust healthcare decisions to private companies whose profits depend on their ability to deny access to healthcare. But this is exactly the situation with private health insurance. Insurers pay close attention to their “medical loss ratio” (MLR)—the share of insurance revenue paid out in health benefits—because a low ratio means that more is available for profits. Every dollar paid out in benefits is a dollar lost from profits. For managers of insurance companies, a high MLR means they are suffering from adverse selection and moral hazard, but a low MLR shows that they are doing their job of maximizing profits. Insurance companies spend heavily to devise “cherry picking” programs to attract low-risk subscribers or to “lemon drop” in order to shed high-cost subscribers. Small-print advertisements, information sessions held in inaccessible locations, offers of gym memberships: all of these methods are used to sell companies whose profits depend on their ability to deny access to healthcare. But this is exactly the situation with private health insurance. Insurers pay close attention to their “medical loss ratio” (MLR)—the share of insurance revenue paid out in health benefits—because a low ratio means that more is available for profits. Every dollar paid out in benefits is a dollar lost from profits. For managers of insurance companies, a high MLR means they are suffering from adverse selection and moral hazard, but a low MLR shows that they are doing their job of maximizing profits. Insurance companies spend heavily to devise “cherry picking” programs to attract low-risk subscribers or to “lemon drop” in order to shed high-cost subscribers. Small-print advertisements, information sessions held in inaccessible locations, offers of gym memberships: all of these methods are used to sell

Insurance causes overutilization

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

The Market Turn in Health Policy: Motivation and Rationales Although some economists have criticized the behavior of private insurance companies, many regularly provide rationalizations for their actions, even claiming they are socially useful. Viewing all problems through the prism of perfect commodity markets, many economists have come to believe that health insurance promotes unnecessary utilization because insured “consumers” do not pay the full cost of their care. They claim that people receiving

healthcare at a cost below the marginal cost of providing that care will only abuse the system, much as they would eat too many donuts if they were free. Ignoring all the other costs of receiving healthcare, and all the ways insurance companies restrict utilization, they argue that the problem of high healthcare spending occurs because healthcare consumers are profligate when spending someone else's money.¹⁰ This focus on overutilization has created an alliance between the health insurance industry and the economists behind programs to restrict access. Economists have favored opening up health insurance markets to competition because they claim only for-profit private companies can be trusted to restrain "overutilization" and "abuse." Yet, even the effective collapse of not-for-profit health insurers in the 1980s failed to restrain the rapid growth in healthcare spending. Instead, moneys saved from reducing utilization were spent on growing bureaucratic waste, even while economists helped insurance companies to develop elaborate tools to restrict utilization, including cost-sharing, deductibles, and copays, and changes in payment systems to discourage providers from caring for the sick. Still, many economists have continued to support spending by insurers to police the use of healthcare, including utilization reviews and requirements for preauthorization for care.¹¹ The new world of healthcare finance created by this alliance of economists and insurance companies has done many things, but it has not controlled spending. It has created mountains of paper and wasteful administration devoted to policing providers and patients, driving many nurses and physicians to distraction, even to early retirement. It has reduced the insurance function by providing less protection for the sick and needy, undermining the quality of care Americans receive. In short, the market turn has brought us to this worst of all possible worlds: an overpriced healthcare system that does not provide adequate healthcare. Wasteful administration comes both in the administration of insurance companies and in bill processing within provider offices, hospitals and physician practices. First, there is the cost of administering insurance companies, including their profits but also the money they spend cherry picking and lemon dropping, and restraining moral hazard by discouraging utilization. Private health insurance is an expensive way to provide coverage. Insurers have managed to drive down the medical loss ratio to under 80%, meaning that over 20 cents of every dollar paid in premiums goes towards administrative costs, including marketing, profit, management salaries, and utilization reviews.¹² In 2018, the United States spent over \$256 billion on administration of the private health insurance system, an expense expected to pass \$400 billion by 2026. By contrast, traditional public social insurance, Medicare, spends over 98 cents of every dollar providing care.¹³ Compared with Medicare, the extra cost of providing coverage through private companies amounted to over \$200 billion in 2018, and the tab has kept rising. Clearly, competition has not driven health insurance companies to minimize costs. The mistake economists have made—one that they make again and again in relation to the healthcare system—is to believe that the search for profit will lead companies to provide quality healthcare at affordable prices. For private health insurers, administrative waste is efficient if it reduces medical losses, either by discouraging utilization, allowing the company to avoid making payments, or by controlling selection among subscribers. While money spent on administration and reviewing claims is a social waste that does nothing to provide better care, it is profitable for insurers if it leads to lemon dropping and cherry picking, or if it discourages utilization. Research that leads to carefully targeted advertising, programs that make policies more attractive to young, healthy people and less attractive to older, sicker people: these can save money way beyond any increase in administrative expense. And in doing so they raise profits. At affordable prices. For private health insurers, administrative waste is efficient if it reduces medical losses, either by discouraging utilization, allowing the company to avoid making payments, or by controlling selection among subscribers. While money spent on administration and reviewing claims is a

social waste that does nothing to provide better care, it is profitable for insurers if it leads to lemon dropping and cherry picking, or if it discourages utilization. Research that leads to carefully targeted advertising, programs that make policies more attractive to young, healthy people and less attractive to older, sicker people: these can save money way beyond any increase in administrative expense. And in doing so they raise profits to the point of killing us.

Private insurance raises administrative costs

Friedman, 2019, Gerald Carl Friedman is an economics professor at the University of Massachusetts at Amherst. He became nationally prominent during the 2016 U.S. presidential election, The Case for Medicare for All

The Cost of Using the Market to Provide Healthcare The \$200 billion administrative burden within health insurance companies only scratches the surface of the cost of the market turn in healthcare policy. Employers spend around \$50 billion (4% of employer-provided health insurance) a year on consultants and brokers who help them to identify and negotiate health insurance for their workers. And this does not include the costs to HR departments of processing paper for the insurance industry, nor the cost to individual subscribers in completing forms and submitting claims.¹⁴ Insurers have succeeded in offloading even more of their administrative waste by imposing expensive, even onerous, reporting requirements on providers and those seeking healthcare. American healthcare providers (hospitals, physicians, etc.) spend significantly more time on administrative tasks than do their counterparts in countries with universal coverage systems.¹⁵ Our physicians, for example, devote over six hours a week to administrative tasks, notably bill processing, four times as much as their counterparts in Canada, where hospitals and physician practices can manage with minimal billing departments because all their billing goes to one government agency.¹⁶ American hospitals and physicians require nearly eight times as many staff to process bills as in other industries.¹⁷ Even other countries that rely on private health insurance, like Switzerland or the Netherlands, have a lower administrative burden for providers through regulations that standardize benefit packages and payment systems. reporting requirements on providers and those seeking healthcare. American healthcare providers (hospitals, physicians, etc.) spend significantly more time on administrative tasks than do their counterparts in countries with universal coverage systems.¹⁵ Our physicians, for example, devote over six hours a week to administrative tasks, notably bill processing, four times as much as their counterparts in Canada, where hospitals and physician practices can manage with minimal billing departments because all their billing goes to one government agency.¹⁶ American hospitals and physicians require nearly eight times as many staff to process bills as in other industries.¹⁷ Even other countries that rely on private health insurance, like Switzerland or the Netherlands, have a lower administrative burden for providers through regulations that standardize benefit packages and power to secure lower prices. The large number of competing private insurers are too small to have the market leverage to negotiate effectively with providers.

Medicare for All Turn

Medicare for All undermines Medicare Advantage, which actually helps seniors

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

Title XVIII of the Social Security Act refers to Medicare, created as part of the Social Security Act Amendments of 1965, meaning this section of the legislation ends Americans' entitlement to the current Medicare program.² Section 701 of the House and Senate bills liquidates the dollars currently in the Medicare trust funds: (d) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund...or the Federal Supplementary Medical Insurance Trust...after the payment of claims for items and services furnished under title XVIII of such Act have been completed, shall be transferred into the Universal Medicare Trust Fund under this section. These financial maneuverings reveal that the authors of single payer haven't proposed expanding the current Medicare program to all Americans so much as abolishing it and instituting a new program. In short, instead of proposing "Medicare for All," Sanders has proposed "Medicare for None."⁴ Single-payer supporters might call this criticism little more than a silly argument over semantics. Sure, the legislation liquidates the current Medicare trust funds, but seniors—along with all Americans—will have access to better benefits than the current Medicare program provides. Who should complain about that? First off, this kind of sleight-of-hand is inherently dishonest, and disingenuous. If Sanders wants to create a new program, he should say so outright, and call it for what it is. That he will not—just like Barack Obama knew, but would not admit, that some people would not be able to keep their health plans—speaks to the deceptive ways liberal politicians must sell their agenda to voters.⁵ But Sanders's lack of candor about the true effects of his single-payer bill may well stem from understanding how its policies would harm current Medicare enrollees. Millions of seniors will lose the private health plans they have now, which provide more coordinated, and arguably better, care than the government-run Medicare plan. Moreover, shifting dollars from the current Medicare program to fund the new national program undermines a promise made to seniors. Yes, the current Medicare program has funding shortfalls, which Congress should address urgently. But taking current Medicare dollars and diverting These financial maneuverings reveal that the authors of single payer haven't proposed expanding the current Medicare program to all Americans so much as abolishing it and instituting a new program. In short, instead of proposing "Medicare for All," Sanders has proposed "Medicare for None."⁴ Single-payer supporters might call this criticism little more than a silly argument over semantics. Sure, the legislation liquidates the current Medicare trust funds, but seniors—along with all Americans—will have access to better benefits than the current Medicare program provides. Who should complain about that? First off, this kind of sleight-of-hand is inherently dishonest, and disingenuous. If Sanders wants to create a new program, he should say so outright, and call it for what it is. That he will not—just like Barack Obama knew, but would not admit, that some people would not be able to keep their health plans—speaks to the deceptive ways liberal politicians must sell their agenda to voters.⁵ But Sanders's lack of candor about the true effects of his single-payer bill may well stem from understanding how its policies would harm current Medicare enrollees. Millions of seniors will lose the private health plans they have now, which provide more coordinated, and arguably better, care than the government-run Medicare plan. Moreover, shifting dollars from the current Medicare program to fund the new national program undermines a promise made to seniors. Yes, the current Medicare program has funding shortfalls, which Congress should

address urgently. But taking current Medicare dollars and diverting them into a larger scheme—the \$30 trillion-plus cost of which liberals have little idea how to fund—betrays those trusting their elderly years to this long-running government program. As the last chapter discussed, the House and Senate single-payer bills' prohibition on private health insurance means that wealthy individuals, and even many millionaires, will not be able to opt out of the new government-run system. By liquidating the current Medicare trust funds, the single-payer bills would effectively take dollars from indigent seniors to fund the health care of affluent millionaires.

SENIORS LOSING COVERAGE A large, and growing, number of seniors receive Medicare benefits not through the government-run Medicare plan, but through Medicare Advantage plans. These privately run insurance plans—plans—whether Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), or special-needs plans for individuals with chronic conditions—deliver to enrollees the Medicare benefits prescribed by law, and often other benefits. The plans provide coordinated care for beneficiaries, and closely resemble the employer-based HMO and PPO plans that many individuals held prior to retirement. As of 2019, Medicare Advantage plans enrolled 22.8 million beneficiaries—more than one-third (37.8%) of the 61.3 million beneficiaries enrolled in Medicare.⁶ The Medicare actuary projects that over the next decade, Medicare Advantage enrollment will continue to rise—both in absolute terms, and as a percentage of overall Medicare enrollees. By 2028, Medicare Advantage enrollment will reach an estimated 30.7 million seniors, or 40% of the estimated 76.7 million Medicare beneficiaries. Ironically, Medicare Advantage enrollment has continued to rise in recent years, even after Obamacare significantly reduced payments to Advantage plans. According to Congressional Budget Office estimates at the time of the law's enactment, Obamacare would reduce Medicare Advantage payments by \$205.9 billion from 2010 through 2019.⁸ At the time, the Medicare actuary predicted that these payment reductions would cause Advantage enrollment to decline from 11.7 million, and 24.7% of all Medicare enrollees, in 2010 to 8.2 million enrollees, and only 13.2% of the entire Medicare population, in 2019.⁹ Medicare Advantage has gained in popularity, rather than losing enrollees after Obamacare's reductions to the program, in large part because it provides better benefits to seniors.¹⁰ Study after study demonstrates the advantages of the privately run Medicare Advantage: More Coordinated Care: After adjusting for demographics and health risk factors, Medicare Advantage enrollees have a lower-than-expected death rate than beneficiaries in traditional Medicare—with the lower mortality rates most pronounced among minorities and those with multiple health conditions.¹¹ That mortality gap may stem from the fact that Medicare Advantage enrollees at risk for diseases such as breast cancer and diabetes were more likely to receive appropriate tests, and to receive preventive treatments like vaccinations for influenza and pneumonia.¹² Advantage enrollees are also 43% less likely to die in the hospital, making them more likely to die a peaceful death at home—the kind of death most Americans would prefer.¹³ Fewer Hospitalizations: Medicare Advantage enrollees are 7% less likely to have surgery on an inpatient basis, and 26% more likely to have surgery on an outpatient basis.¹⁴ Medicare Advantage's greater usage of outpatient surgery compared to inpatient procedures not only saves costs; it gets patients home sooner while reducing the risk of adverse events, like a hospital-acquired infection. Advantage patients also have 20-25% fewer inpatient admissions than patients in traditional Medicare, and 25-35% fewer emergency room visits.¹⁵ And patients who leave Advantage to join traditional Medicare had a 60% increase in hospital use, without any improvement in quality or mortality, suggesting that Advantage plans do a better job of coordinating care in ways that prevent unnecessary, or low-value, health spending.¹⁶ Better Benefits: Because plans must return savings back to beneficiaries in the form of lower costs or enhanced benefits, seniors see the results in

their wallets. Nine in ten (90%) Medicare beneficiaries can access a Medicare Advantage prescription drug plan without a monthly premium—and more than half (55%) of Advantage enrollees do so.¹⁷ Advantage enrollees also receive more generous coverage of their prescription drugs than do enrollees in traditional Medicare.¹⁸ And large numbers of Advantage enrollees have signed up for plans that offer supplemental eye exams (77%), fitness benefits (69%), and dental coverage (62%).¹⁹ Greater Efficiency: Medicare Advantage enrollees have 10-25% lower spending than enrollees in traditional Medicare in the same county, even after controlling for differences in health status.²⁰ Lower Spending in Traditional Medicare: A 1% increase in Medicare Advantage plan penetration in a given area leads to an average 1.7% reduction in spending for enrollees in traditional Medicare, as well as fewer and shorter hospital stays for traditional Medicare patients.²¹ An increase in Medicare Advantage plan penetration also leads to shorter hospital stays, and a decrease in overall hospital spending, for non-Medicare patients.²² Medicare Advantage growth leads doctors and hospitals to improve care coordination, yielding positive benefits for the health of an entire region. Critics claim that Medicare Advantage plans game the system, either by selecting healthier patients, or via healthier patients who self-select into Medicare Advantage, giving the private program an unfair edge.²³ However, that claim misses an important point: If some individuals do self-select into Medicare Advantage, that selection only occurs because government bureaucrats have (unsurprisingly) made government-run Medicare the default option for seniors. Medicare Advantage plans could provide infinitely better care to seniors at a much lower cost—but do such considerations matter more than the leftist ideology ideology that proclaims, “Government good, private bad?” Of course not. The liberal criticism speaks to the Left’s inherent bias in favor of government-run care, and against private options. First they sabotage private plans, by making it tougher for them to enroll seniors. Then they attack the plans by criticizing the seniors Medicare Advantage insurers do get to enroll. If you think this system seems rigged against private insurance and in favor of government-run Medicare, you’d be correct. Liberal attacks notwithstanding, most evidence strongly suggests that Medicare Advantage’s coordinated care provides better benefits at a lower cost. Most seniors see many physicians, but Medicare Advantage plans do a better job of coordinating care—making sure the primary care physician speaks to, and works closely with, specialists like the cardiologist treating a patient’s heart failure, or the orthopedist performing a senior’s hip replacement. Traditional Medicare has established demonstration projects to try and coordinate seniors’ care, including several created by Obamacare. However, Medicare Advantage plans have undertaken such coordinated care for years—and largely succeeded at it. At a time when more and more seniors have joined Medicare Advantage, and when uncoordinated care helps keep health spending high, policy-makers should work to ensure that all seniors—and all Americans—have the coordinated care that Medicare Advantage provides. But instead of allowing private plans to continue—whether for seniors enrolled in Medicare, or the under-65 population—single payer will make them “unlawful,” and throw nearly 23 million seniors off their Medicare Advantage plans. All this so single-payer advocates can use the current Medicare program as a slush fund to try to finance government-run health care for all Americans, which has a terrible track record.

Jacobs, Chris. The Case Against Single Payer . Republic Book Publishers. Kindle Edition.

Illegal Immigration

Single payer increases illegal immigration

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

An unlikely source has expressed disagreement with this approach: Hillary Clinton. In September 1993, when testifying before Congress about the legislation her health-care task force had proposed, she said the following about taxpayers paying for services to individuals unlawfully present: We do not think the comprehensive health care benefits should be extended to those who are undocumented workers and illegal aliens. We do not want to do anything to encourage more illegal immigration into this country. We know now that too many people come in for medical care, as it is. We certainly don't want them having the same benefits that American citizens are entitled to have.²⁹ According to Mrs. Clinton's reasoning from 1993, single payer will increase health costs in the United States, and increase unlawful migration into the United States. Yet, in a sign of how much liberals continue to move ever leftward, some single-payer supporters now believe that American taxpayers should fund benefits for those in this country unlawfully. Asked by CNN about the language above in the Senate single-payer bill, and whether she supports "giving universal health care, Medicare for all to people who are in this country illegally," presidential candidate Sen. Kamala Harris (D-CA) responded thusly: Let me just be very clear about this. I am opposed to any policy that would deny in our country any human being from access to [sic] public safety, public education or public health, period.³⁰

Hospital Collapse

It's not reasonable for the Feds to be able to determine hospital budgets

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

The process envisioned under the House bill provides tremendous authority to the regional directors, and to HHS as a whole. The bill allows for the HHS secretary to set the number of regions and appoint the regional directors.²⁵ While the current head of the Centers for Medicare and Medicaid Services (CMS) must receive Senate confirmation, the bill denies the Senate any ability to provide “advice and consent” over the regional directors—even though these officials would effectively set the budgets for all the hospitals in their assigned areas.²⁶ Nor does the bill provide any ability for hospitals to appeal the regional director’s determination, should a hospital consider their quarterly payment amounts inaccurate or insufficient. Supporters of single payer would argue that providing hospitals with global payments will encourage efficiencies, by requiring them to stick within a defined budget. But the idea that the federal government can set accurate budgets for thousands of hospitals nationwide seems fanciful at best, and dangerous at worst. If the federal government does not set accurate budget levels, and some hospitals end up under-funded, they will likely have to deny patients care. As the next chapter will explain in greater detail, paltry global budget payments in Great Britain have resulted in “severe financial strains” for that country’s National Health Service, with tens of thousands of operations canceled and massive delays, even for emergency care.²⁷

Jacobs, Chris. The Case Against Single Payer . Republic Book Publishers. Kindle Edition.

Waiting hurts the economy

Chris Jacobs, 2019, writer @ The Federalist, The Case Against Single Payer, Kindle Book

Waiting for care has monetary and emotional, to say nothing of physical, costs. The Fraser Institute attempted to quantify the value of these health care queues on the Canadian economy. Their research concluded that waiting lists cost Canadians \$2.1 billion in reduced economic output during working hours, and a total of \$6.3 billion including their non-working hours. Moreover, because this Fraser study only incorporated waiting times after patients saw a specialist, it significantly underestimated the effects of health-care queues on Canadian patients, most of whom must wait months to see a specialist in the first place. Some individuals might think that, while Canadians must wait for months to receive specialist care, at least Canada provides prompt access to primary care. Think again. A 2016 survey of patients in 11 countries, including the United States, found that Canada also had comparatively poor access to primary care: The lowest percentage of patients (43%) who said they could get an appointment the same day or the next day to see a doctor or nurse; The second-lowest percentage of patients (34%) who said it was easy to receive after-hours care without going to the emergency room; The lowest percentage of patients (59%) who said they often or always receive an answer the same day when

calling the doctor's office about a medical issue; The highest percentage of patients (41%) using the emergency room; and The highest percentage of patients (29%) waiting four or more hours in the emergency room.⁷ Canada's health-care system provides such poor access to care that between 217,500 and 323,700 patients—nearly 1% of Canada's population—left the country for care in 2017, choosing to pay out-of-pocket rather than suffer seemingly perpetual waits for "free" treatment.⁸ With poor access to both specialists and primary care, Canada's single-payer system provides a grim picture of the future Americans might soon face. Canada's health system provides such poor access to care that the nation's Supreme Court issued a landmark ruling against it. In 2005, the court heard a case in which George Zeliotis, a Canadian who had struggled to receive access to care, and Jacques Chaoulli, a physician rejected for a license to open an independent hospital, challenged the province of Quebec's ban on private health insurance—the same kind of prohibition included in the House and Senate single-payer bills. The court, noting that "access to a waiting list is not access to care," struck down Quebec's ban on private coverage.⁹ One line in particular from Canada's Supreme Court should warn single-payer supporters. The court found that Prohibiting health insurance that would permit ordinary Canadians to access health care, in circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death, interferes with life and security of the person.¹⁰ "Interfer[ing] with the life and security of the person" aptly describes the health-care system in Canada, and the restrictions single-payer supporters wish to export to the United States. Jacobs, Chris. *The Case Against Single Payer*. Republic Book Publishers. Kindle Edition.

