How Can We Be Fair and Equitable? The Principle of Justice

Brendan's Big Book of Bioethics | Brendan Shea, PhD (Brendan.Shea@rctc.edu)

1 CONTENTS

2 WHAT IS FAIR? INTRODUCING THE PRINCIPLE OF JUSTICE

Learning Outcomes. In this section you'll be learning to:

1. Differentiate between formal and material principles of justice.
2. Describe and apply major philosophical theories of justice, including utitlitarianism, libertarianism, liberal egalitarianism, and communitarianism.

We have discussed three principles of the common morality so far: **autonomy, nonmaleficence,** and **beneficence.** The final principle involves **justice,** or the "fair, equitable, and appropriate distribution of benefits and burdens determined by norms that structure the terms of social cooperation." Justice is concerned with "distributing" benefits and burdens such as property, taxes, food, shelter, health care, and opportunities for education and employment.

Every person who cares about the common morality must be committed to the principle of **formal justice,** which requires that *"equals must be treated equally, and unequals must be treated unequally."* However, this principle does not say anything about which particular properties are relevant to determining whether two people are "equal" in the relevant sense. These properties are specified by principles of **material justice.** Disagreement about principles of material justice is at the heart of recent debates about how health care should be funded.

2.1 WHAT SHOULD A PRINCIPLE OF MATERIAL JUSTICE LOOK LIKE? SOME PROPOSALS

B-C present some of the most influential principles of material justice, and argue that we must balance *all* of these when making decisions about health care (since it is unlikely that people will ever agree completely on which principle is best). Among other things, these principles have consequences for how we *fund* health care (Should it be private? Or paid for by the government?) and how we make decisions about treatment (How should we decide who gets transplant organs? How do we distribute scarce drugs?).

2.1.1 Utilitarianism

> *"To each person according to policies and actions that maximize net utility [happiness]"*

How does it work? Among other things, people's happiness is affected by things like (1) meeting their basic needs for food and shelter, (2) having money and time for recreation, and (3) being in good health. Utilitarians claim that our policy makers ought to look solely at *total utility.* In the context of health, utilitarians argue that we should adopt whatever health care system delivers the best *results* (in terms of life expectancy or whatever) for the lowest cost. This may involve infringing on people's "rights."

Problems? Utilitarianism says that there are no *fundamental* rights to autonomy or nonmaleficence. In the context of health care, this might mean loosened restrictions on biomedical research, denying people expensive medical treatment (when the resources could be better used elsewhere), or extremely high tax rates on the rich if this "paid off" in terms of improved health outcomes for the poor. Conversely, utilitarians might be fine with allowing rich people to "buy" better medical care, if this allowed better funding for medical care overall.

2.1.2 Libertarianism

> *"To each person according to what he/she can obtain by making exchanges in a fair, well-regulated free market that maximizes personal liberty."*

How does it work? Pure libertarians generally claim that the government's *only* role is to enforce contracts, punish crime, and (perhaps) to provide a "fair chance" for the young. They generally oppose all government spending on health care for competent adults.

Problems? Libertarians often underestimate the role of *luck* in the way the free market distributes goods ("good" genes and "good" families are, in many societies, the strongest predictors of how much money someone will make). They also underestimate the extent to which an individual's accumulation of wealth

depends upon investments made by the government and by other individuals. This theory may lead to extremely poor health outcomes for the poorest or most vulnerable members of society.

2.1.3 Communitarianism

"To each person according to the principles adopted by his or her moral community."

How does it work? Communitarians argue that since different religious, political, business, and social groups will have different ideas about what "justice" requires, we ought to develop policies that allow people to respect the rules of their communities. A local Catholic hospital serving a predominantly Hispanic community, for example, might have different priorities from a large, international research hospital, at least in part because of the different values.

Problems? What happens if an individual is being mistreated by his or her group, or simply disagrees with the rules adopted by the groups they are part of? For example, Jehovah's Witnesses (as a group) refuse to accept blood transfusions. This doesn't mean that *individual* Jehovah's witnesses will always refuse them. Communitarians have a tough time with these cases.

2.1.4 Liberal Egalitarianism

Figure 1 Lady Justice (Brendan Shea x Dall-E).

"To each person an equal measure of personal liberty; then, goods are fairly distributed in a way that maximizes the well-being of the worst off (those who are least well-able to meet their needs)."

How does it work? When applied to medicine, this principle means that (1) people's rights to autonomy and to not be harmed must be respected, (2) there can be no unjustified discrimination (**fair opportunity rule)**, and (3) inequalities(in medical care or anything else) can be allowed, but only if they maximize the position of the worst off (the **difference principle)**.

Problems? The government will need be to be intimately involved in distributing health care resources, and the end result will not be the outcome that "maximizes life expectancy" or "minimizes cost." It will redistribute resources from the rich to the poor. It is a limited theory of justice in the sense that it *only* deals with how a political state should distribute "goods" or "stuff" (in the form of money, resources, etc.) to its citizens, and does not dealt with "human well-being" or "happiness" in the broader sense that utilitarianism does.