Bioower/Caitalism Kritik

No Justification for National Action

States can implement single-payer – preemption is unlikely if enough do it – key to maintaining federalism balance

Leonard 12 – Visiting Professor of Law at the University of Georgia and a Professor of Law at the University of Kansas

[Elizabeth Weeks Leonard, The Rhetoric Hits the Road: State Resistance to Affordable Care Act Implementation , 46 U. Rich. L. Rev. 781 (2012)]

The intermingling of federal and state exchange implementation demonstrates familiar federalism values of voice, diversity, and exit.¹³³ Rather than a one-size-fits-all approach, States are exploring alternative funding, legislation, and coordination strategies. States may satisfy diverse tastes and priorities through a choice of fully federal, fully state, or cooperative federal-state strategies.¹³⁴ Indeed, the choice between a national exchange and state-based exchanges was exhaustively vetted through the political process in congressional debates, with the latter carrying the final vote.¹³⁵ Critics of state-based exchanges nevertheless raise practical concerns about some states' risk pools being too small for exchanges to operate effectively and the qualified success of existing pre-ACA state exchanges.¹³⁶ More to the point of this essay, commentators fault the —state-centric framework|| for creating an ongoing opportunity for states to obstruct implementation and perpetuate political battles.¹³⁷ The preceding description undoubtedly confirms that dynamic but does not compel the normative conclusion that it necessarily is a bad thing. That sort of friction and jarring, which —promot[ed] deliberation and circumspection,|| was part of the Framers' design.¹³⁸ Although the system of health insurance exchanges ultimately implemented by the states and the federal government may be different from Congress's vision or single-payer adherents' preferences, at least it will be a system with which most participants can live.¹³⁹ It remains to be seen how credible the federal government's preemption threat will be in the face of pervasive state resistance.¹⁴⁰ If the federal government cannot marshal sufficient financial and administrative resources to overcome states' resistance to implementing exchanges, the response could threaten the overall success of the ACA. Or, states' uncooperativeness could force a change in policy.¹⁴¹ But if state-based and federally operated exchanges can comfortably coexist as —marble cake|| alternatives,¹⁴² like the PCIP, then state resistance may have little effect in altering the path of federal health reform.

Pharma R&D is up but requires sustained investment

Gyurjyan, 17-- Gayane Gyurjyan, associate partner in McKinsey's London office, Shail Thaker, Kirsten Westhues, and Carla Zwaanstra, 2017, "Rethinking pharma productivity," McKinsey & Company, <http://www.mckinsey.com/industries/pharmaceuticals-and-medical-products/our-insights/rethinking-pharma-productivity>, NCC Packet Draft

*Citing a study published in Nature

Reinvesting in R&D. Over the past five years, pharma companies have refreshed their innovation pipeline, improved their decision making, and reversed their decade-long decline in clinical success rates. A recent Nature article noted, "For the first time since we started analysing such data, cumulative success rates are up in the three years to 2014, compared with the previous three-year period."¹ However, companies will need to commit to significant further investment if this upward trend is to continue. Funding is needed in three areas in particular: developing new capabilities such as advanced

analytics to improve R&D effectiveness, capturing the promise of new tools and technologies such as immuno-oncology and gene editing, and reshaping business development and licensing (BD&L) as deals with small start-ups and other external partners become an increasingly common route for accessing innovation.

Medical regulation removes the incentive for pharma innovation- empirically proven by the EU

Pope 13 (Christopher, Graduate Fellow in the Center for Health Policy Studies at the Heritage Foundation, “Legislating Low Prices: Cutting Costs or Care?”, August, <http://www.heritage.org/health-care-reform/report/legislating-low-prices-cutting-costs-or-care>)

Drug innovation is particularly vulnerable to regulatory predation. On average, researching and developing a new biopharmaceutical molecule costs \$1.3 billion.[92] Yet once developed, it can often be replicated for a few cents per dose. Nor are drug research and development (R&D) investments reliably profitable. Only the top 30 percent of drugs generate enough revenue to cover the average R&D costs.[93] Unless firms are allowed to reap a substantial share of the value that their most successful innovations generate, they have little incentive to make the colossal up-front investments necessary to produce new drugs. Patents are therefore needed to secure the revenues generated by new drugs for those investing in innovation. However, governments have a strong temptation to renege ex post facto on promises to defend these firms' revenues and to undermine patent rights by dictating low prices to manufacturers. This temptation is particularly acute for countries without substantial pharmaceutical industries, who seek to free-ride on drug development elsewhere

§ Marked 14:51 §

Governments in most of the world use their power to dictate lower prices for originator drugs, resulting in average drug prices that are 74 percent of U.S. price levels in Canada; 64 percent in France, and 74 percent in Germany.[94] As a result, the U.S. accounted for 41 percent of the pharmaceutical industry's \$605 billion revenues in 2005, on which the \$120 billion global pharmaceutical annual R&D budget has become increasingly dependent.[95] In the mid-1980s, Europe spent 24 percent more on R&D than the United States, but by 2004, it contributed 15 percent less.[96] Between 2001 and 2009, 60 percent of drug patents were granted to U.S.-based inventors.[97] By 2012, the U.S. biotech industry employed 100,000 people—twice as many as in all of Europe.[98] While America has shouldered a disproportionate share of R&D financing, attempts by other nations to free-ride are not pain free. The effective patent life in the U.S. is 2.5 years longer than in France or Germany.[99] The launch of new drugs is often delayed in price-controlled countries, and Americans benefit from better and more effective drugs.[100] Where price regulation does not serve to undermine patents, it appears only to inflate costs. As a result, generic drugs cost 133 percent of U.S. prices in Canada, 108 percent in France, and 151 percent in Germany. Countries with highly regulated prices also tend to use generics less, with 74 percent of off-patent drugs available as generics in the United States, compared with 44 percent in France.[101] By incentivizing the use of generics over more expensive branded drugs, the Medicare Part D program has further demonstrated the capacity of competitive pricing to drive down projected costs over time.[102] The U.S. government has recently required drug makers to provide drugs to Medicare and Medicaid at substantial discounts to the average manufacturer price.[103] As the ACA increasingly shifts responsibility for financing American health care to the public-sector balance sheet, such practices will likely become more prevalent. Although price controls can trim budgetary expenses in the short run by undermining patents, patents cover drugs for only a temporary period, so the only lasting effect is to

undermine future drug development. Indeed, since drugs are much cheaper to provide than inpatient hospital care, facilitating drug innovation that provides effective substitutes may even save taxpayers money in the long run.[104]

Pharma innovation is key to the global economy & US Tech leadership, crucial to developing vaccines and antibacterials, and high drug prices result in reduced medical costs overall

IFPMA 17 (International Federation of Pharmaceutical Manufacturers & Associations, "THE PHARMACEUTICAL INDUSTRY AND GLOBAL HEALTH", <https://www.ifpma.org/wp-content/uploads/2017/02/IFPMA-Facts-And-Figures-2017.pdf>)

The research-based pharmaceutical industry is estimated to have spent nearly USD 149.8 billion globally on pharmaceutical R&D in 2015¹⁶. Of all industrial sectors, the research-based pharmaceutical industry has consistently invested the most in R&D, even in times of economic turmoil and financial crisis.

Compared with other high-technology industries, the annual spending by the pharmaceutical industry is 5.5 times greater than that of the aerospace and defense industries, 5 times more than that of the chemicals industry, and 1.8 times more than that of the software and computer services industry¹⁷.

Innovation cannot happen without a number of enabling conditions, such as access to world-class researchers, political and financial stability, and a regulatory framework that protects and rewards innovation. All countries have the potential to foster innovation and improve the functioning of the innovation process. In the United States, R&D investments of pharmaceutical companies have grown consistently over the past 15 years, and more than doubled the publicly-funded National Institutes of Health's (NIH)¹⁹ expenditures in 2014²⁰. R&D intensity by the researchbased pharmaceutical industry in Japan amounts to 13.3%, in the US to 17.1%, and in the European Union to 13.3%²¹. In 2014, the pharmaceutical industry registered 7,691 patents through the Patent Cooperation Treaty (PCT) of the World Intellectual Property Organization²². No other business sector has such high levels of R&D intensity According to European Commission statistics, 5 of the 11 leading global R&D firms in 2014 were pharmaceutical companies²⁵. In 2014, R&D spending by the pharmaceuticals and biotechnology sector grew by 8.7% from the previous year, strengthening its position as the top R&D investing sector²⁶. These facts are a clear demonstration of the significant contribution the pharmaceutical sector makes to the world economy. Pharmaceutical R&D and its Impact on Global Health Pharmaceutical R&D has dramatically improved the lives of patients. Medical discoveries, big and small, have increased life expectancy and resulted in a better quality of life for many. Vaccines have proven to be one of the most effective preventative technologies in the fight against infectious diseases with an almost unparalleled impact on public health, including, but by no means limited to, ridding the world of smallpox, driving polio to the brink of eradication, and virtually eliminated measles, diphtheria and rubella in many parts of the world. Currently, vaccines save the lives of over 2.5 million children each year. Between 2000 and 2014, immunization campaigns cut the number of deaths caused by measles by 79%²⁷, with a reduction of 92% in Africa between 2000 and 2008²⁸. The new generation of vaccines is making the same kind of public health impact as their pioneering predecessors, dramatically reducing the burden of

pneumococcal disease and rotavirus disease – § Marked 14:52 § two of the biggest killers of children – and cancers caused by HPV (human papilloma virus). Since 1928, scientists have discovered and developed 19 classes of antibiotics²⁹. Currently, 34 new antibacterial compounds are in development of which 15 are vaccines and 19 small and large molecules³⁰. With the help of major

medical discoveries, the researchbased pharmaceutical industry has developed more than 35 antiretroviral treatments for HIV/AIDS, essential to control of the epidemic³¹. More than 7,000 medicines are in Pharmaceutical progress has led to a dramatic decline in death rates for diseases such as HIV/AIDS, cancer, polio, and measles. For example, death rates for HIV/AIDS in the United States have fallen from 10.2 deaths per 100,000 people in 1990 to 2.0 deaths per 100,000 people in 2014, a reduction of 80%³⁴. The number of AIDS-related deaths worldwide peaked at 2.5 million in 2005 and has since fallen to an estimated 1.1 million deaths in 2015³⁵. This can be largely attributed to the introduction of new antiretroviral therapies (ARTs) combined with more patients being provided with treatment. In the past 10 years alone, 293 medicines have been approved that offer new hope to patients with hard-to-treat diseases³⁷. The introduction of innovative drugs usually has a two-fold benefit for society. First, it improves the physical and mental well-being of individuals. Second, it reduces hospitalization and other healthcare costs. Thus, for every dollar spent on prescription drugs in the United States, more than two dollars are saved in hospitalization costs³⁸. Today, if diagnosed early, leukemia can be driven into remission with a once-daily treatment. High cholesterol and other cardiovascular diseases, which required extensive treatment in the 1970s, can now be easily managed with oral therapy. Meanwhile, improvements in existing cancer treatments have cut annual death rates by half³⁹. Pharmaceutical innovation can also reduce the costs incurred by governments and healthcare systems. For example, every USD 1 spent on childhood vaccination in the United States saves USD 10.20 in disease treatment costs⁴⁰. Another study demonstrated that lack of adherence to type 2 diabetes therapy in the United States generates USD 4 billion per year on avoidable costs to the national healthcare system⁴¹. In this manner, pharmaceutical innovation directly impacts patients' health and indirectly alleviates the unseen economic burden of disease

The future is bright for US biopharma – 7000 drugs in the pipeline and half a trillion dollars in R&D are primed to pay off – market-based system is key

Bremer, 2017 (Steve, Editor of the European Pharmaceutical Review and Drug Target Review, “Future has “never been brighter” for US biopharmaceuticals”, European Pharmaceutical Review, 7/24/2017,

<https://www.europeanpharmaceuticalreview.com/news/64325/future-bright-us-biopharmaceuticals/>//JBS

The future for the US biopharmaceuticals industry “has never been brighter”, with around 7,000 medicines in development and about three quarters having the potential to be first-in-class treatments, according to a new report. Biopharmaceuticals companies invest about \$75bn annually in research and development in the US, according to the industry's representative body, PhRMA. This is more than any other industry in America, and it supports nearly 4.7m jobs across the country, according to PhRMA's 2017 Biopharmaceutical Industry Profile. In the last decade, the US biopharmaceuticals industry has invested half a trillion dollars, and these investments are “just beginning to pay off”, according to the report. The growing use of deductibles and coinsurance for prescription medicines reduces access, with high cost-sharing linked to lower medication adherence. But biopharmaceuticals companies are committed to ensuring that patients have access to medicines, says the report, with copay assistance and patient assistance programmes helping under- and uninsured patients afford treatments. Conditions such as diabetes and heart disease are the leading causes of death and disability in the US, and patients with these

conditions account for 90% of healthcare spending. Yet **medicines costs in the US are growing at the slowest rate in years**, according to PhRMA, **with spending on retail and physician-administered medicines representing only 14% of overall healthcare spending – a proportion predicted to remain the same.** **The market-based system in the us promotes incentives for continued innovation while leveraging competition to control costs**. For example, **90% of all prescriptions are for generic medicines**, and PhRMA predicts that **\$140bn of US brand sales will face generic or biosimilar competition over the next five years.**

Price controls kill R&D- Shrinks 60%

Francis 17 (David, e NBER is a private, non-profit, non-partisan organization dedicated to conducting economic research and to disseminating research findings among academics, public policy makers, and business professionals. "The Effect of Price Controls on Pharmaceutical Research", May, <http://www.nber.org/digest/may05/w11114.html>)

One of the main concerns of both business and Washington policymakers in recent years has been soaring health care costs. This was an issue behind the passage of the Medicare Modernization Act in 2003 and during the more recent debate on legislation dealing with the re-importation of drugs, from Canada or elsewhere. "It seems likely, therefore, that pharmaceutical price controls are just around the corner," Thomas Abbott and John Vernon write in The Cost of U. S. Pharmaceutical Price Reductions: A Financial Simulation Model of R&D Decisions (NBER Working Paper No. 11114). "Indeed, the U.S. pharmaceutical market is currently the only market in the world where drug prices remain largely unregulated. In every other major market, governments regulate drug prices either directly or indirectly." Some critics of the drug companies assume that patent protection and the freedom to price drugs in the United States at market prices, along with an ability to exploit inefficiencies in the existing insurance system, actually encourages pharmaceutical firms to exploit consumers with high costs. However, **numerous economic studies indicate that price controls**, by cutting the return that pharmaceutical companies receive on the sale of their drugs, also **would reduce the number of new drugs being brought to the market**. So, a short-run benefit for consumers could lead to a long-run **negative impact on social welfare**. And, this damage wouldn't be fully felt for several decades because it takes so long to develop new drugs. Abbott and Vernon apply a new technique to studying this question about research and development (R and D). **They maintain that their approach is more closely aligned with the actual structure of R and D investment decisions by firms. They take account of the uncertainty around R and D research costs, the success rates for drug developments, and the financial returns to those products that are successfully launched onto the market.** **Their basic finding is that cutting prices by 40 to 50 percent in the United States will lead to between 30 and 60 percent fewer R and D projects being undertaken in the early stage of developing a new drug.** Relatively modest price changes, such as 5 or 10 percent, are estimated to have relatively little impact on the incentives for product development - perhaps a negative 5 percent. For the pharmaceutical industry, one economic problem is that only 3 out of every 10 of their products generate after-tax returns (measured in present value terms) in excess of average, after-tax R and D costs. The scientific process is heavily regulated, and involves significant technical risk. Only one in several thousand compounds investigated ever makes it through the full development process to gain approval of the Food and Drug Administration. The vast majority of R and D projects fail for reasons related to safety, efficacy, or commercial viability, the authors note. For compounds that do gain FDA approval and are taken to market, the entire process from discovery to launch takes on average about 15 years. Further, it's estimated that the pre-tax cost of a new drug runs around \$802 million. The after-tax cost of an average drug is about \$480 million, assuming the company

has sufficient revenues to take advantage of the tax benefits or can somehow sell the tax benefits to another firm. The average net revenues for a new drug amount to about \$525 million in present value. Thus at the time of a product launch, the drug company can foresee a potential average profit or economic value for their pharmaceutical R and D of about \$45 million. With this economic scene as background, a company must make a financial decision about whether to take an R and D project into clinical development. This step is called the Phase 1 Go/No-Go decision. Only one out of five projects that are given the "Go" signal into clinical development actually reach the market as a product. Factoring in this uncertainty, the authors write, is essential to understanding the behavior of the industry. This uncertainty factor may explain what critics say is a tendency of the pharmaceutical industry to focus on only minor innovations (me-too products) because of their greater probability of success, at the expense of conducting more revolutionary research that carries a higher risk of failure but also may yield greater health improvements

Neoliberalism Kritik

Shell

Promoting healthcare functions as a common sense approach that spreads neoliberal logic – it elevates faith in the market to a theological status.

-sensus communis = common sense

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[“Neoliberalism as Common Sense in Barack Obama’s Health Care Rhetoric,” *Rhetoric Society Quarterly*, published online: February 13, 2017, p. 1-18, Accessed Online through Emory Libraries]

The problem of neoliberalism requires a consideration of the constitutive nature of rhetoric and what it means for neoliberalism to operate as part of the sensus communis of U.S. democracy. If Galbraith is correct that conventional wisdom is the glue that holds economic policy and action together, then we must further examine its rhetorical characteristics. The primary questions to be addressed are as follows: How does neoliberalism manifest in language, specifically through embedded language that carries it forward as common sense? How is it reinforced in everyday discourse without our realizing that it is being reinforced? Finally, how can critics theorize ways to counter neoliberalism's deep hegemony? A more nuanced look at the rhetorical nature of conventional wisdom can potentially offer insight into how neoliberal language persists in language and has become the dominant default setting in political discourse. As Catherine Chaput suggests through her analysis of Milton Friedman’s persuasive power, economic rhetoric is at its most effective when it fits within the “fluid and recursive context that connects the present situation to multiple past experiences, as well as similar, but distant, current initiations of that issue” (189). Neoliberal discourse gains strength in part from its ability to offer persuasive explanations for economic growth, stagnation, and depression that fit neatly within a certain reading of American culture that emphasizes individual liberties and distrusts collective political action. Neoliberalism as Conventional Wisdom Neoliberalism is the United States' dominant framing narrative, best understood as a simplified set of ideas regarding individualism, the role of the government, markets, and economics in general as they relate to the "American way of life." Jodi Dean offers a concise description: Neoliberalism is a philosophy viewing market exchange as a guide for all human action. Redefining social and ethical life in accordance with economic criteria and expectations, neoliberalism holds that human freedom is best achieved through the operation of markets. Freedom (rather than justice or equality) is the fundamental political value. The primary role of the state is to provide an institutional framework for markets, establishing rights of property and contract, for example, and creating markets in domains where they may not have existed before. (51) Dean’s reading of neoliberalism as a “philosophy” can be reimagined more broadly as a discursive formation, as neoliberalism encompasses the totality of mainstream economic discourse. That is, neoliberalism is more like an active philosophy that cannibalizes other philosophical positions through discursive repetition as conventional wisdom in the public sphere. Taking Michel Foucault as a guide, it is clear that in order to understand an economic discursive formation, we must look more broadly into the culture to see where it lives beyond strict conversations about the economy (38; 323). Indeed, as Foucault presciently argued in 1979, neoliberalism represents “the extension of economic analysis into a previously unexplored domain ... [and] the possibility of giving a strictly economic interpretation of a whole domain previously thought to be non-economic” (41). Neoliberal discourse is dispersed throughout culture, pulling previously non-economic discourses into the sphere of economic rhetoric. The neoliberal discursive formation is held together by what Marnie Holborow calls “neoliberal keywords” that exist in all domains of political culture. Drawing on the work of Raymond Williams, Holborow argues that “[An] examination of keywords ... lays stress on the making and unmaking of dominant ideology with reference to wider social relations” (40). The emphasis here is not on how these key terms constitute reality, but rather on how they provide “living evidence of the dynamic interaction of the material and the representational” (40). The keywords she identifies as central to neoliberal ideology—“deregulation” and “human capital” in particular—are thus seen not as constituting reality, but as being derived from a certain ideological perspective. That is, the terms are both causes and effects: effects in that they can be taken as evidence of neoliberalism's discursive hold, and causes because their continued circulation increases that hold on the social imaginary, persistently re-emphasizing a version of reality that promotes individualism through a rational self-interest model of democratic life (41). Further, these keywords

"often involve a process of re-semanticisation (or 'meaning-stretching') which allows for the extension of semantic boundaries into new fields for ideological purposes" (41). Thus, the terms operate in such a way as to continually expand their influence through repetition, flexibility, and adaptability to different meanings and situations. They reflect the dominant common sense of society (Ivie and Giner 581–82). In neoliberal discourse, capitalism tends to be seen as an "all or nothing" affair: the less government interferes, the more markets can thrive; the more markets can thrive, the freer the individual is to become a rational actor in all domains of life. This logic not only authorizes radical shifts in public policy (e.g., the privatization of education in the form of charter schools), but it also diminishes the role of democracy, subsuming its collectivist entailments almost entirely to the individualistic concerns of (neo)liberalism. Neoliberal keywords elevate the individual as the key player in public life, positioning the government and appeals to community in general as threats to the individual's freedom. As David Harvey notes, "individualism" is perhaps neoliberalism's primary keyword and its fundamental organizing principle, positioning economic freedom as incompatible with state intervention in markets (5; see also Mudge 706–707). Although the United States is a liberal democracy premised on a balance of individualism and community, individualism has come to be the dominant ideological perspective in American culture, acting as a guiding logic of governmental action and political discourse (Hanson 13). Individualism in neoliberal culture is rhetorically intertwined with the concept of freedom and thus acts as a stand-in for democratic practice overall. Democracy, in this arrangement, is positioned as a safeguard for individual liberties and a protection against encroachment by the collective. By extension, the government should divest interest in key areas and give way to privatization. The market, by this logic, is democratic because it allows free, rational actors to pursue trade, business, wealth, and the like absent from governmental encumbrance. The conflation of democracy and capitalism has become naturalized, and free market logic has come to inflect not only dominant theories of capitalism but also dominant perspectives of political culture in general, resulting in what Daniel Stedman Jones has described as the "elevation of the market to an almost theological status" (35). Political culture is imagined as no different from economic culture, and democratic governance has been reduced to stewardship of the economy. Citizens are viewed (and view themselves) in economic terms—homo economicus—and, by extension, basic necessities like health care are viewed as commodities to be consumed (Foucault 292).

Neoliberal logic will destroy the world – rejection of small adjustments in favor of systemic change is necessary.

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[*The Wrath of Capital: Neoliberalism and Climate Change Politics*, 2013, p. 145-147]

A quick snapshot of the twenty-first century so far: an economic meltdown; a frantic sell-off of public land to the energy business as President George W Bush exited the White House; a prolonged, costly, and unjustified war in Iraq; the Greek economy in ruins; an escalation of global food prices; bee colonies in global extinction; 925 million hungry reported in 2010; as of 2005, the world's five hundred richest individuals with a combined income greater than that of the poorest 416 million people, the richest 10 percent accounting for 54 percent of global income; a planet on the verge of boiling point; melting ice caps; increases in extreme weather conditions; and the list goes on and on and on.² Sounds like a ticking time bomb, doesn't it? Well it is. It is shameful to think that massive die-outs of future generations will put to pale comparison the 6 million murdered during the Holocaust; the millions killed in two world wars; the genocides in the former Yugoslavia, Rwanda, and Darfur; the 1 million left homeless and the 316,000 killed by the 2010 earthquake in Haiti. The time has come to wake up to the warning signs.³ The real issue climate change poses is that we do not enjoy the luxury of incremental change anymore. We are in the last decade where we can do something about the situation. Paul Gilding, the former head of Greenpeace International and a core faculty member of Cambridge University's Programme for Sustainability, explains that "two degrees of warming is an inadequate goal and a plan for failure," adding that "returning to below one degree of

warming . . . is the solution to the problem:⁴ Once we move higher than 2°C of warming, which is what is projected to occur by 2050, positive feedback mechanisms will begin to kick in, and then we will be at the **point of no return**. We therefore need to start thinking very differently right now. We do not see the crisis for what it is; we only see it as an **isolated symptom** that we need to make a few minor changes to deal with. This was the message that Venezuela's president Hugo Chavez delivered at the COP15 United Nations Climate Summit in Copenhagen on December 16, 2009, when he declared: "Let's talk about the cause. We should not avoid responsibilities, we should not avoid the depth of this problem. And I'll bring it up again, the cause of this disastrous panorama is the metabolic, destructive system of the capital and its model: capitalism."⁵ The structural conditions in which we operate are advanced capitalism. Given this fact, **a few adjustments here and there to that system are not enough to solve the problems that climate change and environmental degradation pose.**⁶ Adaptability, modifications, and displacement, as I have consistently shown throughout this book, **constitute the very essence of capitalism**. Capitalism adapts without doing away with the threat. Under capitalism, one deals with threat not by challenging it, but by buying favors from it, as in voluntary carbon-offset schemes. In the process, one gives up on one's autonomy and reverts to being a child. Voluntarily offsetting a bit of carbon here and there, eating vegan, or recycling our waste, although well intended, are not solutions to the problem, but a symptom of the free market's ineffectiveness. By casting a scathing look at the neoliberal options on display, I have tried to show how all these options are ineffective. We are not buying indulgences because we have a choice; choices abound, and yet they all lead us down one path and through the golden gates of capitalist heaven. For these reasons, I have underscored everyone's implication in this structure – myself included. If anything, the book has been an act of outrage – outrage at the deceit and the double bind that the "choices" under capitalism present, for **there is no choice when everything is expendable**. There is nothing substantial about the future when all you can do is survive by facing the absence of your own future and by sharing strength, stamina, and courage with the people around you. All the rest is false hope. In many respects, writing this book has been an anxious exercise because I am fully aware that reducing the issues of environmental degradation and climate change to the domain of analysis can stave off the institution of useful solutions. But in my defense I would also like to propose that **each and every one of us has certain skills that can contribute to making the solutions that we introduce in response to climate change and environmental degradation more effective and more realistic**. In light of that view, I close with the following proposition, which I mean in the most optimistic sense possible: **our politics must start from the point that after 2050 it may all be over.**

Neoliberalism is the root of health inequality, which arbitrarily executes thousands every year. They can't solve the aff within a system of neoliberalism.

The alternative is to transform health care into a social institution instead of a system of insurance and governance.

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[“Neoliberalism is Bad for Our Health,” *International Journal of Health Services*, Vol. 42, No. 3, 2012, p. 383-401, Accessed Online through Emory Libraries]

As the commodification of health care continues, it is too often seen as being solely about individual care. There has been a neglect of health care as an institution, especially as a **social institution**. In this sense, the framework of the market has been retained and there has been little or no recognition of wider considerations and value systems that might accommodate the idea of health care as a social institution—where not only outcomes, but also processes, are valued. There is all too little research on the political economy of health care. Mackintosh and Koivusalo (44), however, in their political economy of health services, argue that “health services must aim for universality of access according to need, and solidarity in provision and financing, and . . . health systems should be judged against these objectives. Solidarity here is about robust redistribution and cross-subsidy to sustain access on the basis of need.” They add: “This implies that **health system performance should not be exclusively defined in terms of health outcomes.**” Such thinking is rare but much needed. I have argued (1) that **there is a need to view health care more as a social institution than a commodity** and to move toward community values in society more generally, in essence promoting the ideas of communitarianism. On both fronts, **this means an explicit abandonment of neoliberalism.** Before that, however, **there needs to be clear recognition and acceptance of the fact that neoliberalism is the problem.** That is the starting point and, given the current global power structure, achieving that recognition will be no small step. There are, however, **countries such as Cuba and Venezuela and the Indian state of Kerala that have been able to find a route to health, even though none of these three economies is wealthy.** So the message is not just an attack on neoliberalism, but a more hopeful one that another economic system and ideology **do exist** and can create a healthy environment. The relationships between neoliberalism and **economic growth and between wealth and health are complex, but there is little reason to believe neoliberalism has brought faster economic growth.** Even if that were the case, it is not clear whether wealth beyond a relatively low level brings greater health to a society. The Venezuelan model is based on primary care, funded by the public and with public participation in decision making, as described by Muntaner and colleagues (45): “This integrated model of care emphasises a holistic approach to health and illness through the coordination of [the primary health care organization with others] addressing education, food security, public sanitation and employment, among other key social determinants of health.” They explain that “people lacking potable water who suffer from recurring intestinal infections are not only prescribed the appropriate antibiotics but also encouraged to organise to demand adequate access to clean water” (45). The organizational structure is such that “health teams and patients are supported by Health Committees comprised of [community] residents.” In this way, local community residents “exercise their participation in primary health care clinics.” I have argued (11) for a **communitarian approach**, in essence because of neoliberalism’s deleterious effects on health, primarily through the **individualism that this form of political economy promotes.** Such individualism is highlighted by Wilkinson (46): **We are used to feeling indignation at the human rights abuses** in countries where people are imprisoned without trial, are tortured, or simply disappear, **but health inequalities exact a much greater toll.** What would we think of a ruthless government that arbitrarily imprisoned all less well-off people for a number of years equal to the average shortening of life suffered by the less privileged in our own societies? Given that higher death rates are more like arbitrary execution than imprisonment, perhaps we should liken the injustice of health inequalities to that of a government that **executed a significant proportion of its population each year without cause.** And as Navarro (6) emphasises: “It is not **inequalities that kill people. It is the people who produce and reproduce inequalities through their public and private interventions that kill people.**” Within the specific context of health care systems, where markets fail and the question of what to do about the failing of consumer sovereignty fails, Joan Robinson (47) argued in a more general context that [N]o-one who has lived in the capitalist world is deceived by the pretence that the market system ensures consumers’ sovereignty. The true moral to be drawn from capitalist experience is that production will never be responsive to consumer needs as long as the initiative lies with the producer. Even within capitalism consumers are beginning to organise to defend themselves. In a planned economy the best hope seems to be to develop a class of functionaries, playing the role of wholesale dealers, whose career and self-respect depend upon satisfying the consumer. They could keep in touch with demand through the shops; market research which in the capitalist world is directed to finding out how to bamboozle the housewife could be directed to discovering what she really needs; design and quality could be imposed upon manufacturing enterprises and the product mix settled by placing orders in such a way as to hold a balance between economies of scale and variety of tastes. Also relevant here is Hegel’s emphasis on the role of institutions “so that self-conscious individuals could become more aware of the meaning of the institutions in which they participated—a step towards feeling at home in these institutions” (48). I have previously taken up this issue (1): Social institutions matter. It is important that we as citizens of our own countries but also citizens of the world “feel at home” in our institutions and that participation in social institutions, as integral parts of the state, is encouraged. **There is further a need to defend our social institutions and, most fundamentally, to recognise the importance of, and in turn celebrate, the**

institution of community autonomy. A sense of belonging counts. The social institutions that are health care, public health and health policy need more often to be recognised as valuable in their own right. Societies do value them for the health and other outcomes they produce, as conventional health economics implies; but these institutions per se can also be valued as contributing to a better, more decent society. They also need to be valued in more direct Hegelian terms as providing pillars (along with other social institutions) to protect the state, not least from being overrun by the forces of the neoliberal market place. Neoliberalism kills. We need to find a better way. The idea of a communitarian economics in which—locally, nationally, and globally—people have a real say in what kind of social institutions they have and how these are run is one way to address the planet's health problems. There are others. The crucial issue, however, is to accept as Navarro (6) has argued that public health must be political and that fundamental to any genuine progress in addressing poverty, inequality, and ill health at a global level is to recognize that, first, neoliberalism is at the root of these problems and, second, some alternative must be found. That is the debate on which public health must embark. Whatever the solution, what is needed is a new political economy of public health. CONCLUSION There is something badly wrong that the world today, while having more abundant resources than ever in its history, is not having more success in improving the health of the global population. I have tried to show that a major contributor to this lack of success is the increasing pervasiveness of neoliberalism and the fact that this “creed,” not democratic values, drives our global institutions. These institutions could do so much to reduce poverty and inequality and, in turn, improve global health. It is difficult to understand why they do not do more, until we recognize that they are trapped in the ideology of neoliberalism and a seemingly unshakable belief that the market has the answer to most things and hence must have the answers to global health problems. The power of the marketplace now pervades so much of the thinking surrounding health care. The influence wielded by large corporations on governments is such that society too seldom looks for other value sets or, perhaps increasingly, fails to look at all. The “growth fetishism” of neoliberalism forces out other value sets; even the threat of other values can bring extraordinary responses such as the attack on Obama as a Socialist. Neoliberalism brings increasing inequalities and class divisions that can only impact negatively on the health of the poor and, more likely, the health of populations in general. Governments are more and more wont to serve corporations rather than act democratically. Corporations, especially transnational corporations, act either hand-in-hand with governments or above governments. Health care and health are increasingly commodified and the idea of health care systems as social institutions is being lost. To address this, the answer would seem to lie in accepting that the major actor missing from the stage of health and health care policy is the critically informed citizen. Adopting community or communitarian values in societies, returning health care systems to “the people,” and resurrecting the idea of such systems as social institutions can allow the goals of health maximization to be realized, while there are many examples of how things have gone wrong with respect to such goals, where countries or regions have followed these values, even relatively poor parts of the world have achieved remarkably good health for their populations.

General Link Extensions

The logic of health insurance is neoliberalism – deductibles, co-pays, and a variety of services maintains the logic of the market. It's not enough to just help a few people
Gaffney 14 – Physician – Blogs at the ProgressivePhysician

[Adam Gaffney, The Neoliberal Turn in American Health Care, <https://jacobinmag.com/2014/04/the-neoliberal-turn-in-american-health-care>]

To be fair, the fact that the ACA falls well short of a system of universal health care says little about Obama, and much more about the political context in which he was operating. Obama, after all, had in previous years voiced support for a single-payer system. During the 2009 health care reform campaign, he also supported a “public option,” a government insurance plan that would compete against private plans. But whatever his personal proclivities on the matter might have been, he was operating in a political landscape much different than that of Ted Kennedy and Richard Nixon in the early 1970s — one dominated like never before by powerful corporate “stakeholders” whose ability to shape the political debate had undergone a massive transformation in the intervening decades. The fingerprints of the health care industry on the ACA — in particular the lobbying groups of the insurance industry and the pharmaceutical industry (American’s Health Insurance Plans [AHIP] and PhRMA, respectively) — are clear. As the sociologist Paul Starr demonstrates in his history of American health care Remedy and Reaction, AHIP gave its support to universal coverage (meaning it wouldn’t exclude based on pre-existing conditions) only if it were coupled with an individual mandate. PhRMA, on the other hand, was willing to support Obama’s legislation if it prevented Medicare from directly negotiating over drug prices, a reform that could have saved the government hundreds of billions of dollars a year. To appreciate the magnitude of the neoliberal turn in the political economy of American health care over the period covered in this paper, consider the following. Ted Kennedy’s 1969 “Health Security” plan would have established a single-payer, government-run, national health insurance system which would have covered health care free at point of service. Republican President Richard Nixon’s plan two years later, Paul Starr explains in Remedy and Reaction: The Peculiar American Struggle over Health Care Reform, would have kept in place a system of private health insurance, but would have established a mandate for employers to buy health insurance for their workers as well as a new health insurance system for the poor (for families up to 121 percent of the poverty level). Some forty years later, the ACA is passed: it keeps in place a system of private insurance (albeit with many new regulations and subsidies), establishes an “employer mandate” (like the Nixon plan), adds a requirement (to some degree at the behest of the insurance lobby) that all uninsured individuals purchase private insurance (the “individual mandate,” as first proposed by the Heritage Foundation), and expands Medicaid to cover all of those up to 138 percent of the poverty level. While the ACA will undoubtedly help many, there can be no mistaking the close resemblance of Obama’s plan to Nixon’s, and of its marked divergence from the universalism of Kennedy’s. The health care political center, in other words, has moved to the right very sharply indeed. Perhaps the greatest testament to this is the fact that the ACA, despite its roots in the proposals of moderate conservatives of previous eras, is now deemed rank socialism by today’s conservatives. The health insurance plans offered on the new state level exchanges, furthermore, are to some degree an embodiment of Pauly’s (or Hayek’s) idea that people should be free to choose whether to “buy more comprehensive medical care and medical insurance,” or, in his words, “to save more to spend on other goods.” The plans are divided into metallic “tiers” — Bronze, Silver, Gold, and Platinum — that have actuarial values (meaning the percent of average annual health care costs that the insurance will cover) of 60, 70, 80, and 90 percent, respectively. They will feature copays, deductibles, and co-insurance, with out-of-pocket expenses rising to as much as \$12,700 a year (depending on income) for a family (after the premium is paid). Again, the notable comparison is Ted Kennedy’s early plan, which would have made health care free at the point of service. The point is not so much that the ACA creates new levels of cost sharing; rather, the ACA simply permits the progression of an already established “consumer-driven” trend, wherein insured individuals and families pay more and more out of pocket each year whenever they become ill. One element of the law that is a particularly clear manifestation of the neoliberal turn is the tax on so-called “Cadillac” health care plans. As we have explored, comprehensive “overinsurance” resulting from overly generous tax-subsidized employer-based health insurance had been deemed a significant part of the problem of the American health care system ever since Pauly’s 1968 paper; there have been calls for the end of (or at least a limit on) the tax-deduction ever since, which would remove the incentive towards comprehensive plans. The “Cadillac” tax functions more or less as such a limitation. It imposes a 40 percent excise tax on the issuers of expensive health care plans, and while it will initially affect few plans, over the years, an increasing proportion of plans will be affected — perhaps as many as 75 percent of plans after a decade in effect. Despite the “Cadillac” moniker, however, these plans cover little in the way of

unnecessary or extravagant medical services, and instead simply have low cost sharing and broad networks of providers. To avoid paying the tax, insurers and employers will have to prevent premiums from rising; the main way for them to accomplish that will be with progressively restricted coverage and higher cost sharing. Indeed, to avoid hitting the premium threshold at which the tax goes into effect, employers have already started trimming benefits, a move that has strongly been resisted by municipal unions, which over the years have bargained hard for comprehensive health benefits.

The Quiet Revolution

In an August interview with the New York Times, Dr. Drew Altman, president of the health policy think tank the Kaiser Family Foundation, described a “quiet revolution” in health care, “from more comprehensive to less comprehensive, with higher deductibles.” The health vision that conservatives had “always favored,” he added, “with more skin in the game, is the one that’s coming to dominate in the marketplace.” Such a perspective sheds light on the ongoing transformation of American health care. For whether we like it or not — and whether today’s right admits it or not — we have unambiguously moved towards the vision of such neoliberal thinkers as Hayek, Friedman, Pauly, and Goodman. Patients will be playing with their “own money” more and more. The growth of high-deductible plans and “consumer-directed plans” and the rise of copays and co-insurance will continue unabated — neither caused nor deterred by the ACA — in the years to come. But beneath the complexity of the law, the essence of the neoliberal vision, as Hayek had laid it out, becomes clear. The fundamental social-democratic idea of universalism — of an entire population with the equal right to equally comprehensive health care benefits — has all but disappeared from the political center. Hayek’s dismissal of an “objectively ascertainable standard of health,” perhaps a fringe idea at the time, now seems to be the reigning paradigm.

Expanding healthcare without transforming the system of care entrenches neoliberalism

Gaffney 14 – Physician – Blogs at the ProgressivePhysican

[Adam Gaffney, The Neoliberal Turn in American Health Care, <https://jacobinmag.com/2014/04/the-neoliberal-turn-in-american-health-care>]

Last year’s three-ring Congressional shutdown circus — for many little more than a desperate rearguard action by an isolated right-wing fringe to undo the fait accompli of Barack Obama’s health care reform — reinforced with each passing day the gaudy dysfunction of the American political system. But we miss something crucial if we construe the perseverance of Barack Obama’s 2010 Affordable Care Act (ACA) as nothing more than the overdue victory of commonsense health care reform over an irrelevant and intransigent right, or, even more, as the glorious culmination of a progressive dream for American universal health care long deferred. For many commentators, though, this is precisely what the ACA represents. With the law’s passage in March 2010 and its survival in the face of a constitutional review by the Supreme Court, they have concluded that the battle “over universal health coverage,” as one writer for the Washington Post put it, “is basically over.” Unfortunately, the evidence does not permit such a sanguine conclusion. Most plainly, when we consider the provisions and limitations of the law, it becomes clear that though it may help many, the ACA fails fundamentally to create what so many had hoped for: a system of universal health care. Leaving millions still uninsured and many more “underinsured” — a well-described and researched phenomenon in which the possession of health insurance still leaves individuals and families with dangerous financial liability when illness strikes — the ACA falls well short of the standard of universal health care as it is understood elsewhere in the social democratic world. But more broadly, when we consider the ACA through the lens of political economy, an even more concerning narrative emerges, one that says even less about the triumph of social democracy and more about the sharp shift of the political center and the disintegration of the New Deal left. For the law fundamentally leaves intact a system of health care predicated, as we shall see, on key neoliberal health care beliefs, for instance the “moral hazard” of free care, the primacy of health consumerism, and the essentiality of the private health insurance industry. This is not, however, an acute development: indeed, as we survey the last half-century, a long, slow, yet unambiguous

neoliberal turn in the political economy of American health care becomes evident, during which the window for true universal health care — wide open as recently as the 1970s — has been slowly closed simultaneous to a historic rise in inequality and an unprecedented expansion of corporate power. These developments are, of course, manifestations of a single transformation. Yet the neoliberal revolution of the political economy of American health care remains inadequately contextualized, requiring much deeper analysis and demystification — particularly in light of parallel changes unfolding in other nations throughout the world — if it is to be understood.

Prioritization of economic growth transforms citizens into consumers, enabling constant sacrifice of human capital at the altar of growth, enabling permanent crises to continue.

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[“Sacrificial Citizenship: Neoliberalism, Human Capital, and Austerity Politics,” *Constellations*, Vol. 23, No. 1, March 2016, p. 3-14]

In short, at the same time that links between the state, finance, and corporate capital are intensified, concerted action by workers, consumers, and citizens is all but eliminated in fact, in political discourse, and in the elite and popular political imagination. And when consumer, worker, and citizen organizations are defanged by the law, these forms of identity and the antagonism they represent soon dissolve, generating that transformation of the soul Margaret Thatcher identified as fundamental to the success of the neoliberal project. These kinds of legal decisions combined with the neutralizing strategies of governance aim at this effect, replacing such identities with that of human capital. Conversion of the worker, the consumer, the activist citizen — all entities capable of linking together into a social force — into isolated bits of self-investing human capital both makes them more governable and integrates them into a project: economic growth, to which they may potentially be sacrificed. The conversion breaks down barriers to this governance and integration; it also abets both. To grasp how and why this occurs, however, we must return to the general problematic of neoliberal governance formations and consider in particular two of its component parts, devolution and responsibilization.

Devolution, Responsibilization and Shared Sacrifice

Neoliberalism's economization of the political, its jettisoning of the very idea of the social, and its displacement of politics by governance diminishes all significant venues for active citizenship. One can see these three forces combined in the metrics by which the costs of higher education are now appraised — on the one hand, in terms of the investment by consumers in their own economic future, on the other hand in terms of the investment by the state in its economic future. These metrics occlude the historical concern of higher education with developing or renewing citizens, knowledge, civilization, culture, or the public's capacity to govern itself.

Another example of compressing democratic citizenship and democratic justice into economic purposes can be seen in President Obama's 2013 “State of the Union” address, delivered shortly after his re-election. In a speech soaring with calls for social justice and ecological renewal, each item in what many pundits saw as a revived progressive agenda was expressly legitimated by its contribution to economic growth. Thus, while Obama argued on behalf of Medicare, tax reform, immigration reform, an end to Washington bickering and brinksmanship, raising the minimum wage, fighting sex discrimination and domestic violence, and increased government investment in science and technology research, clean energy, home ownership, education, each cause was framed in terms of its contribution to economic growth or American competitiveness. “A growing economy that creates good, middle-class jobs — that must be the North Star that guides our efforts,” Obama declared.²³ “Every day,” he intoned midway through the speech, “we must ask ourselves three questions as a nation.” And what were these questions whose answers would constitute supervenient guides to law and policy formation, and to collective and individual conduct in the world's oldest democracy and most dominant nation?

How do we attract more jobs to our shores? How do we equip our people with the skills needed to do those jobs? And how do we make sure that hard work leads to a decent living?²⁴

Success in these three areas, Obama promised, would in turn yield the ultimate goal of the nation and the government stewarding it: broad-based growth for the economy as a whole.

This framing weighs all policy issues, including justice and planetary survival, according to their **GDP-generating capacities**. Indeed, if one item on Obama's progressive agenda turns out to deter (or even fail to stimulate) growth, it would apparently have to get scratched from the program. This framing also reduces citizenship to participation in national growth and thus to political passivity, continuous with (if more subtle than) G.W. Bush's infamous encomium to "shop, fly, and spend" as consummate acts of patriotism in the immediate aftermath of 9/11. From a governance perspective, where what is prized is teamwork in achieving the goal of growth rather than contestation and deliberation about norms, there is no place for agitated or agonistic citizenship. Nor is there a place for citizen expression bound to interest groups and ad hoc mobilizations, both of which are treated as failures of buy-in or consensus-building.

However, while neoliberal political rationality administered through governance eliminates the last classical republican traces of citizenship formulated as public engagement, it retains even as it transforms the idea of citizen sacrifice. If citizen virtue is reworked as responsibilized entrepreneurialism, it is also reworked as the "shared sacrifice" potentially required for a healthy or troubled but above all a flexible economy. Such sacrifice may range from suffering the direct effects of job outsourcing, furloughs or pay and benefits cuts, to suffering the indirect effects of stagflation, credit crunches, liquidity or currency crises. It may be shared widely as the curtailed state investment in education; it may be suffered individually as a "last-hired, first-fired" phenomenon; or, as is most often the case, it may be suffered disproportionately by a weak group or class, as is the case with furloughs or reduced government services. Whatever the case, active citizenship is slimmed to tending oneself as responsibilized human capital, while sacrificial citizenship expands to include anything related to the health of a firm or nation, or again, the health of the nation as firm. This slimming and expansion are facilitated through the neoliberal supplanting of democratic political values and discourse with governance, that consensus model of order that integrates all into a supervenient project. Recall that governance replaces law with guidelines related to project goals, conflicting class positions with "stakeholders," class consciousness with team consciousness, and political or normative challenges with a focus on the technical and the practical. It is through such replacements and the reduction of national political purpose to economic survival and growth that, for example, tax-paying workers become an acceptable revenue source for the bailouts of investment banks managed by billionaires. This is also what legitimates slashing public employee salaries and pensions or hiking student tuition in response to finance capital meltdowns, state fiscal crises, and regressive tax policy. In short, neoliberal governance converts the classically modern image of the nation comprising diverse concerns, issues, interests, and points of power to the nation on the model of Walmart where managers are "team leaders," workers are "junior associates," and consumers are "guests" — each is integrated into the smooth functioning of the whole and bound to the single end of economic prosperity defined in terms of investment climate and growth.

In the era of Post-Fordist capitalism neoliberalism has changed the operation of power, the 1AC'S response to modern healthcare systems maintains complicit in a logic of neoliberal recovery that increasingly produces resilient subjects able to bounce back from institutional violence. In this new mode resistance becomes a somatic exercise in harnessing the health of the subject.

Howell and Voronka 2012. Alison Howell is Assistant Professor of Political Science at Rutgers University, Newark, where she is also an affiliate member of the Department of Women's and Gender Studies. "Introduction: The Politics of Resilience and Recovery in Mental Health Care". Jijan Voronka is SJE PhD Graduate @ University of Toronto Ontario Institute For Studies In Education. Studies in Social Justice Volume 6, Issue 1, 1-7, 2012] VR

Recovery and resilience are now two of the central frameworks for organizing mental health care in the Western world.

These frameworks posit that mental health "patients" can recover from their illnesses, and that resilience may be developed as a strength in order to avert or prevent so-called mental illness from the outset. The turn to "recovery" and to "resilience" has occurred in a context wherein mental health governance models based centrally on institutionalization had been the subject of much political resistance from those who have been psychiatrized, and also in a context of the retrenchment of state services through neo-liberal restructuring and cost-cutting measures. Large-scale deinstitutionalization in the second half of the 20th Century was met with the development of "Community-based" care as an alternative. Currently, those negotiating mental health services often find themselves subject to a mixture of institutional and community based mental health services, as well as other secondary institutional systems that offer mental health interventions (universities, work places, primary education, etc). Although such shifts apparently respond to the concerns expressed in the political resistance directed at total institutions (see Goffman, 1961), these new models of community care have arisen within a neo-liberal context, wherein social services are increasingly subject to prove their

effectiveness through efficiency models that require community agencies to meet targets, ensure flow-through, and collect evidence-based data on their effectiveness. Simultaneously Western states are downloading their social responsibilities to the voluntary sector and to citizens themselves. Whilst the concepts of resilience and recovery, then, originated

in antiinstitutionalization movements, they have increasingly been incorporated into, and some would say co-opted by, medical reason and mental health policy. They have thus been refigured: psychiatric experts now iterate that through recovery and resilience those who are deemed to have disordered minds can live "meaningful lives" despite the ostensible permanence of their illness. This understanding works to deny the possibility of a kind of recovery that would place patients or "clients" outside the remit of medical authority. Whereas twenty years ago resilience and recovery were harnessed as organized frameworks for psychiatric survivors to avert the medical system through alternate means (including peer knowledge and support), they are now harnessed to incorporate psychiatric survivors into medical systems. They now work in ways that attempt to make psychiatric survivors responsible for their own adherence to prescribed ways of governing their interior lives while at the same time leaving medical authority intact.

since psychologists and psychiatrists have become experts in recovery and resilience. This raises serious questions about the social justice implications of these ostensibly humane approaches to mental health. Approaching mental health through a social justice lens can reveal rich connections that highlight some of the most important themes in social justice research: inclusion, power, recognition, political economy, difference, equity and rights. And yet, the richness of this area of research has not been fully explored by social justice studies. This relates, in part, to the questionable notions of progress that surround psychology and psychiatry. With the march of time, we are told, these professions have become humane, liberal, and scientifically advanced. The sporadic attention to mental health in social justice studies also relates to the inadequacy of predominant approaches in the field. To be sure, any number of connections could be drawn between social justice and systems of mental health governance, but a limited number of approaches have been explored. For instance, connections have been drawn between social justice and

mental health through the analysis of the psychological consequences of injustices. Scholars working in this vein (see Shephard, 2002) argue that high rates of depression in women or schizophrenia in AfroCaribbean men, are the result of, or exacerbated by, societal unfairness.

Mental illness in this approach, is essentially figured as the result of social injustice.

While laudable in attempting to raise social questions to the overarchingly individualistic disciplines of psychology and psychiatry, this approach, however, fails to question psychiatric authority

and its diagnoses, including "depression" and "schizophrenia." The result is that this approach merely supplements a medical or biological model

by providing complementary social explanations. It fails, however, to account for how marginalized

people such as the poor, colonial subjects, racialized people, queers and gender variant people, the disabled tend to get disproportionately diagnosed or pathologized

by the psychiatric profession, and how the psychiatric profession has been implicated in processes of colonialism, racism, sexism and heterosexism, as well as in disability and war-making

(Howell, 2011; Metzl, 2010). A second line of inquiry into the connections between mental health and social justice focuses on fair and equal access to health services and welfare provision. Here, concerns over the decline of the welfare state and in particular of public health care provision are transposed onto questions of mental health, though again, without adequately questioning the authority of psychiatric practice. As such, questions about how "stigma" prevents the mentally ill from accessing services, or how socio-economic status, race and/or gender can impede or accelerate access to diagnoses and treatments are explored (Corrigan, Watson, Byrne, & Davis, 2005; Cook & Ngwena, 2007; Kronenfeld, 2008; WHO, 2008), but the authority of such diagnoses and treatments, and the psychiatric professions more generally, go largely unquestioned. More recently scholarship located broadly in the field of critical disability studies has opened up new ways of thinking through the connections between social justice and mental health, precisely by challenging the norms that underpin the very value of "mental health" or "mental illness" as useful categories or ways of thinking about people. This scholarship takes inspiration, in particular, from re-invigorated activism that has developed out of anti-institutionalization and the service user/consumer/survivor/expatient movements (Church, 1995; Crossley, 2006; Everett, 2000), as well as the mad movement (Morrison, 2005; Fabris, 2011), which is exploring the positive valuing of madness as a form of difference, particularly through activism carried out under the banner of Mad Pride. This coincides with developments in critical disability studies, where scholarship on the human rights of people living with disabilities is complemented by

scholarship illustrating that disability is a matter not of deficit, but of difference in embodiment. It may further take inspiration from studies in the history and sociology of medicine that trace the very contingent rise of psychiatric and psychological authority

(Hacking, 1995; Rose, 1998; Young, 1997), and also highlights a broader unease with bio-medicalism. At the same time, methods for peer/survivor research are increasingly being pursued, wherein survivors themselves contribute to knowledge production through user-controlled research (Beresford, 2002; Faulkner, 2004; Faulkner & Nicholls, 1999; Godfrey, 2004; Sweeney, Beresford, Rose, Faulkner, & Nettle, 2009). Readers might best approach the articles in this special issue by suspending any belief in the authority of psychology and psychiatry, and questioning the bio-medicalism that deems some people normal, and others abnormal. Indeed, the articles included here help those interested in social justice to pose questions about sanism, which, for Perlin and Dorfman, "is inspired by (and reflects) the same kinds of irrational, unconscious, bias-driven stereotypes and prejudices that are exhibited in racist, sexist, homophobic and religiously- and ethnically-bigoted decision making" (Perlin & Dorfman, 1993, p. 49). Further, we must query how and why it is that we are able to continue to approach the "thinking differently" of thoughts, experiences, behaviours and knowledge that is evoked through madness as inherently a problem that needs to be eradicated. Thus, the articles included here can be approached with an eye to viewing madness not as a deficit, but as a matter of difference, so as to view those who are subject to diagnosis as rightfully able to make choices about their engagements—or disengagements—with systems of mental health care, as well as medical and other authorities. This is not only a political stance: it can open up rich avenues for re-thinking the connections between mental health and social justice, and furthermore, for re-thinking social justice itself. Indeed, the articles included here do just that, in particular by examining the concepts of resilience and recovery are put to work in contemporary systems of mental health governance. Why resilience and recovery? The answer: precisely because these concepts appear so benign at first glance. Unpacking these notions can reveal the ways in which they are powerful tools in the governance of those deemed mentally ill, and also by extension, all citizens. In the case of recovery, what was once a term that was generated from the survivor movement, the focus was on "recovery in," whereas its current reiteration has

transformed into "recovery from." To distinguish, the idea of "recovery in" presumes "that recovery must be grounded in a focus on survivor rights, peer support and recovering from the oppressive effects of being a mental patient" (Poole, 2011, p.15). However, as mental health systems have yielded to demands that they be more recovery-oriented, the social justice-orientation of "recovery in" has shifted into a model that has become

"recovery from." Focusing on problematic neoliberal individualist principles including hope, empowerment, self-determination and responsibility, and the offering that with client-centred intervention and support, some can find cure, others "resume normalcy" while still others can build meaningful lives while living with mental illness (Poole, 2011), thus reinstating the expertise and authority of psychiatry and psychology. Importantly, "recovery from" has become a quantifiable measurable concept, model, and framework that practitioners

evidencebased research on, and through which they have found a place where they can remain central professionally. As for resilience, the concept parallels the notion of recovery. Where recovery posits the ability of subjects to recover from an illness, the notion of resilience ostensibly recognizes the innate capacities of people to "bounce back" in the face of challenges or sources of distress. The capacity to be resilient is not, however, left to chance: psychologists have become authorities in instilling resilience, especially through the increasingly authoritative techniques such as cognitive behavioural therapy, or "positive psychology." These changes are deeply tied to broader austerity measures: getting citizens to be resilient in the face of challenges is not only cheap in that it diverts patients out of public health care systems, in favour of self-help and positive thinking, it is also about aspiring to create a resilient citizenry, able to cope with uncertainty. This is a technology of looking inward: rather than confronting austerity measures or other matters of social justice through political action, citizens are enjoined to look inward, gather their strengths, and be resilient. Recovery and resilience, then, are notions deeply embedded with both the economic and the social imperatives of contemporary neoliberalism

The affirmatives invocation of the "health insurance" tragedy as a means for the politics relies on an affective appeal to liberalism for the lubrication of the sentimental public sphere. Rather than a technique of liberation, these representations elide a structural analysis of health care in favor of a resilient subjectivity that generates resentment and cruel hope

Shomura 2010. Chad Shomura is Chad Shomura is a political theorist, teacher, and artist based in Denver, Colorado. Chad was born and raised on O'ahu, Hawai'i. He received his BA and MA in Political Science from the University of Hawai'i at Mānoa and his PhD in Political Science from the Johns Hopkins University with a focus in Political Theory. He is now Assistant Professor of Political Science at the University of Colorado Denver. "Tales of Cruel Optimism for 2009, or the Political Temporality of Hope in Depressing Times". Western Political Science Association 2010 Annual Meeting Paper] VR

The personal seems so integral to the operations of sovereignty within this episode of crisis dramaturgy and so deserves more attention than allotted by the New York Times. Immersed amongst his fellow, ordinary

Americans, Obama speaks a speech to the crowd surrounding him and in so doing becomes subtly submerged into that anonymous crowd through both the spatial staging and revelations of the personal. From New Hampshire to Colorado to Montana, the personal seems so integral

to magnetizing together Obama and the crowd in a forcefeld of affects shared by "ordinary Americans" who are "no different from anybody else":³⁷ Obama is introduced by a family member of a victim of the diabolical health care system; he speaks of the kind of story of health care tragedies that he has "read in letters and heard in town halls all across America"; and he narrates his own mother's fght against cancer along with her insurance company's refusal to cover costs of treatment. The town-hall aesthetic of the personal animates a sovereignty alternative to that procured through misreadings of Agamben that identify the location of sovereignty within locutions of the "decision."³⁸ Here, we view at work what we might call the performativity of sovereignty by which demarcations between sovereign subjects and the sovereign subject matter little from the standpoint of animations and modifications of the necessary normative frameworks summoned to successfully authorize and execute particular political decisions. Another way to describe the stakes in this scene is through what William E. Connolly terms the "ethos" of sovereignty, or the composite of resonant energies, genres, and practices that direct the postures and positions of sovereignty.³⁹ The clamor of lauds and applause, the gasps escaping faces agape from health care horror stories, and so on, along with all their invigorating affective excitements, mark the rhythms of a sovereignty channelled through the town-hall crowds and far beyond Obama. As the predominant genre tapping and stimulating the audience's energies, the shallows of the personal keep performative sovereignty afloat. Yet this Sovereignty rides the wave of a personal that is not any less abstract because it has acquired a "human face."⁴⁰ That human face is one contorted in the sensational sensation of the pain of loss, an irreducibly singular but, as it turns out, broadcastable experience that is, as Elaine Scarry writes, "language-destroying: as the content of one's world disintegrates, so the content of one's language disintegrates; as the self disintegrates, so that which would express and project the self is robbed of its source and its subject."⁴¹ But in light of this evisceration, the experience of pain into language through tales told, which develops a new "source" of the self. So when those who introduced Obama or Obama himself testify to their pain, we may not understand their pain even as we nonetheless identify with it within the available genres of the pain of loss instigated by the ailing health care system. Under the town-hall scene's mandate to narrate one's painful relation to the health care scare story, the personal, it seems, becomes the impersonal, rendered legible and legitimate by its presumed proximity to sensations of pain and emotions of loss. This town-hall public of strangers is strangely intimate under qualifications qualified by Berlant: "[An intimate public] fourishes as a porous, affective scene of identifcation among strangers that promises a certain experience of belonging and provides a complex of consolation, confirmation, discipline, and discussion about how to live as an x."⁴² In short, public intimacy and the sovereignty it properly props up emerge insofar as the purely personal experience of pain and loss recedes like a sunset beyond the horizon of normative meaning-making. Yet this impersonal personal of the pain of loss seems to have powerful political effects insofar as the political itself evaporates (from view). "To promote health care plan, Obama makes it personal." In the town hall, the personal is not the political, nor is the personal made the political. Rather, the personal purges the political altogether. As Obama argues, "we know this isn't about politics. This is about families and businesses. And at this moment... this is about whether we will be able to look back years from now and say we did what was right. We did what was hard. We did what was necessary to leave for our children a country stronger than the one we found."⁴³ The family, capitalism, futurity, and the child provoke the evacuation of the political via the figure of the pained person. According to Obama, divides are drawn, not by conflicting conceptual commitments and disjunctive dispositions, but in a "contest between hope and fear."⁴⁴ But his rhetoric – that "we are held hostage at any given moment by health insurance companies that deny coverage, or drop coverage, or charge fees that people can't afford at a time when they desperately need care," that "what is truly scary – what is truly risky – is if we do nothing"⁴⁵ – this rhetoric appears to have the divine effect of liquefyng hope and fear in an affective state of indistinction. The very contrariness of hope and fear glues together the town hall because, as Berlant notes, intimate publics fourish precisely because of the messiness of affective dispositions organized as the feld of potential political response.⁴⁶ Through hope-fear, political activity becomes reduced to narrations, more or less shared by everyone in the town halls, of stories organized by the personal experience of the unfairly felt pain of loss to be

averted outside the political. Zizek aptly apprehends this affective dimension of “postpolitical” politics: “With the depoliticized, socially objective, expert administration and coordination of interests as the zero level of politics, the only way to introduce passion into this field, to actively mobilize people, is through fear, a basic constituent of today’s subjectivity.”⁴⁷ Indeed, after speaking of the uncertain future in which everyone, regardless of political position, may become a character in health care horror stories, Obama returns to the promise of hope, energized by fear, to organize the sovereign activity of his audience: “So if you want a different future – a brighter future – I need your help. I need you to stand for hope.”⁴⁸ **Sensorially reminding us that we are bare, precarious life with respect to health care in the unhealthy but surmountable status quo, hopefear becomes the affective support – the ethos – for postpolitical sovereignty.** Perhaps hope-fear, at least regarding the impersonal personal of the pain of loss, is a crucial tenet of cruel optimism. For **whilst we anticipate a better tomorrow, one in which a happy ending is brought to our health care system woes through the audacious efforts of an ethos of performative sovereignty affectively charged by the experience of pain, what attritional conditions become solidified today?** In the targeting of the health insurance industry, we identify all too easily what Wendy Brown has detailed as the dangers of “wounded attachments” and their opening and reopening **within the circuits of** a Nietzschean **ressentiment vitalizing an endless search for a blamable subject upon which the suffering may exact revenge;**⁴⁹ **subjectivity emerges as an “I,” an “I” that has been wronged.** Temporality here centers about the publication of painful events while keeping concealed the episodic seamlessness of “structural subordination” that, as Berlant writes, “is not a surprise to the subjects who experience it... [because] the pain of subordination is ordinary life.”⁵⁰ We **become impersonal persons of hopefear, “subjects of true feeling,”** I’s that have been wronged who feel violence, evental and eventual, rather than immersion within structurally infected modalities of suffering. **Under this mode of biopolitical production attuned to the rhythms of the individual rather than those relays of power through which the individual emerges,** it matters little which “I” we are (think of the many personae in Obama’s speeches: I-as-I, I-as-worker, I-as-mother, and so on). The point **is a commitment to the “I,”** the many incarnations of **which nonetheless fit the mold of the** ordinariness of the **American Dream populated by those “working hard” and “meeting their responsibilities”** but are **“held hostage by health insurance companies.”**⁵¹ Animated by an ordinariness interwoven with figures of hard working, responsible Americans aggregated under the genre of the pain of loss, **this “I” buries** those **structural striations around which our subjectivity’s roots remain affectively attached and for which the contagion of hope-fear in the town-hall aesthetic of sovereignty fills our intimate public with yet another deadly strain of cruel optimism.**

Imagination is how the free market functions

Haiven 14. Max Haiven is an Assistant Professor in the Division of Art History and Critical Studies at the Nova Scotia College of Art and Design, Canada. Crises of Imagination, Crises of Power: Capitalism, Creativity and the Commons. London, GBR: Zed Books, 2014. ProQuest ebrary, Copyright © 2014. Zed Books, p. 240-245)//TR

This **renewed interest in the imagination**, however, **has been part of a troubling broader shift**, traced in Chapter 6. For one, the imagination went from being a relatively distasteful and distrusted term to having the status of a mainstream concept. Since the 1970s, for example, encouraging children’s imagination has become an unquestionable good in schooling, which could not have been said of education prior to that time. We are, today, constantly exhorted in self-help books and in advertising to imagine as an antidote to social dislocation and alienation. But these **shifts occurred apace with a general social transformation as capitalism evolved to meet, quash, redirect and co-opt the struggles of the 1960s and 1970s.** 43 Neoliberalism, **post-Fordism** or globalization, whatever its name, **marks a period over the last thirty to forty years that has witnessed a massive expansion of the market into everyday life**, the global redistribution of the production of commodities and a wholesale rise in corporate and financial power. So, too, has it witnessed terrifying new advances in the repressive power of the state and its punitive institutions at the expense of social welfare programmes and forms of collective wealth and insurance. **The result has been the rise of virulent, consumerist and depoliticizing individualism spurred by increasingly isolated and community-starved lifestyles and the transformation of social cooperation into ever more fragmented, ‘flexibilized’ and precarious work.** Within this shift, **imagination has gone from** being a shorthand for **liberation and**

possibility to functioning as a rhetoric of economic and personal restructuring for the new economy. On the one hand, we now have the vaunted 'creative class', who are held up as the solution to corporate and governmental crises and whose mere presence is supposed to revivify urban areas and be the midwife of the new economy (for more on this, see Chapter 6). In this economy, as Angela McRobbie observes, we are told that 'everyone is creative' and that we ought to be 'free' of the fetters of societal obligations like permanent jobs, social securities and pensions.⁴⁴ Artists, no longer social reprobates, have become the iconic 'pioneers' of this brave new world. Under the sign of unleashing the imagination, we are encouraged to 'liberate' ourselves from an understanding of work as a lifelong career (characterized by stability, hierarchy and firm bonds) and leap gleefully into the entropy of the market, cultivating and hawking a portfolio of skills for part-time, temporary contracts that allow us maximal personal freedom and earn us 'intangible' rewards like 'personal satisfaction' and 'professional recognition'. Neoliberal ideology holds that the market is the best system for harnessing the power of the imagination for social good: only under the free market will 'useful' imagination be encouraged and rewarded. While emergent discourses of creativity and creative cities promise a brand new world of liberated, fun and rewarding employment, the reality is that the vast majority of work has become ever less imaginative even as it has become ever more precarious. The 'global sweatshop' has seen the manufacture of commodities fragmented and globalized, with individual workers in 'emerging economies' performing mind-numbing deskilled piecework that affords virtually no imaginative element. Within the growing service sector, labour has become ever more routinized, fragmented and deskilled with even human emotions and reactions scripted to conform to a monolithic 'corporate culture'. Within the 'knowledge economy' personal freedom and imagination are rarely valued and most workers feel themselves having to conform to an ever tighter, if less tangible, set of 'invisible' rules in order to advance in an ever more tangible if unnamed hierarchy. And while pundits proclaim the end of industrial and agricultural toil, the reality is that these have been moved 'offshore' where wages are lower, labour and environmental laws laxer, and corporate profits higher. Flexibility and creativity for economic elites have meant record profits as they divest themselves of the meagre responsibilities they once bore towards workers while effectively 'externalizing' to these very same workers the responsibility for innovation, self-organization and production. For workers, flexibility and creativity as hallmarks of this new regime of capitalism have meant more insecurity, more precariousness, and more exploitation.

Their 1ac's affirmation of hope is framed by a revolutionary politics that on the level of form adheres to the terrain of the status quo. Their depiction of utopian futures relies on a fantasy of overcoming the master, but in so doing reinscribes politics in a teleological will to mastery

Rogers 15. Juliet Brough Rogers, professor of political science at the University of Melbourne (Australia), "A Stranger Politics: Resistance in Psychoanalytic Thought and Praxis" in Jacques Lacan: Between Psychoanalysis and Politics, Routledge, 2015: 186

The conundrum of change in psychoanalysis (and beyond) highlights the first of two particular problems of, and with, resistance that appear when the subject attempts such a change of rules. First, change rarely (if ever) involves the creation of what Douzinas (2013: 141) calls 'a new political subject'. That is, subjects are always already subjected – let us say occupied – a priori and thus all imaginations of resistance are framed in a priori discourse. As such, the subjects' imaginations, including their imaginations of the results of revolution – or of a new mode of being – are always colonized with what is available to them. This is why – for Žižek (2007) and for Lacan (2007) – in post-revolutionary states, what the subject will get is more of the same. The second problematic that haunts acts of resistance, and of more specific concern to psychoanalytic practice, is that any employment of violence as a means to an end, and particularly as an effort toward a violent unsettling of the regime, can only be understood as the effort to capture a definitive answer to the insistent and formative question to the

Other, expressed by Lacan (2006) as, 'che vuoi Autre?' – 'what do you want from me?' In some cases this may be a violent effort toward capture, exercised to the point of a defiance of the existence of the question. What this means is that one acts, violently, in order to produce a known future, as the answer. The two problematics of resistance overlap because the answer is always imagined in the terms/signifiers available from the past. That is, the answer appears in the frame of the categories which produce the subject, and thus recruits the first problematic: 'you are (always) already subjected'. I'll tackle these problematics in turn. First, 'you are already subjected'. If we even partially accept Judith Butler's (1997: 6) treatise on the formation of subjectivity as a series of 'passionate attachments' to 'subjection',¹⁰ then it is difficult to understand how the subject might be what Douzinas (2014) described as 're- or de-subjectivised' in the first site of becoming a resisting subject.¹¹ For the political subject of democracy, recognition is, as Claude Lefort (1989) has told us well, the condition of being a subject. This means recognition within the signifiers – let us call them biopolitical categories – allocated to the identity of the subject of democracy. The stage of political recognition is populated by signifiers which broker little dissent – by others and even by the self. In Butler's terms, we are 'passionately attached' to our gender, imaginations of health, rights, and, in Lacan's terms, the 'goods' – as objects and as ideas – which offer us the imagination of recognition. We are occupied as subjects through our own occupation with a recognizable identity before democracy, with the qualities (objects) that reflect that identity. This occupation allows for little, if any, dissent as to the naturalness, goodness, and reality of the signifiers that produce the subject – as signifiers which adhere fundamentally to economies of desires: as desires for recognition of identity and rights, as desires for capital. That is, the subject is occupied a priori with these categories and recognizes (and demands recognition) via these categories. If we accept the premises of subjection framed above then the argument follows that the resisting subject is still a subject, but one who looks for recognition beyond the common political forms. That is, we can say that the resisting subject is still 'passionately attached' to the ideas and objects which offer recognition, but these may be recognition by an alternative political party, a Cause or, in Lacanian psychoanalysis, we would say s/he attaches to (another) Master's discourse. They may resist one Master, but they chose another Master. They do not resist mastery. And here we have the basic difficulty with theories and actions of resistance. These difficulties are that somehow, in some way, any acts of resistance always become modes of, in Lacan's terms, the desire for (another) Master (2007). Resistance, understood this way, is a state of being that is always already subjectivized within the parameters of its own claims, or within the parameters of the subject's imagination of its goals. This is the obvious reference made by Lacan in his comments to the students who participated in the 'resistances' of 1968 in France (and elsewhere). As he says, 'What you aspire to as revolutionaries is a Master. You will get one' (Lacan 2007: 207).¹⁴ The provocative comment to the students – some of whom have come to listen to him and some who have come to (apparently) resist him – is a comment on their acting out the discourse of the Master that they imagine they can overcome, through listening (or even objecting) to another Master, namely, Lacan. In this attempt at resistance which falls prey to its own conditions of subjection, we can say that the subjectivity of the resisting subject – the student – is preoccupied with the signifiers available to resist, where the best they can hope for is to be re-occupied by the imagination of securing (another) truth. This hope, at least for the students in France at this time – understood through Lacan (and his discussions in 1969) – is the hope for the Other's knowledge. A knowledge which the subject presumes the Other has. A knowledge which is imagined to be able to be accessed and had. A knowledge which is presented as the answer to the question 'che vois Autre?' And here appears the second psychoanalytic concern with resistance: resistance as a belief

in an access to an answer, or, in its most extreme or crude terms, resistance as psychosis. Resistance, understood as a desire for a Master, becomes a performance of what the subject imagines is the answer. The answer as a closed course of action with a fixed teleological imagination, such that the resisting subject might say: 'If I do this I will be this', or 'if I do this then the final result will be this', or, in its psychotic form, 'if I do this the world will be this'. It is important to stress, however, that this may not follow for all acts of resistance – which I will postulate later – but when Lacan says of the students in France that what they want is a Master, this form of psychotic achievement of an answer is precisely what he is referring to. Theirs is the desire for a discourse that holds within it the knowledge that the subject imagines is required (and can be acquired/obtained/had) to achieve a perfection of the signifier, an imagination that the subject can acquire, what Lacan (2007: 14–15) describes as the 'Other's jouissance'. The students, in Lacan's suggestion, want to resist in order to obtain the answer when it is the existence of an answer at all they are supposedly resisting.

Alternative Extensions

The alternative is to reject the affirmative in favor of how learning to die. This is not a literal death but a metaphor for, but an ontological refusal to live life under neoliberal health that constantly demands the death of its subjects.

Shukin 2016. Nicole Shukin is NICOLE SHUKIN is Associate Professor in the Department of English at the University of Victoria, and faculty member of the interdisciplinary graduate program in Cultural, Social, and Political Thought (CSPT). “The Biocapital of Living—and the Art of Dying—After Fukushima”. Postmodern Culture Volume 26, Number 2, January 2016] VR

The Art of Dying

Cazdyn's theorization of “the already dead” is helpful in elucidating an art of dying opposed to the resilient subject's adjustment to continuous catastrophe. For Cazdyn, “[t]he paradigmatic condition illustrating the already dead is that of the medical patient who has been diagnosed with a terminal disease only to live through medical advances that then turn the terminal illness into a chronic one” (4). As he notes, “[t]he disease remains life threatening, still incurable, even though it is managed and controlled, perhaps indefinitely” (4). Although Cazdyn doesn't refer to the governmental philosophy of resilience per se, his likening of a catastrophic system of global capitalism to a terminal illness that is managed as a chronic condition as opposed to being radically contested speaks closely to the resource, or biocapital, of resilience. Rather than some zombie state cooked up by popular culture, the already dead, as he formulates it, is an ontological refusal to accept the unlivable conditions of capitalist life as a chronic condition. “It is only when the living remember that they are already dead that the possibility for liberation emerges,” he proposes (190). Cazdyn's formulation of the already dead is unwittingly echoed by Evans and Reid's invocation of death in their more explicit critique of resilient life: “Resilience cheats us of ... [the] affirmative task of learning how to die. It exposes life to lethal principles so that it may live a non-death” (13). Yet Evans and Reid, while challenging neoliberal and biopolitical rationalities that have effectively monopolized the meaning and substance of life and death, finally propose an “art of living” rather than an art of death in response (175). Moreover, the art of living they elaborate hinges upon a reconstituted understanding of the human as a fundamentally political subject; one empowered by its hubristic belief in an ability to secure itself from those elements of the world it encounters as hostile to its world, rather than being cast in a permanent condition of resilient adaptation to a biologized understanding of the nature of the world as such. (43) Neither Evans and Reid nor Cazdyn consider how ontological protest against the capitalization of life might involve other animals. The art of dying in kinship with other animals that emerges in the Fukushima exclusion zone, however, suggests that it is precisely when humans are biopolitically reduced to resilient organisms and radiation experiments that it becomes crucial that animality be occupied as a counter-practice. Foucault suggests something along these lines in *The Courage of Truth* (1983–84), when he says of the cynical mode of life (most infamously modeled by the Greek philosopher Diogenes, who shamelessly chose to live in the open like a dog) that by virtue of being “indexed to nature, and only nature, [it] ends up giving a positive value to animality” (282). More than just a “material model of existence” (283), Foucault proposes, “[a]nimality is an exercise. It is a test for oneself, and at the same time a scandal for others” (283). The art of dying after Fukushima involves confronting the deadliness of the nuclear economy with a “practice of animality” in this sense (288). As Cazdyn writes, “[t]he already dead refuse ... either to die or to be alive until these categories can be remade to accommodate the unique and new existence the already dead experience” (198). Most importantly, perhaps, the question of the already dead is inseparable from the problem of trying “to imagine what comes after globalization” (Cazdyn 161). As Cazdyn declares, “[...] if you find this difficult, if not impossible, then perhaps it is because imagining what is beyond globalization is like imagining what comes before or after time—a mind-bending exercise indeed” (161).

The aff is neoliberal individualism and self-help rhetoric that undermines collectivity at the level of subjectivity and political agency – neoliberalism must be constantly reproduced through affirmation of this ideology, which means the aff reinscribes the system they critique, turns the case

Türken et al 15 (Salman Türken - Ph.D. student, Department of Psychology, University of Oslo, Norway; Hilde Eileen Nafstad - Professor of Social and Developmental Psychology, University of Oslo, Norway; Rolv Mikkel Blakar - Professor of Social Psychology, University of Oslo, Norway; Katrina Roen - research spans critical psychology and gender studies, with a focus on youth, discourse, identities, and embodiment; "Making Sense of Neoliberal Subjectivity: A Discourse Analysis of Media Language on Self-development", Globalizations, Volume 13, 2016 - Issue 1, 16 Apr 2015)

Neoliberalism posits that social problems are best alleviated through free market processes and through the activity of responsible individuals, rendering collective solutions unnecessary (Bourdieu, 1998, Harvey, 2005). Rose (1999) argues that autonomisation and responsibilisation may function as disciplinary strategies of neoliberalism which encourages action on the self by the self as a means of providing individual well-being. The rhetoric of self-development, as revealed in our data, underpins such neoliberal discourse, indicating the degree to which individualization of the social is promoted in parts of Norwegian and Turkish media. Our analysis indicates that the discourse of self-development may thus work as a technology of neoliberalism. The four frameworks that emerged in our analysis resonate well with Foucault's (2008) theory of governmentality which posits that citizens in neoliberal societies are constituted as autonomous, rational, calculating, self-directing agents who understand themselves as entrepreneurs continually acting to increase their value; their human capital. Although media is a powerful tool to disseminate meaning and thereby influence subjectivity in society, people do negotiate their own understandings and may even oppose media's positioning of subjecthood (Fairclough, 2001; Gill, 2008). The present study does not investigate how media discourse on self-development is negotiated by the readers. This could be a fruitful approach for future studies. The aim of our study has been to explicate the subject positions that are made available within the media discourse of self-development and discuss how this discourse relates to neoliberalism. As we see it, it can be fruitful to place the media discourse on self-development, revealed in this study, within a global self-help discourse that has become increasingly influential in the last few decades (Binkley, 2011; Rose, 1999). Indeed, promotion of self-help has been intended as a device to save public expenditure and encourage individuals to take greater responsibility for their own well-being in neoliberal societies (Cheshire, 2006). Self-help discourse has been increasingly infiltrating everyday thinking and contributing to instilling the idea of the entrepreneurial subject in both the Norwegian (Madsen, 2014) and Turkish (Can, 2013) societies. Regarding the Norwegian context, for instance, a study by Tu'rken, Carlquist, and Allen (in press) revealed similar discourses to the ones we found in Aftenposten in a Norwegian debt TV show: individual debtors are positioned as sinners who can save themselves only through self-development. Tu'rken and colleagues argue that neoliberal discourses in such TV shows contribute to the individualization of the social, and discipline participant debtors as well as the public/viewers. Stretching the argument of self-help to modernity, self-development and self-mastery become characteristics of the modern self (McGee, 2005), a thought in line with Giddens' (1991, p. 75) claim that 'we are, not what we are, but what we make of ourselves'. Constructions of self-development as becoming a better version of oneself and a prerequisite for success, as exposed in our analysis, imply a transformable or malleable subject. This is also the idea on which the global self-help discourse is based (Binkley, 2011). Both constructions normatively state what society prescribes for its members: to become a self-directing successful subject who needs to continually improve herself. Individuals are cast into a binary opposition between 'inadequate' subjecthood and 'successful' subjecthood. The moral aspects of the current discourse of self-development make it clear to the individual what is expected of her. The failing subject is constituted in such a way that she feels the need to improve herself toward becoming a successful subject. If the rational autonomous individual takes responsibility to refashion herself with enough self-confidence, there would be no hindrance on her way to success. The individual is constituted as 'the master of her life' (Bauman, 2001) who is thus obliged to 'work on the self' to accomplish life (Rose, 1999). Underlying both the negatively and positively weighted subject positions is the fundamental assumption of strong individualism: none of the positions offered allows for collectivity, citizenship, or group identity. Everything is focused on the individual's personal (ir)responsibility, (un)awareness, and (un)willingness to

change. These are powerful ways to frame the future selves of, for instance, young people, setting up a **constraining binary** (positive self/negative self), and impressing upon the reader her personal responsibility to make her dreams come true or be consigned to endless struggle and disadvantage. **Strengthening individualism, neoliberalism provides social control**, as Foucault (2008) argued and preserves parts of status quo, legitimating and reproducing social structural inequalities in a neoliberal system. In this sense, discourses of self-development may reinforce neoliberal values and frames of understanding. Morgan and Gonzales (2008) argue, for instance, that even the daily workings of the welfare state in the USA paradoxically subject the beneficiaries of welfare services to neoliberal discipline, promoting individual success narratives and individual behavioral modifications. Our analysis reveals a certain contradiction within media discourse on self-development in each of the national contexts: While the social and structural nature of life conditions (e.g. unemployment) is acknowledged, the burden of tackling these problems is placed on the shoulders of the individual. Equally important, we found no resistance to the subject positions offered within the discourses explored in our empirical data. In the Turkish case, moreover, the collectivist values of solidarity and social responsibility seem to be reproduced, within the discourse of self-development, to make way for projects that aim to empower and equip the individual with more resources rather than seeking collective solutions to the systemic problems that produce disadvantaged subjectivities. Such empowerment privileges individual autonomy and thus works in ways consonant with neoliberal subjectivity as Bondi (2005) concludes. Harvey (2005) suggests that **today neoliberalism has become the modus vivendi**. Many scholars (e.g. Bourdieu, 1998; Foucault, 2008; Rose, 1999) agree with him. **Neoliberal hegemony is persistent despite its many visible failures and limitations** (Scholl & Freyberg-Inan, 2013). Much research from different fields of study provides insights into the ways in which subjectivity is constructed by discourses which may work to reinforce neoliberalism (e.g. Archer, 2008; Ayers & Carbone, 2007; Bragg, 2007; Kelan, 2008; Nafstad et al., 2007; O'Flynn & Petersen, 2007; Walkerine, 2003, 2006): **the dominant individualistic subject of contemporary society is reproduced and refashioned as an entrepreneur of herself**. The specific discourses of selfdevelopment in the two distinct media contexts, as our analysis reveals, offer an individualistic subjectivity which fits well with neoliberal governmentality and mostly limits communality and collective identity. As argued by Bourdieu (1998) and Harvey (2005), **neoliberalism has been successful in constraining system critique**. The discourses of self-development revealed in our analysis, to conclude, may be argued to contribute to reproduction of status quo to fit the demands of the current neoliberal stage of capitalism. Yet, hegemony does not require unanimity, and **neoliberalism needs to be produced and reproduced continually**. Although there might not be a coherent or consistent alternative political vision available for the majority of poor and working-class people (Bourdieu, 1998), there are today examples of counter-hegemonic struggle in global 'uncivil' society (Sullivan et al., 2011). Thus, **we need to pay more attention to counter-hegemonic perspectives** which 'reveal ideological and political possibilities that are closed down when neoliberal ideology is theorized as seamless and complete' (Morgan & Gonzales, 2008, p. 233).

Capitalism causes mass death, anti-blackness, and environmental destruction

Dean 15 (Jodi, Political Theorist @ Hobart William Colleges, "Red, Black, and Green," Rethinking Marxism: A Journal of Economics, Culture & Society, 27:3, pp. 399-401)

Two ideas voiced in the present discussion impress the urgency of the need for a left party oriented toward communism: racism (Buck 2015) and the Anthropocene (Healy 2015). Given anthropogenic climate change, the stakes of contemporary politics are almost unimaginably high. They range from the continued investment in extractive industries and fossil fuels constitutive of the carbon-combustion complex (see Oreskes and Conway 2014), to the dislocations accompanying mass migration in the wake of floods and droughts to the racist response of states outside what Christian Parenti (2011, 9) calls the "Tropic of Chaos" (the band around the "belt of economically and politically battered post-colonial states girding the planet's mid-latitudes," where climate change is "beginning to hit hard"), all the way to human extinction. That one city, state, or country brings carbon emissions under control—while certainly a step in the right direction—may be irrelevant from the standpoint of overall warming. Perhaps its carbon-emitting industries were shipped elsewhere. Perhaps another country chose to expand its own drilling operations. Climate change forces us to acknowledge that we can't build new worlds (Helepololei). We live in one world, the heating up of which threatens humans and other species. Not all communities, economies, or ways of life are compatible. Those premised on industries and practices that continue to contribute to planetary warming have to change significantly, and soon. **Forcing that change is the political challenge of our time.** Given the persistence of racialized violence and the operation of the state as an instrument for the maintenance not only of capitalist modes of production but also and concomitantly of racialized hierarchy,

the challenges of organizing politically across issues and identities are almost insurmountably daunting. No wonder the Left resorts to moralism and self-care instead. **It's easier to catalog difference than it is to build up a Left strong enough to exercise power**, especially given the traversal of state power by transnational corporations, trade, and treaties. **It's also easier to go along with the dominant ideology of individualism**, which enjoins us first and foremost to look after ourselves, **than** it is to put ourselves aside and focus on **formulating a strategy for using collective power to occupy, reconfigure, and redirect institutions** at multiple levels. Here again, not every vision of community is compatible with every other. Those premised on fantasies of racial, religious, ethnic, or linguistic purity directly oppose those premised on diversity. Those premised on reproducing structures of class hierarchy directly oppose those insisting on equality. If something like a party of the radical Left can stretch beyond Greece and Spain, if it can be imagined in North America, it will only be possible as a combination of communism, antiracism, and climate activism. **I use “red, black, and green” as a heuristic for the coalition of concerns necessary for such a party.** I invoke the heuristic here to double down against critics who prefer a thousand alternatives to the party form. **A thousand alternatives** (see Healy 2015) **is no alternative. It leaves the political system we have—the one that puts all its force behind the preservation of capitalist class interests—intact.** Some ideas need to be chosen, systematized into a program, and defended.¹ Consciously reiterating the colors of the Black Liberation Flag, the red, black, and green heuristic positions itself within the histories of communist, people's, and anticolonial struggles. Left Unity in the UK uses red, black, and green in their logo to suggest a similar constellation. The colors don't have a fixed meaning; they have appeared differently in the histories of emancipatory egalitarian struggle. In recent struggles, red suggests a politics against debt, austerity, and corporate personhood and allies with anticapitalism and communism as well. Black pays tribute to the IWW, anarchists, black power, and movements against aggressive policing, incarceration, and the murder of African Americans. Green points to climate justice, an approach to climate change that exceeds capitalist emphases on carbon markets and green commodities to encompass the dismantling of the carbon-based economy and the global redistribution of wealth.¹ **The three colors should not be read as three separate issues or groups. They should rather be understood as a kind of mutually supporting scaffold.** An equitable response to the changing climate, for example, is incompatible with the continuation of capitalism. **A communism anchored in extractive industry is incompatible with the mitigation of** and adaptation to **climate change. Antiracism directs our attention to those most likely to be exploited** and sacrificed **in market-driven schemes** to address climate change. It also marks the fact of the history of divisions within the Left that have stood in the way of our forging collective counterpower.¹ Here and now, movements are pushing the organizational convergence of communist, climate, and race politics. Moral Mondays, the ongoing protests in North Carolina, bring together an array of political concerns around racial justice, cuts to public services, and the environment. These protests include marches and acts of civil disobedience. The heartbreaking reminder that “Black lives matter” calls for the abolition of structures of institutionalized power that continue to impoverish, imprison, and kill black people everywhere. Protests in Ferguson, Missouri, in the wake of the murder of Michael Brown, have turned the spotlight on the militarization of the police and the buildup of state forces for the defense of the wealthy and white against the proletarianized—poor, brown, and black. Similar buildups of police borders in the United States and abroad attempt to push back the many on the move in response to the “catastrophic convergence” of decades of violent expropriation and climate change (Parenti 2011). **The demand for climate justice places the economic inequalities accompanying and constitutive of capitalist “development” at the center of global discussions of climate change.** Images from New Orleans after Hurricane Katrina and terms like “sacrifice zones” help articulate the two. **Every time an activist reminds us that issues can't be considered in isolation** or every time a student repeats the mantra of intersectionality, **the Left is instructing itself to make connections and formulate a politics capable of grasping complexity and of changing the world.** **The party is a form for that connecting. It provides a location where we see and relate to ourselves as comrades, as solidary members of a fighting collective.**

The alternative is to endorse ‘The Party’. Debate is a space for political organizing towards collectivity. This is mutually exclusive with the 1AC.

Jodi Dean 16, Professor of Political Theory at Hobart and William Smith Colleges, 2016, Crowds and Party

Crowds and Party comes out of this moment of collective de-subjectivation. Occupy Wall Street foundered against a contradiction at its core. The individualism of its democratic, anarchist, and horizontalist ideological currents undermined the collective power the movement was building. Making collective political action dependent on individual choice, the “theology of consensus” fragmented the provisional unity of the crowd back into disempowered singularities.³ The movement’s decline (which began well before Occupiers were evicted) exposes the impasse confronting the Left. The celebration of autonomous individuality prevents us from foregrounding our commonality and organizing ourselves politically. At the same time and together with the global wave of popular unrest, the collective energy of Occupy at its height nevertheless points to an “idea whose time has come.” People are moving together in growing opposition to the policies and practices of states organized in the interest of capital as a class. Crowds are forcing the Left to return again to questions of organization, endurance, and scale. Through what political forms might we advance? For many of us, the party is emerging as the site of an answer. Against the presumption that the individual is the fundamental unit of politics, I focus on the crowd. Across the globe, crowds are pressing their opposition and rupturing the status quo, the actuality of their movement displacing the politics of identity. Bringing together thinkers such as Elias Canetti and Alain Badiou, I highlight the “egalitarian discharge” of the crowd event as an intense experience of substantive collectivity. I make fidelity to this event the basis for a new theory of the communist party. Because global movements are themselves pushing us to consider the possibilities in and of the party form, we have to recommence imagining the party of communists.⁴ Who might we be and become as an international revolutionary party again, in our time? To think clearly about these questions, we need to consider the party form unfettered by the false concreteness of specific parties in the contingency of their histories. Liberals and democrats are not the only political theorists who can reflect on their modes of association in the abstract. Communists must do this as well. As a means of breaking out of the binaries of reform or revolution, mass or vanguard party that historically have inflected discussions of the party form, I approach the function and purpose of the communist party psycho-dynamically. I draw from Robert Michels and Jacques Lacan to think through the affects the party generates and the unconscious processes it mobilizes. The role of the party isn’t to inject knowledge into the working class. Nor is it to represent the interests of the working class on the terrain of politics. Rather, the function of the party is to hold open a gap in our setting so as to enable a collective desire for collectivity.⁵ “Through such a gap or moment,” Daniel Bensaïd writes, “can arise the unaccomplished fact, which contradicts the fatality of the accomplished fact.”⁶ The crowd’s breach of the predictable and given creates the possibility that a political subject might appear. The party steps into that breach and fights to keep it open for the people. Canetti makes a point I return to throughout the book: crowds come together for the sake of an absolute equality felt most intensely in a moment he refers to as the “discharge.” Akin to Lacan’s notion of “enjoyment” (“jouissance,” the only substance known to psychoanalysis), the discharge provides a material ground for the party. The party is a body that can carry the egalitarian discharge after the crowds disperse, channeling its divisive promise of justice into organized political

Free Market Best

High costs are a product of government mandates that undermine competition and distort the risk pool---causes insurers to hike premiums or leave the market---that's Schansberg

Competition makes high cost health care mathematically impossible

Kel Kelly 11, Wall Street trader, a corporate finance analyst, and a research director for a Fortune 500 management consulting firm. 3/9/11, "The Myth of Free-Market Healthcare"
<https://mises.org/library/myth-free-market-healthcare>

Every election cycle, we hear politicians talk only of cost controls, electronic medical records, and preventing lawsuits in order to solve our medical crisis. **We do not hear from them discussions of the real problems of government-paid insurance, the third-party-payer system, and medical boards.**

Some pundits argue that technology increases medical costs. Though technology lowers costs in other industries, people think that it somehow increases costs in the healthcare industry. Indeed, Paul Krugman claims that healthcare costs rise simply "because of medical progress."^[11] **With these kinds of backward notions, our "leaders" set out to implement yet more regulation and price controls, which will only exacerbate the problem.**

What **we need** are truly **free markets in healthcare, which would bring about an increased supply of doctors and healthcare facilities, and drastically lower costs. By bringing free-market profits to the industry, the quality of care would improve due to the competition of providers to make the most money by trying to please the most consumers.**

Healthcare costs used to represent 5 percent of national income, and now it is 17 percent.^[12] Each year, due to increased demand paid for by companies and the government, a greater proportion of our income is funneled into healthcare expenditures and a smaller proportion into other goods. Under free markets, healthcare prices would fall in real terms (if not also nominal terms), and **the cost of staying in a hospital would approximate the costs of staying in a hotel plus the additional marginal costs of the labor services of nurses and doctors, and the costs of the use of the tools and technology.**

If we all paid for our own healthcare, instead of having others pay, **it would be mathematically impossible for costs to be at a level above what each of us could afford; doctors and hospitals could not make as much money if they charged more than people could afford to pay. This is why we can afford things in other industries – because goods are priced at a level commensurate with our incomes.** The key is to pay for our own healthcare as needed. **Costs of healthcare would be affordable to everyone in the same way that food, televisions, and tools at Home Depot are;** they would be just another average cost that we pay.

Cosmetic surgery proves

Mark J. Perry 15, is concurrently a scholar at AEI and a professor of economics and finance at the University of Michigan's Flint campus. 4/7/15, "What economic lessons about health care can we learn from the market for cosmetic procedures?" <http://www.aei.org/publication/what-economic-lessons-about-health-care-can-we-learn-from-the-market-for-cosmetic-procedures/>

How would the market for medical services operate differently if consumers were paying out-of-pocket for medical procedures in a competitive market? Well, we can look to the \$7.5 billion US market for elective cosmetic surgery for some answers. In every year since 1997, the American Society for Aesthetic Plastic Surgery has issued an annual report on cosmetic procedures in the US (both surgical and nonsurgical) that includes the number of procedures, the average cost per procedure (starting in 1998), the total spending per procedure, and the age and gender distribution for each procedure and for all procedures. Here is a link to the press release for the 2014 report, and the full report is available here.

(Note: Interestingly, there is a huge gender imbalance for cosmetic procedures – women accounted for 90% of the 10.6 million cosmetic procedures last year.)

The table above (click to enlarge) shows the top five most popular surgical procedures and top five most popular non-surgical procedures for 2014, the number of each of those procedures performed last year, the total expenditures for each procedure, the average price per procedure both in 1998 and 2014 (in current dollars), and the percent increase in price since 1998 for each procedure. Here's what's interesting:

1. For the top ten most popular cosmetic procedures last year, none of them has increased in price since 1998 more than the 45.8% increase in consumer price inflation (the price for the hyaluronic acid procedure wasn't available for 1998), meaning the real price of all of those procedures have fallen over the last 16 years.
2. For three of the top five favorite non-surgical procedures in 2014 (botox, laser hair removal and chemical peel), the nominal prices have actually fallen since 1998 by large double-digit percentage declines of -23.6%, -31.2% and -30.1%. That is, those prices have fallen in price since 1998, even before making any adjustments for inflation.
3. Most importantly, none of the ten cosmetic procedures in the table above have increased in price by anywhere close to the 88.5% increase in medical care services since 1998. The 33.7% average price increase since 1998 for last year's top five most popular surgical procedures, isn't even close to half of the 88.5% increase in the cost of medical care services over the last 16 years.
4. For the other dozen or so cosmetic procedures not displayed above, but for which there are prices both in 1998 and 2014, there were only three procedures that increased in price by more than the 45.8% increase in general prices, but the price increases were all below the 88.5% increase in the cost of medical services: chin augmentation (+69.7%), upper arm lift (+65.3%) and buttock lift (+46.7%).

MP: The competitive market for cosmetic procedures operates differently than the traditional market for health care in important and significant ways. Cosmetic procedures, unlike most medical services, are not usually covered by insurance. Patients paying out-of-pocket for cosmetic procedures are cost-conscious, and have strong incentives to shop around and compare prices at the dozens of competing providers in any large city. Because of that market competition, the prices of almost all cosmetic procedures have fallen in real terms since 1998, and some non-surgical procedures have even fallen in nominal dollars before adjusting for price changes. In all cases, cosmetic procedures have increased in price by less than the 88.5% increase in the price of medical care services between 1998 and 2014.

Question: If cosmetic procedures were covered by insurance, Medicare and Medicaid, what would have happened to their prices over time? Basic economics tell us that those prices would have most likely risen at about the same 88.5% increase in the prices of medical services between 1998 and 2014. And perhaps another economic lesson here is that the greater the degree of market competition, price transparency and out-of-pocket payments, the more contained prices are, in health care or any other sector of the economy. On the other hand, the greater the degree of government intervention, opaque prices and third-party payments, the less contained prices are, in health care or any other sector of the economy.

Consumer Directed Health Plans prove

Kevin Dayaratna 13, Senior Statistician and Research Programmer, Center for Data Analysis, Institute for Economic Freedom and Opportunity. 12/20/13, "Compelling Evidence Makes the Case for a Market-Driven Health Care System" <http://www.heritage.org/health-care-reform/report/compelling-evidence-makes-the-case-market-driven-health-care-system>

Empirical Evidence: Consumer-Directed Health Plans

The U.S. health care system is generally not a competitive marketplace. In particular, current law largely restricts consumers to purchasing insurance within their own states. Additionally, current tax policy offers a tax advantage to employer-based health insurance but not individually purchased insurance, causing most Americans to gravitate toward job-based coverage instead of buying insurance on their own. These distortions, generated by government policy, have largely insulated consumers from their health care choices.[12]

The dearth of true competition in the health care industry does not mean, however, that there is no evidence of what type of health care consumers might choose in a competitive environment. In fact, there have been numerous academic studies that shed light on the subject and point to the very positive impact consumer choice would have on costs and quality.

Several studies strongly suggest that health care shares many common characteristics with competitive industries. In a 1994 study published in the Journal of Health Care Marketing, Goutam Chakraborty, Richard Ettenson, and Gary Gaeth studied patient choice in health insurance and determined nearly 20 factors significantly affected what consumers selected in terms of health insurance. The most notable factors were hospitalization coverage, the choice of physicians, insurance premiums, dental coverage, and options for choosing hospitals.[13]

Since the Chakraborty study, a series of peer-reviewed academic papers have consistently shown consumers to be highly sensitive to health insurance premiums, with a willingness to switch to more cost-efficient plans.[14] Other research has found that providing consumers with information about quality raises this sensitivity.[15] A number of other studies have found that even hospital choice is driven by consumer decision making.[16] The proliferation of information online, accessible by people of all income levels, has made comparing medical providers easier than it has ever been.[17]

One of the most important developments in health policy in recent years has been the rapid growth of consumer-directed health plans (CDHPs). CDHPs constitute a fundamental change in the manner in which health care has traditionally functioned by placing the focus on consumers. Through tax-free health savings accounts (HSAs) and health reimbursement accounts (HRAs), CDHPs **allow consumers to treat their health care expenses as they would other expenses. These plans are often associated with high-deductibles for catastrophic care. Many studies have confirmed that CDHPs are effective at decreasing the rate of growth of health spending and create pressure for much greater price transparency.**[18]

These results should not be surprising. One of the most well-known studies of consumer behavior in health care, by economist Joseph Newhouse of the RAND Corporation, found that those who had "free" health care consumed more care than they needed.[19] In other words, consumers are price sensitive in health care, just as they are in every other sector of the economy. Since the RAND study, there has been a significant body of academic research suggesting that CDHPs can lower spending and make people more prudent about their health care expenditures, including use of hospital and physician services and the purchase of prescription drugs.[20]

The CDHP concept was tested prominently in the state of Indiana. Then-Governor Mitch Daniels (R) signed the Healthy Indiana Plan into law, offering HSA plans to employees of the state and their families. An evaluation of the plan by Mercer found that the HSAs decreased the state's health care expenses by roughly 11 percent. The evaluation suggested a distinct change in behavior as consumers had begun to ask important questions about providers and treatments, as well as about the prices of generic medications.[21] These results indicate that the HSAs worked as planned: **Consumers became engaged, and the market pressure that resulted produced better results for the state's taxpayers as well as those enrolled in the plans.**

Some critics have asserted that CDHPs will cause people to underuse necessary care.[22] There is plenty of evidence suggesting otherwise, however. In a properly functioning market, CDHPs, and their variants, will compete with more traditional health insurance plans. With easily accessible information, consumers will be able to properly decide which plans are best for them.[23] Some with chronic illnesses may choose to stick with more traditional, comprehensive plans, whereas others may migrate toward CDHPs or their variants.

Other critics contend that CDHPs will attract healthy low-risk enrollees and traditional plans will subsequently consist of more chronically ill patients at a higher cost.[24] This phenomenon is known as "adverse selection." A recent study published in Health Services Research investigated the presence of adverse selection in the health offerings from the University of Minnesota. In the study, employees had the option to choose a CDHP or a more traditional plan. The study found no evidence that CDHPs had disproportionately enrolled lower-risk individuals.[25]

Moreover, appropriate risk-adjustment mechanisms should minimize the distortions from risk segmentation among competing insurers.

segmentation among competing insurers. In fact, proper risk-adjustment mechanisms can help stimulate the development of innovative and integrated approaches to treating the most chronically ill patients, as recent research has suggested.[26]

Singapore proves

Megan McArdle 12, former senior editor at the Atlantic, 3/8/12, "The Myth of the Free-Market American Health Care System," <https://www.theatlantic.com/business/archive/2012/03/the-myth-of-the-free-market-american-health-care-system/254210/>

The other important market-oriented counterexample is Singapore. Singapore has, arguably, **the most market-oriented system in the world**. Singapore's GDP per capita is about 20 percent higher than America's, with comparable (if not higher) health outcomes, and spends an absurdly low amount on health care relative to the West. How do they do it?

The counterplan leads to health status insurance---Solves pre-existing conditions, job lock, and coverage

John H. Cochrane 9, Myron S. Scholes Professor of Finance at the University of Chicago Booth School of Business, 2/18/09, "Health-Status Insurance How Markets Can Provide Health Security"
<https://object.cato.org/sites/cato.org/files/pubs/pdf/pa-633.pdf>

The Problem of Long-Term Insurance

None of us has health insurance, really. Most Americans have coverage through their employer, or the employer of a parent or spouse. **But suppose you get cancer, heart disease, HIV, have a stroke, discover a genetic defect, or develop any other long-term expensive health problem—and then lose your job, divorce, outgrow your parents' plan, or your employer or insurer goes out of business. You lose your health coverage. You now have a preexisting condition, and insurance will be enormously expensive—** if it's available at all. This happens to real people. A significant and expensive health problem is a common root cause of catastrophic economic descents in the United States. Many people stick with bad jobs or bad marriages just to keep their health insurance.

The lack of secure, long-term, portable health insurance is the greatest single problem with our current health care system. Solving this problem is a central goal of every health care reform proposal from all parts of the political spectrum. There are plenty of other problems with our health sector: the uninsured, hospitals' hotel-minibar pricing policies, poor information, the drudgery of useless paperwork, cost recovery of new medicines, optimal copayment levels, and so on. But all of these are fairly clear problems, each limited in its reach, with fairly clear remedies. The lack of long-term insurance, by contrast, seems a harder nut to crack. And unlike, say, the plight of the uninsured, it is a problem that faces each of us directly.

Free and competitive markets are the best way to spur innovation, provide better service, and reduce costs. So far, however, many people have thought that competition undermines long-term insurance, leading to the extensively regulated market we now face and to proposals for further regulation. **Health-status insurance lets us break out of this dilemma. Health-status insurance can give us both completely portable, lifetime health insurance and great individual freedom of choice in a deregulated, competitive—and hence—efficient and innovative market.**

Unsurprisingly, **health-status insurance requires** a thoughtful **deregulation of insurance markets, starting with an end to the strong tax and regulatory preference for employer provided group coverage.** It does not need a

new layer of regulation. The small individual insurance market is already starting to feel its way toward health-status insurance. The deregulatory path will allow this effort to blossom fully.

Health-Status Insurance

Market-based lifetime health insurance has two components: medical insurance and health-status insurance. 1 Medical insurance covers your medical expenses in the current year, minus deductibles and copayments. Health-status insurance covers the risk that your medical insurance premiums will rise. If you get a long-term condition that moves you into a more expensive medical insurance premium category, health-status insurance pays you a lump sum large enough to cover your higher medical insurance premiums, with no change in out-of-pocket expenses.

Why can't medical insurers just charge everyone the same premium? In a competitive market, medical insurers must charge sick people higher premiums, and charge healthy people lower premiums. If an insurer charged everyone the same price, then a competitor could woo away healthy low-cost customers, and the original insurer would go out of business. Furthermore, the main reason insurance companies refuse coverage, deny coverage for preexisting conditions, or more subtly avoid or mistreat people with long-term expensive conditions, is that they cannot charge those people enough to cover their costs. If medical insurers can charge enough, they will compete for the business of every customer, even the sickest. Freely risk-rated, competitive medical insurance gives everyone access, albeit at a cost. It leaves people vulnerable to the financial risk of large premium increases, but health-status insurance would fill that gap.

The combination of health-status insurance and competitive, freely priced medical insurance solves the central problem of our current health insurance market: the lack of real, long-term, portable health security. With health-status insurance, you can always get medical insurance, no matter if you get sick, change or lose jobs, move, divorce, take some time out of the labor force, or even let your medical insurance lapse. The lump-sum payment from the health-status insurer means you can always pay your medical insurance premiums.

Health-status insurance would also give each of us much greater freedom and choice. No matter how sick you become, you would always be free to change medical insurers. You could always afford the higher premiums a new medical insurer will demand, just as you could afford the higher premiums your current insurer will require. You would not depend on the good treatment of one insurer, the vagaries of one group, the link to one employer, or the bureaucratic decisions of one government-provided plan.

Best of all, when every consumer is free to switch insurers at any time, medical insurance companies will compete for everyone's business. They will compete for the business of expensive, high-risk customers, rather than try to get rid of them or "contain their costs." They can also compete for the business of people who are currently healthy, as such competition will not undermine the implicit cross-subsidy to people with preexisting conditions. Constant competition for every consumer will have the same dramatic effects on cost, quality, and innovation in health care as it does in every other industry.

In sum, health-status insurance can simultaneously give us complete and portable long term insurance, great individual choice, and cost-containment beyond the dreams of any health policy planner. And, as I show below, it doesn't cost consumers anything. The combined health-status and medical insurance premiums are the same as those of a lifetime individual insurance contract, and the same in present value terms as those of a (hypothetical) successful group or pooling program, even before we factor in cost savings from greater competition.

And, it solves children and truly pre-existing conditions--starting with government subsidization of health-status accounts gets the process started, and leads to a system of total coverage

John H. Cochrane 9, Myron S. Scholes Professor of Finance at the University of Chicago Booth School of Business, 2/18/09, "Health-Status Insurance How Markets Can Provide Health Security"
<https://object.cato.org/sites/cato.org/files/pubs/pdf/pa-633.pdf>

and a Research Associate at the National Bureau of Economic Research.

What about People Who Are Already Sick?

Private insurance cannot cover events that have already happened. You can't tell an insurance company, "My house just burned down. How about some insurance?"

Many people feel that government should insure events that have already happened, especially when no insurance was available and the unfortunate are in some sense blameless. Health-status insurance accounts offer a good way to help people who are already sick. The government could simply deposit money in an individual's health-status insurance account and then get out of the way. Private charities could help people in the same way. This is much more straightforward, flexible, and **less distortionary** of markets **than directly running a government-sponsored health insurance plan**, or forcing private insurers to take such patients and treat them well.

The problem of people who have preexisting conditions is most critical at start up, when people will not yet have had a chance to buy health status insurance. **Once health-status insurance is widely available, people will be able to insure against more events than one might think. Parents could buy family insurance that provides health-status insurance accounts for their children.** Then, **children who develop rare long-term diseases would be covered for life** without government intervention. **Health-status insurance could even apply to unborn children, and thus insure against genetic defects from birth.**

Having the government set up such accounts for people with preexisting conditions might also be useful in getting the whole process going. This step would establish the legal and regulatory framework for health-status insurance accounts, and it could be done at the same time government deregulates premiums: regulators and legislators would be more willing to allow free risk-rating if they knew that the most vulnerable populations could afford the extra payments.

Even if the CP doesn't solve pre-existing conditions, it massively increases coverage from the status quo baseline

Avik Roy **16**, Senior Fellow at the Manhattan Institute for Policy Research, and author of The Apothecary, a Forbes blog on health-care and entitlement reform, 11/12/16, “Donald Trump Is Right: You Can Repeal Obamacare And Still Cover Everyone With Pre-Existing Conditions,” <https://www.forbes.com/sites/theapothecary/2016/11/12/donald-trump-is-right-you-can-repeal-obamacare-and-still-cover-everyone-with-pre-existing-conditions/#4cc7e18875a5>

In addition, **contrary to Democratic talking points, very few people are uninsured because they have a pre-existing condition. A pre-Obamacare Congressional Budget Office study found that, among the uninsured, only 3.5 percent were uninsured because their health was too poor to qualify. On the other hand, 71 percent said they were uninsured because of the high cost of insurance.**

State Lines

Allowing insurers to compete across state lines lowers premiums and increases coverage---onerous regulations are responsible for high costs

Kevin Dayaratna 13, Senior Statistician and Research Programmer @ The Heritage Foundation, 8/19/13, "Competitive Markets in Health Care: The Next Revolution," <http://www.heritage.org/health-care-reform/report/competitive-markets-health-care-the-next-revolution>

Due to the McCarran–Ferguson Act of 1945, group and individual health insurance must largely be purchased within one's own state.^[6] Consequently, lobbyists have persuaded local and state officials to mandate extraneous benefits on insurance companies. Such regulations include mandates for alcoholism treatment (45 states), smoking-cessation programs (two states), drug-abuse treatment (34 states), acupuncture (11 states), chiropractic care (44 states), naturopathy (four states), and hair pieces (10 states). In some cases, consumers are required to purchase coverage for services that they might be better off financially purchasing directly. Such services include mammograms (50 states), treatment for cervical cancer (29 states), colorectal cancer (28 states), newborn hearing (17 states), ovarian cancer (three states), prostate cancer (33 states), uncomplicated deliveries (21 states), and well-child care (31 states).^[7] These state-based mandates, coupled with other onerous regulations, drive up the cost of health insurance.^[8]

In 2011, Stephen Parente, Roger Feldman, Jean Abraham, and Yi Xu published research in the Journal of Risk and Insurance about developing a national marketplace for individual health insurance.^[9] Using 2005 Medical Expenditure Panel Survey data, they performed a series of microsimulations to determine how the market would evolve if consumers could purchase health insurance across state lines. They looked at a number of options, including dividing the country by regions and allowing for regional competition among state-based insurance markets as well as a nationally competitive market. Their results suggest that reforms to enable people to purchase insurance across state lines could lower the number of uninsured Americans by over 12 million due to reduced premiums. The Parente et al. study thus clearly illustrates that a competitive, national marketplace for health insurance could greatly expand consumer choice and reduce costs.

AT Healthcare is Different

Healthcare isn't different---it can function like any other free market

Kevin Dayaratna 13, Senior Statistician and Research Programmer, Center for Data Analysis, Institute for Economic Freedom and Opportunity. 12/20/13, "Compelling Evidence Makes the Case for a Market-Driven Health Care System" <http://www.heritage.org/health-care-reform/report/compelling-evidence-makes-the-case-market-driven-health-care-system>

Debunking the Claims Against Markets in Health Care

Many economists believe that health care is inherently different from other industries and cannot operate in a normal marketplace. They argue that governmental regulation, however unsatisfactorily it may be administered, is better than allowing a dysfunctional marketplace to misallocate resources and generate inequities.

These views generally rest on the theoretical arguments offered by distinguished economist Kenneth Arrow some two generations ago.[5] In a famous 1963 essay, **Arrow identified a number of characteristics of health care that, he argued, made it unsuitable for normal competition in the marketplace:**

Health care expenses are random and therefore not predictable.

Health care is plagued by barriers to entry for potential new suppliers of services.

Health care requires trust in the doctor–patient relationship.

Providers have more information than patients; therefore, patients are not capable of making well-informed decisions.

Patients do not see bills until after services have been offered.

Although some of **these points** are indisputable, collectively they **do not necessarily mean that the country is better off with a heavily regulated approach to health care** as opposed to one driven more by market forces.

For starters, the question is one of balance. The health system will always be regulated to some degree, such as with licensure requirements for physicians and oversight of insurance. The question is: To what degree will market prices and competition in the health sector be given the necessary space to work, or will Arrow's arguments lead policymakers to adopt a completely regulated approach to allocating health resources?

Recently, Avik Roy of the Manhattan Institute studied Arrow's points and made the case that they should not prevent a move toward a market-based system.[6] First, Roy points out that **the concept of unpredictable expenses is not unique to health care.**

From durable goods to services, people purchase extended warranties to protect against unforeseen catastrophic failures. Health insurance serves the same purpose.

Additionally, **Roy suggests that in many industries—including the airline, finance, and legal sectors of the economy—there are barriers to entry for new entrants.** **Barriers** to entry, however, **are no reason to completely abandon a market system.** Of course, market barriers in medicine are particularly onerous and fundamentally distort provider supply. Certificate-of-need laws make it difficult for hospitals to expand, for instance.[7] These barriers, however, should not be accepted as unchangeable facts; on the contrary, policymakers should work toward lowering them.

Evidence from other countries illustrates why lowering these barriers to entry is important. In India, Devi Shetty, a surgeon, has taken advantage of economies of scale to develop large, 1,000-bed hospitals that make health care more affordable. Dr. Shetty's heart treatment hospital charges \$2,000 for open-heart surgery—American hospitals average slightly more than 150 beds and charge between \$20,000 and \$100,000—while providing high-quality care.[8] Dr. Shetty is currently setting up a chain of similar hospitals in the Cayman Islands to make his services more accessible to patients from the United States as well as the rest of the world.[9]

Roy also points out that the significance of trust is not unique to health care markets. Trust is required in many simple economic transactions, such as purchasing a car or buying a plane ticket, and is important in many other industries, ranging from clothing stores to airlines. In these and other industries, the concept of building trust has become an important aspect of customer relationship management.[10]

Furthermore, informational asymmetry is not nearly as much of a problem today as it may have been in the past. A number of academic studies suggested that, when offered meaningful information, consumers make well-informed decisions. Additionally, as a result of the proliferation of computer technology and websites such as WebMD.com, NJHospitalCompare.com, and PharmacyChecker.com, health care information has become radically more accessible to consumers of all income levels.[11]

Arrow's final criticism, that delayed billing is inherent in health care, is not true, as a growing number of examples indicate. When consumers are more directly engaged in paying for health services, pre-service price transparency becomes the norm rather than the exception.

AT Too complex/No information

Data disproves their argument

David **Brooks** 17, Op-Ed Columnist for NYT, Professor at Yale University, 1/13/17, "Do Markets Work in Health Care?" <https://www.nytimes.com/2017/01/13/opinion/do-markets-work-in-health-care.html>

Proponents of market-based health care rely less on theory and more on data. The most fair-minded review of the evidence I've read comes from a McKinsey report written by Penelope Dash and David Meredith. They noted that sometimes market forces lead to worse outcomes, but "we have been most struck by health systems in which provider competition, managed effectively, has improved outcomes and patient choice significantly, while at the same time reducing system costs."

There's much research to suggest that people are able to behave like intelligent health care consumers. Work by Amitabh Chandra of Harvard and others found higher-performing hospitals do gain greater market share over time. People know quality and flock to it.

Furthermore, health care providers work hard to keep up with the competitors. When one provider becomes more productive, the neighboring ones tend to as well.

There are plenty of examples where market competition has improved health care delivery. The Medicare Part D program, passed under President George W. Bush, created competition around drug benefits. The program has provided coverage for millions while coming in at 57 percent under the cost of what the Congressional Budget Office initially projected. A study of Indiana's health savings accounts found the state's expenses were reduced by 11 percent.

Laser eye surgery produces more patient satisfaction than any other surgery. But it's generally not covered by insurance, so it's a free market. Twenty years ago it cost about \$2,200 per eye. Now I see ads starting at \$250 an eye.

There's a big chunk of evidence that market incentives would work in health care, especially in non-acute care. The harder problem for Republicans may be political. This is a harried society. People may not want the added burdens of making health care decisions on top of all the others. This is a distrustful society. People may not trust themselves or others to make decisions. This is an insecure society. People may not want what they perceive as another risk factor in their lives.

The problem is government mandates---removing them makes buying insurance simple

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<http://healthaffairs.org/blog/2016/10/11/the-future-of-the-acas-exchanges/>

The private sector is much better positioned to market products effectively to the American consumer. The rules for using premium (or tax) credits to purchase coverage should be eased substantially to allow consumers to purchase a plan outside the exchange, or through a privately run portal. This kind of competition, if allowed within a single regulatory framework (including risk adjustment mechanisms) would improve outreach and the quality of the process for selecting an insurance product.

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The Affordable Care Act is much more than the exchanges that were set up to facilitate the individual insurance market. The law expanded Medicaid, implemented far-reaching changes in Medicare, imposed new requirements on employer-sponsored insurance plans, increased federal spending by hundreds of billions of dollars over a decade, and raised taxes on individual and numerous industries in the health sector. Opponents of the law have significant and legitimate concerns over the direction of all of these changes, in addition to their concerns about the viability of the exchanges. It is highly unlikely that they would set aside these concerns and agree to a narrowly written plan to make modifications just to the ACA's exchange framework.

Nor, in our opinion, would that be advisable. The problems emerging in the exchanges are a symptom of a larger disease, which is that the ACA moved far too much power and regulatory control over the health sector to the federal government. Building a broader consensus around reform of the individual insurance market will almost certainly require revisiting other fundamental aspects of the ACA that have sharply divided policymakers.

The ACA exchanges will not be able to continue indefinitely without substantial reform. But reform will only be possible if the American public believes that this will not merely be another intrusion into their personal health decisions and their wallets. It will be up to Congress and the next President to decide if America's health care system is worth the political risk needed to enact responsible and necessary reforms.

Information on health is readily available---patients acting as informed consumers is the new norm

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The physician-patient relationship today bears a much diminished relationship compared to what it used to be. Physicians no longer command the same authoritarian and semi-priestly status of earlier years. Higher education and medical information levels diminish the need for patients to depend entirely on medical authority.

Accordingly they have become less acquiescent and submissive. To be sure, physicians continue to be held in high regard, but without the mystique and awe commanded when medicine was more of a mystery to an uninformed public. Whereas patients formerly tended to rely totally on physicians to make medical decisions on their behalf and complied without question to medical authority, a more highly educated public and the greater availability of user-friendly medical information enables them to be more independent and assertive in matters concerning their health treatment choices.

Greater transparency of clinical data together with information on the quality and cost of hospital and physician services on a provider specific basis, all of which is easily accessible on the Internet and in consumer information publications, underlies the process whereby patients are being transformed into consumers (for more on this transformation, see Herzlinger 1997). Thus shopping around for the best medical care is becoming the norm, and the seeking of second opinions, something eschewed in the past by physicians as errant patient behavior, is now openly encouraged and a synonym for rational behavior.

As consumers, individuals now want to know more about the various treatment alternatives available to them along with the latest evidence on the benefits and risks involved. Such behavior differs markedly, of course, from the old physician-patient model in which medical information was considered beyond the comprehension of laypersons and anxiety over the seriousness of symptoms rendered individuals incapable of reliably acting on their own behalf.

Health care isn't too complex---doctor's solve and the bureaucracy is worse

Lee Kurisko 15, Canadian physician, radiologist with Consulting Radiologists Ltd. 11/20/15, "WHY SINGLE PAYER IS NOT THE ANSWER" <https://www.medibid.com/blog/2015/11/why-single-payer-is-not-the-answer/>

A free market in health care would have three pillars.

The patient/consumer controls the cash. Prices would then have to be transparent and aligned with what people are willing to pay.

The system would be based on true insurance. Insurance normally is a vehicle to buffer risk for large unexpected financial losses. If your roof blows off, homeowners insurance kicks in. It doesn't when you need a new bottle of floor wax. We all can expect to have minor illnesses and injuries. Rather than paying massive taxes and/or insurance premiums to third parties that tell us what the money can be used for, we should keep the majority of this money ourselves and make purchase decisions in conjunction with our doctors. Even when expensive care is needed, insurance reimbursement should go to the patient/consumer to spend in a competitive market. **People will claim that healthcare is too complex for people to make their own decisions. Computers and cars are complex also, but it is easy to seek out enough information to make informed purchase decisions. If a patient working with his or her trusted physician cannot make these decisions, why would you expect a nameless, faceless bureaucracy to do so?**

The role for charity in a free market cannot be understated. Alieta and John Eck in New Jersey were going broke seeing Medicaid patients and so opened a free clinic in their church basement with the aid of volunteer doctors, nurses, and support staff. The cost of a Medicare patient being seen in the local ER is at least 1000 taxpayer dollars. In the local federally qualified health clinic, it is 160 dollars also from the taxpayer. In their private clinic, the cost averages 13 dollars all paid for through voluntary charity. They have a waiting list for people that want to volunteer. For hospital-based care, we need to look at tax credits or deductions for charity care rather than regulations and price controls. Most people are decent human beings that do not want their fellow mankind to suffer. People want to help. **Government needs to get out of the way.**

Would a free market be perfect? No it would not. Utopia does not exist and the word was coined from Greek meaning "no place". It is not in any person's power to create a perfect world, but **if government would get out of the way, we can make a better world.**

Health Innovations

Eroding US innovation capacity fuels Chinese rise---disrupts power balance

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I am not a supporter of the faddish idea that America is in decline. Despite all the hullabaloo about the rise of China, the United States Still boasts the most formidable military force and the largest, most innovative economy. But as a student of international studies, I am keenly aware that the rise and fall of great nations are often associated with significant historical events. It is hard to deny that the 2008 financial crisis exposed the Achilles' heel in our economy and accelerated the shift in the international power balance. This month, the self-inflicted U.S. government shutdown highlighted the partisanship and immobilism in our political system and undermined our ability to engage with the outside world. China for example lost no time in questioning U.S. global leadership, urging all emerging countries to consider building of a "de-Americanized world." At the same time, an OECD report forecast that China will overtake the United States in 2016 to become the world's largest economy.

One might argue that these developments do not represent a permanent setback to U.S. global leadership – after all, we continue to enjoy unrivaled advantage in the ability to innovate, a critical pillar of U.S. superpower status. Since the mid-19th century, the United States has been the engine of almost all the major technological advancements. Indeed, nine of the eleven 2013 Nobel Prize winners in science and economics are U.S.-based. In a 2012 article, Gary Shapiro attributes the U.S. strength in innovation to "[a] can-do attitude, a free market system that rewards savvy risk takers[,] an education system that encourages questions rather than rote learning [, and a] First Amendment that promotes different views without government censorship." In contrast, any major innovation efforts in China have to struggle with a social-political system that supports censorship and corruption, and suppresses curiosity and creativity. The miraculous economic growth in China, to paraphrase Paul Krugman, was largely the result of perspiration (manufacturing capacity) rather than inspiration (technology innovation). Take Chinese pharmaceutical industry: despite the size of Chinese pharmaceutical exports – averaging \$67 billion annually – virtually none of the revenue is derived from truly innovative products. Up until 2007, roughly 97 percent of chemicals produced in China were generic, and only two drugs—artemisinin and dimercaprol—were developed domestically.

The past decade, however, has witnessed the rapid erosion of the financial and institutional underpinnings of innovation in the United States. Our free market system rewards risk takers at the expense of the general public, many of our politicians (and the political system itself) seem to have lost their ability to be effective, and our kids lag globally in math and science. Simply, we have been increasingly unable to innovate, compete, and get things done. As Tom Friedman observed, "too many of our poll-driven, toxically partisan, cable-TV-addicted, money-corrupted political class are more interested in what keeps them in power than what would again make America powerful, more interested in defeating each other than saving the country."

The sapped U.S. strength in innovation is epitomized by the NIH research funding trends. Between 2003 and 2013, the number of applications increased from nearly 35,000 to more than 51,000, while NIH appropriations shrunk from \$21 billion to \$16 billion (in 1995 dollars). As a consequence, it has become increasingly difficult for our scientists to garner an NIH grant. Overall application success rates fell from 32 percent in 2000 to 18 percent in 2012. This is particularly bad news for the new applicants, most of whom are young scientists who are at their most productive age and are most in need of grant support: not only have the number of research project grants dropped in absolute numbers, but the success rates for first-time award recipients has dropped from 22 percent to 13 percent.

The story is dramatically different on the China side. The government is determined to be the next technology innovation center in the world. By 2011, China had already become the world's second highest investor in R&D. Government research funding has been growing at an annual rate of more than 20 percent. At the end of 2012, for example, 7.28 billion yuan was spent on promoting life and medical sciences, nearly 10 times the 2004 level. Even more troubling (for the United States), in 2011, 21 percent of the applications were supported, and for young scientists, the application success rate was 24 percent, both of which were higher than the U.S. level. It was predicted that if the U.S. federal government R&D spending continues to languish, China may overtake the U.S. to be the global leader in R&D spending by 2023.

Of course, being the leader in R&D spending does not automatically make China the next innovation center. China's research culture suffers problems of cronyism, mismanagement and ineffectiveness. But continuing to cut U.S. research funding while China's research spending soars could lead to a brain drain and even

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further, **the abdication of the United States as an innovation leader**. If you still think this sounds alarmist, just read what a professor from George Mason University said: "I have just laid off my technician and will lose my postdoc in six months. My Ph.D. students need funds to finish their degrees, and now they are working in the lab without pay. The lab may have to be closed. I will move my lab to China."

Causes nuclear war

Graham Allison 17, an American political scientist and professor at the John F. Kennedy School of Government at Harvard, Destined for War: Can America and China Escape Thucydides's Trap? Scribe Publications Pty Limited, Jul 3, 2017, DOA: 8-28-17, y2k

Two centuries ago, Napoleon warned, "Let China sleep; when she wakes, she will shake the world." Today China has awakened, and the world is beginning to shake. Yet many Americans are still in denial about **what China's transformation** from agrarian backwater **to "the biggest player** in the history of the world" **means for the United States**. What is this book's Big Idea? In a phrase, Thucydides Trap; **When rising power threatens** to displace **a ruling power, alarm bells should sound**: danger ahead. **China and the United States are currently on a collision course for war**-unless both parties take difficult and painful actions to avert it. As a rapidly ascending China challenges America's accustomed pre-dominance, these two nations risk falling into a deadly trap first identified by the 'ancient' Greek historian Thucydides. Writing about a war that devastated the two leading city-states of classical Greece two and a half millennia ago, he explained: "It was the rise of Athens and the fear that this instilled in Sparta that made war inevitable." That primal insight describes one perilous historical pattern. **Reviewing the record of the past five hundred years**, the Thucydides's Trap Project I direct at Harvard has found sixteen cases in which a major nation's rise has disrupted the position of a dominant state. In the most infamous example, an industrial Germany rattled Britain's established position at the top of the pecking order a century ago. The catastrophic outcome of their competition necessitated a new category of violent conflict: **world war**. Our research finds that twelve of these rivalries ended in war and four did not - not a comforting ratio for the twenty-first century's most important geopolitical contest. This is not a book about China. It is about the impact of a rising China on the US and the global order. For seven decades since World War II, a rules-based framework led by Washington has defined world order producing an era without war among great powers. Most people now think of this as normal. Historians call it a rare "Long Peace." To-day, an increasingly powerful China is unraveling this order throwing into question the peace generations have taken for granted.

In 2015, the Atlantic published "The Thucydides Trap: Are the US and China headed for War?" In that essay I argued that this historical metaphor provides the best lens available for illuminating relations between China and the US today. Since then, the concept has ignited considerable debate. Rather than face the evidence and reflect on the uncomfortable but necessary adjustments both sides might make, pol icy wonks and presidents alike have constructed a straw man around Thucydides's claim about "inevitability." They have then put a torch to it -arguing that war between Washington and Beijing is not predetermined. At their 2015 summit, Presidents Barack Obama and Xi Jinping discussed the Trap at length. Obama emphasized that despite the structural stress created by China's rise, "the two countries are capable of managing their disagreements." At the same time, they acknowledged that, in Xi's words, "should major countries time and again make the mistakes of strategic miscalculation, they might create such traps for themselves." I concur: war between the US and China is not inevitable. Indeed, Thucydides would agree that neither was war between Athens and Sparta. Read in context, it is clear that he meant his claim about inevitability as hyperbole: exaggeration for the purpose of emphasis. The point of Thucydides's Trap is neither fatalism nor pessimism. Instead, it points us beyond the headlines and regime rhetoric to recognize the tectonic structural stress that Beijing and Washington must master to construct a peaceful relationship. If Hollywood were making a movie pitting China against the United

States on the path to war, central casting could not find two better leading actors than **Xi Jinping and Donald Trump**. Each personifies his country's deep aspirations of national greatness.

Much as Xi's appointment as leader (if China in 2012 accentuated the role of the rising power, America's election of Donald Trump in a campaign that vilified China promises a more vigorous response from the ruling power. As personalities, Trump and Xi could not be more different. As protagonists in a struggle to be number one, however, they share portentous similarities. **Both** are driven by common ambition: to make their nation great again. - Identify the nation ruled by the other as the principal obstacle to their dream. - Take pride in their own unique leadership capabilities. See themselves playing a central role in revitalizing their nation. *Have announced daunting domestic agendas that call for radical changes. **Have fired up populist nationalist support** to "drain the swamp" of corruption at home and confront attempts by each other to thwart

their nation's historic mission. Will the impending clash between these two great nations lead to war? Will Presidents Trump and Xi, or their successors, follow in the tragic footsteps of the leaders of Athens and Sparta or Britain and Germany? Or will they find a way to avoid war as effectively as Britain and the US did a century ago or the US and the Soviet Union did through four decades of Cold War? Obviously, no one knows. We can be certain, however, that the dynamic Thucydides identified will intensify in the years ahead. Denying Thucydides's Trap does not mean just accepting whatever happens. We owe it to future generations to face one of history's most brutal tendencies head on and then do everything we can to defy the odds, if we only knew." That was the best the German chancellor could offer. Even when a colleague pressed Theobald von Bethmann Hollweg, he could not explain how his choices, and those of other European statesmen, had led to the most devastating war the world had seen to that point. By the time the slaughter of the Great War finally ended in 1918, the key players had lost all they fought for: the Austro-Hungarian Empire dissolved, the German Kaiser ousted, the Russian tsar overthrown, France bled for a generation, and England shorn of its treasure and youth. And for what? If we only knew. Bethmann Hollweg's phrase haunted the president of the United States nearly half a century later. In 1962, John F. Kennedy was forty-five years old and in his second year in office, still struggling to get his mind around his responsibilities commander in chief. He knew that his finger was on the button of a nuclear arsenal that could kill hundreds of millions of human beings in a matter of minutes. But for what? A slogan at the time declared, "Better dead than red." Kennedy rejected that dichotomy as not just facile, but false. "Our goal," as he put it, had to be "not peace at the expense of freedom, but both peace and freedom." The question was how he and his administration could achieve both. As he vacated the family compound on Cape Cod in the summer of 1962, Kennedy found himself reading The Gun: q/August, Bar bara Tuchman's compelling account of the outbreak of war in 1914. Tuchman traced the thoughts and actions of Germany's Kaiser Wilhelm and his chancellor Bethmann Hollweg. Britain's King George and his foreign secretary Edward Grey, Tsar Nicholas, Austro-Hungarian emperor Franz Joseph, and others as they sleepwalked into the abyss. Tuchman argued that none of these men understood the danger they faced. None wanted the war they got. Given the opportunity for a do-over he made. Reflecting on his own responsibilities, Kennedy pledged that if he ever found himself facing his own responsibilities, Kennedy pledged that if ever found himself facing choices that could make the difference between catastrophe and peace, he would be able to give history a better answer than Bethmann Hollweg's. Kennedy had no inkling of what lay ahead. In October 1962, just two months after he read Tuchman's book, he faced off against Soviet leader Nikita Khrushchev in the most dangerous confrontation in human history. The Cuban Missile Crisis began when the United States discovered the Soviets attempting to sneak nuclear-tipped missiles into Cuba, a mere ninety miles from Florida. The situation quickly escalated from diplomatic threats to an American blockade of the island, military mobilizations in both the US and USSR, and several high-stakes clashes, including the shooting down of an American U-2 spy plane over Cuba. At the height of the crisis, which lasted for a tense thirteen days, Kennedy confided to his brother Robert that he believed the chances it would end in nuclear war were "between one-in-three and even." Nothing historians have discovered since has lengthened those odds. Although he appreciated the dangers of his predicament, Kennedy repeatedly made choices he knew actually increased the risk of war, including nuclear war. He chose to confront Khrushchev publicly (rather than try to resolve the issue privately through diplomatic channels); to draw an unambiguous red line requiring the removal of Soviet missiles (rather than leave himself more wiggle room); to threaten air strikes to destroy the missiles (knowing this could trigger Soviet retaliation against Berlin); and finally, on the penultimate day of the crisis, to give Khrushchev a time-limited ultimatum (that, if rejected, would have required the US to fire the first shot). In each of these choices, Kennedy understood that he was raising the risk that further events and choices by others beyond his control could lead to nuclear bombs destroying American cities, including Washington, DC (where his family stayed throughout the ordeal). For example, when Kennedy elevated the alert level of the American nuclear arsenal to DEFCON II, he made US weapons less vulnerable to a preemptive Soviet attack but simultaneously relaxed a score of safety catches. At DEFCON II, German and Turkish pilots took their seats in NATO fighter bombers loaded with armed nuclear weapons less than two hours away from their targets in the Soviet Union. Since electronic locks on nuclear weapons had not yet been invented, there was no physical or technical barrier preventing a pilot from deciding to fly to Moscow, drop a nuclear bomb, and start World War III, with no way to wish away these "risks of the uncontrollable," Kennedy and his secretary of defense, Robert McNamara, reached deeply into organizational procedures to minimize accidents or mistakes. Despite these efforts, historians have identified more than a dozen close calls outside Kennedy's span of control that could have sparked a war. A US submarine campaign, for example, dropped explosives around Soviet submarines to force them to surface, leading a Soviet captain to believe he was under attack and almost fire his nuclear-armed torpedoes. In another incident, the pilot of a U-2 spy craft mistakenly flew over the Soviet Union, causing Khrushchev to fear that Washington was refining coordinates for a preemptive nuclear attack. If one of these actions had sparked a nuclear World War III, could JFK

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explain how his choices contributed to it? Could he give a better answer to an inquisitor's question than Bethmann Hollweg did? The complexity of causation in human affairs has vexed philosophers, jurists, and social scientists.

In analyzing how wars break out historians focus primarily on proximate or immediate causes. In the case of World War I, these include the assassination of the Hapsburg archduke Franz Ferdinand and the decision by Tsar Nicholas II to mobilize Russian forces against the Central Powers. If the Cuban Missile Crisis had resulted in war, the proximate causes

could have been the Soviet submarine captain's decision to fire his torpedoes rather than allow his submarine to sink, or a Turkish pilot's errant choice to fly his nuclear payload to Moscow. **Proximate causes**

for war are undeniably important. But the founder of history believed **that the most obvious causes for bloodshed mask even more significant ones.** More important than the sparks that lead to war, Thucydides teaches us, are the

structural factors that lay its foundations. Conditions in which other-wise manageable events can

escalate with unforeseeable severity and produce unimaginable consequences. THUCYDIDES'S TRAP In the most frequently cited one-liner in the study of international relations, the ancient Greek historian Thucydides explained, "It was the rise of Athens and the fear that this instilled in Sparta that made war a." 11.99 Thucydides wrote about the Peloponnesian War, a conflict that engulfed his homeland, the city-state of Athens, in the fifth century BC, and which in time came to consume almost the entirety of ancient Greece. A former soldier, Thucydides watched as Athens challenged the dominant Greek power of the day, the martial city-state of Sparta. He observed the outbreak of armed hostilities between the two powers and detailed the fighting's horrific toll. He did not live to see its bitter end; when a weakened Sparta finally vanquished Athens, but it is just as well for him. While others identified an array of contributing causes of the Peloponnesian War, Thucydides went to the heart of the matter. When he turned the spotlight on "the rise of Athens and the fear that this instilled in Sparta," he identified a primary driver at the root of some of history's most catastrophic and puzzling wars. Intentions aside, **when a rising power threatens to displace a ruling power, the resulting structural stress makes a violent clash the rule, not the exception.**

It happened between Athens and Sparta in the fifth century BC, between Germany and Britain a century ago, and almost led to war between the Soviet Union and the United States in the

1950s and 1960s. Like so many others, Athens believed its advance to be benign. Over the half century that preceded the conflict, it had emerged as a steeple of civilization. Philosophy, drama, architecture, democracy, history, and naval prowess—Athens had it all, beyond anything previously seen! Under the sun, its rapid development began to threaten Sparta, which had grown accustomed to its position as the dominant power on the Peloponnese. As Athenian confidence and pride grew, so too did its demands for respect and expectations that arrangements be revised to reflect new realities of power. These were, Thucydides tells us, natural reactions to its changing station. How could Athenians not believe that their interests deserved more weight? How could Athenians not expect that they should have greater influence in resolving differences? But it was also natural, Thucydides explained, that Spartans should see the Athenian claims as unreasonable, and even ungrateful. Who, Spartans rightly asked, provided the security environment that allowed Athens to flourish? As Athens swelled with a growing sense of its own importance, and felt entitled to greater say and sway, Sparta reacted with insecurity, fear, and a determination to defend the status quo. Similar dynamics can be found in a host of other settings, indeed even in families. When a young man's adolescent surge poses the prospect that he will overshadow his older sibling (or even his father), what do we expect? Should the allocation of bedrooms, or closet space, or seating be adjusted to reflect relative size as well as age? In alpha-dominated species like gorillas, as a potential successor grows larger and stronger, both the pack leader and the wannabe prepare for a showdown. In businesses, when disruptive technologies allow upstart companies like Apple, Google, or Uber to break quickly into new industries, the result is often a bitter competition that forces established companies like IBM, ExxonMobil, Microsoft, or taxi operators to adapt their business models—or perish. Thucydides's Trap refers to the natural, inevitable discommodification that occurs when a rising power threatens to displace a ruling power. This can happen in any sphere. But its implications are most dangerous in international affairs. For just as the original instance of Thucydides's Trap resulted in a war that brought ancient Greece to its knees, this phenomenon has haunted diplomacy in the millennia since. Today it has set the world's

two biggest powers on a path to a cataclysm nobody wants, but which they may prove unable to avoid. ARE THE US AND CHINA DESTINED FOR WAR? **The world has never seen anything**

like the rapid, tectonic shift in the global balance of power created by the rise of China. If the US were a corporation, it would have accounted for 50 percent of the global economic market in the years immediately after World War II. By 1980, that had declined to 22 percent. Three decades of double-digit Chinese growth has reduced that US share to 16 percent today. If current trends continue, the US share of global economic output will decline further over the next three decades to just 11 percent. Over this same period, China's share of the global economy will have soared from

2.8 percent in 1980 to 18 percent in 2016, well on its way to 30 percent in 2040. **China's economic development is transforming it into a formidable political and military competitor.**

During the Cold War, as the US mounted clumsy responses to Soviet provocations, a sign in the Pentagon said: "If we ever faced a real enemy, we would be in deep trouble." China is a serious potential enemy. The possibility that the United States and China could find themselves at war appears as unlikely as it would be unwise. The centennials recalling World War I, however, have reminded us of man's capacity for folly. When we say that war is "inconceivable," is this a statement about what is possible in the world—or only about what our limited minds can conceive? As far ahead as the eye can see, the defining question about global order is whether China and the US can escape Thucydides's Trap. Most contests that fit this pattern have ended badly. Over the past five hundred years, in sixteen cases a major rising power has threatened to displace a ruling power. In twelve of those, the result was war. The four cases that avoided this outcome did so only because of huge, painful adjustments in attitudes and actions on the part of challenger and challenged alike. The United States and China can likewise avoid war, but only if they can internalize two difficult truths. First, on the current trajectory, war between the US and China in the decades ahead is not just possible, but much more likely than currently recognized. Indeed, on the historical record, war IS LIKELY? Add to them a fairly major likely than not. By underestimating the danger, moreover, we are at risk. If leaders in Beijing and Washington keep doing what they have done for the past decade, the US and China will almost certainly wind up at war. Second, war is not inevitable. History shows that ruling powers can manage relations with rivals, even those that threaten to overtake them, without triggering a war. The record of those successes, as well as the failures, offers many lessons for statesmen today. As George Santayana noted, only those who fail to study history are condemned to repeat it. The chapters that follow describe the origins of Thucydides's Trap, explore its dynamics, and explain its implications for the present contest between the US and China. Part One provides a succinct summary of the rise of China. Everyone knows about China's growth but few have realized its magnitude or its consequences. To paraphrase former Czech president Vaclav Havel, it has happened so quickly that we have not yet had time to be astonished. Part Two locates recent developments in US-China relations on the broader canvas of history. This not only helps us understand current events, but also provides clues about where events are trending. Our review stretches back 2,500 years, to the time when the rapid growth of Athens shocked a dominant martial Sparta and led to the Peloponnesian War. Key examples from the past 500 years also provide insights into the ways in which the tension between rising and ruling powers can tilt the chessboard toward war. The closest analogue to the current standoff—Germany's challenge to Britain's ruling global empire before World War I—should give us all pause. Part Three asks whether we should see current trends in America's relations with China as a gathering storm of similar proportions. Daily media reports of China's "aggressive" behavior and unwillingness to accept the "international rules-based order" established by the US after World War II describe incidents and accidents reminiscent of 1914. At the same time, a dose of self-awareness is due. If China were "just like us" when the US burst into the twentieth century brimming with confidence that the hundred years ahead would be an American era, the rivalry would be even more severe, and was even harder to avoid. If it actually followed in America's footsteps, we should expect to see Chinese troops enforcing Beijing's will from Mongolia to Australia, just as Theodore Roosevelt molded "our hemisphere" to his China is following a different trajectory than did the United States during its own surge to primacy. But in

many aspects of China's rise, we can hear echoes. **What does President Xi Jinping's China want?** In one line: **to make China great again.** The deepest aspiration of over a billion Chinese citizens is to make their nation not only rich, but also powerful. Indeed, their goal is a China so rich and so powerful that other nations will have no choice but to recognize its interests and give it the respect that it deserves. The sheer scale and ambition of this "China Dream" should disabuse us of any notion that the contest between Jilin and the United States will naturally subside as China becomes a "responsible stakeholder." This is especially so given what my former colleague Sam Huntington famously called a "clash of civilizations," a historical disjunction in which fundamentally different Chinese and American values and traditions make rapprochement

between the two powers even more elusive. While resolution of the present rivalry may seem difficult to foresee, actual armed conflict appears distant. But is it? In truth, **the paths to war are more**

varied and plausible (and even mundane) than we want to believe. **From current confrontations in the South China Sea, the East China Sea, and cyberspace, to a trade conflict that spirals out of control, it is frighteningly easy to develop scenarios in which**

American and Chinese soldiers are killing each other. Though none of these scenarios seem likely, when we recall the unintended consequences of the assassination of the Hapsburg archduke or of Gorbachev's **nuclear adventure** in Cuba, **we are**

reminded of just how narrow the gap is between "unlikely" and "impossible." Part Four explains why war is not inevitable. **Most**

of the policy community and general public **are naively complacent** about the possibility of war. Fatalists, meanwhile, see an irresistible force rapidly approaching an immovable object. Neither side has it right. If leaders in both societies will study the successes and failures of the past, they will find a rich source of clues from which to fashion a strategy that can meet each nation's essential interests without war. The return to prominence of a 5,000-year-old civilization with 1.4 billion people is not a problem to be fixed. It is a condition—a chronic condition that will have to be managed over a generation. Success will require not just a new slogan, more frequent presidential summits, or additional meetings of departmental working groups. Managing this relationship without war will demand sustained attention, week by week, at the highest levels in both governments. It will require a depth of mutual understanding not seen since the Henry Kissinger-Zhou Enlai conversations that reestablished US-China relations in the 1970s. Most significant, it will mean more radical changes in attitudes and actions by leaders and the public alike than anyone has yet undertaken. To escape Thucydides's Trap, we must be willing to think the unthinkable—and imagine the unimaginable. Avoiding Thucydides's Trap in this case will require nothing less than bending the arc of

***High health care costs increase medical tourism**

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* This is a repeat of the previous card, not medical tourism

The rising cost of healthcare is interfering with everything else that we try to do. Instead of raising wages, employers have been paying more and more for their workers' rising health insurance costs. Real spending on private health insurance per employee has soared since 2007, absorbing an additional \$5000 per employee in family plans—money unavailable to pay workers so that they can pay for housing, vacations, schooling for their children, or to put food on the table. From 2007 to 2014, healthcare spending by middle-class households climbed by 25% even while spending on housing fell by 6%, on food by 8%, and on clothing by 19% (see Figure 4).²⁵ The rising cost of healthcare is not only killing Americans and undermining their children's education, it is also bankrupting them. Around 20% of Americans had medical debt in 2014, leading in too many cases to bankruptcy. Nearly a million Americans went bankrupt in 2017, and as many as 60% of these bankruptcies were due to medical debt.²⁶ Over half a million bankruptcies is a steep price to pay for private health insurance.