2.1.5 Other Approaches: Capabilities and Well-being

Capabilities Approach—"*To each person the goods and skills necessary to develop the core capacities needed for a successful, flourishing life."* Some **core capacities** include: life/survival, bodily health, bodily integrity, sensory/imaginative/cognitive, emotional, practical reason, affiliation with others, relationships with animals/nature, play, political power. **Problems?** It is very difficult to measure a person's level of "capacities." As opposed to the other views, this also seems to leave very little room for people to decide for *themselves* what a "good life" would be.

Well-Being Approach—*"To each person the goods necessary to realize the following dimensions of well-being: health, personal security, reasoning, respect, attachment, and self-determination."* Like utilitarianism, this approach focuses on distributing **welfare** (though it emphasizes equality) and not merely on the *capacity* or *right* or *goods* necessary to achieve this welfare. **Problems?** Again, one worry here is that it may an overly intrusive government/organization, since it provides a detailed list of what is supposed to count as a "good life" for each and every person.

2.2 REVIEW QUESTIONS

1. What is the difference between a "formal" principle of justice and a "material" principle of justice? Why do you think it is so tough for people to agree on which "material principle" of justice is correct?
2. One recent debate about justice has concerned the desirability of allowing people to make "designer babies" with specifically chosen genes. Assume this can be done without raising abortion-related worries (e.g., that it does NOT involve destroying excess embryos, but instead involve merely *manipulating* the genetic material of existing embryos). Which of the following sorts of genetic manipulations (assuming they are someday possible) are consistent with justice? Why or why not? As you are thinking about these, consider the sort of *society* that might result (and what sorts of safeguards or policies you might want to adopt).
    a. Using genetic manipulation to ensure a baby is NOT born with a serious genetic condition (such as cystic fibrosis or hemophilia).
    b. Doing this to correct a less serious health issue (e.g., a "designer baby" that will be less prone to high cholesterol or breast cancer during middle age, or Alzheimer's during old age).
    c. Doing this to "improve" a trait that may be somewhat below normal levels (e.g., tinkering with genes related to substandard height, intelligence, propensity to anxiety/depression, etc.).
    d. Doing this to choose sex, hair (or eye or skin) color, or similar traits.
    e. Doing this to *intentionally* have a child that is blind or deaf (perhaps because the parents are blind or deaf, and would like to have a child that shares this experience with them).
    f. Doing this to "improve" a trait so that the resulting child will be significantly ABOVE normal (intelligence, strength, beauty, happiness level, etc.)

2.3 ACTIVITY: DESIGNING A NEW SOCIETY

Suppose that you are in charge of starting a new society, which you will then *randomly* be assigned a role in. For the purposes of this exercise pretend that you do NOT know the following things: how much money you will have, what your physical or mental abilities will be, how healthy you will be, what gender or race you are, or what your religious or philosophical beliefs are. You have the following options. Why which would you choose why?

1. Anarchism—It's everyone for themselves! The advantage is that, if you are strong/clever, you can steal everyone else's stuff. The disadvantage is that the same is likely to happen to you. Since there are no enforceable laws or taxes, cooperative projects that depend on these (police, fire, education, health care, business contracts, etc.) are basically impossible. Life is likely to be "nasty, brutish, and short."
2. Utilitarianism—Goods are distributed in whatever way maximizes *net* happiness. For example, health care spending might be distributed to maximize average life expectancy. Utilitarians prefer a society in which three people lived to 100 and one person lived to 25 (total = 325 years) to a society where three people lived to 80 and one lived to 60 (total = 300 years). There is no guarantee your rights will be respected (maybe we kill the 25-year old to use her organs), though utilitarians think that it is *usually* a good idea to respect the principles of autonomy and nonmaleficence, and to distribute resources equally.
3. Libertarianism—To capture the idea that one can't choose one's parents, goods will be *randomly* distributed to each person (though each person will be guaranteed a small amount of "free" goods corresponding to the benefits of publicly funded education of children). However, some people will start with much more than others. Fundamental rights to autonomy and non-maleficence will be protected. Health care (along with everything else) is distributed according to ability to pay.

4. Liberal Egalitarianism—Fundamental rights to autonomy, non-maleficence, and fair opportunity will be protected. After that, goods (including the resources relevant to providing health care) will be distributed to maximize the position of the *worst off*. For example, liberal egalitarians would prefer the situation in which the "worst off" person lives to 55 to the one in which she lives to 25, and will distribute health care resources accordingly.
5. Marxist (Absolute) Egalitarianism— Insofar as it is possible, goods will be distributed to ensure absolute equality. For example, people who require lots of resources will be given these, while those who are extremely talented will be made to work more to provide these. Marxists try hard ensure equality of outcomes, even if this requires violating "rights."

For a concrete example, here is how each theory might distribute your stuff (money, resources, etc.) among six people Abby, Ben, Claire, Dennis, Eileen, and Frank. Remember, you don't know which "person" you will be, since this is randomly determined. I've included a few notes on the sorts of things that might explain why/how various things might happen. **Note: These numbers are made up! The idea is just to give you a sense of the general *types* of outcomes that each theory might be OK with.**

	Anarchism (No rules! No society!)	Utilitarianism	Libertarianism	Liberal Egalitarianism	Marxism
Abby	0 (dead)	0 (dead, sacrificed for the greater good. Perhaps she simply has an illness that is resource-intensive to treat)	1 (no one can kill her, but she's still pretty badly off)	3 (she gets some aid from others; she is as well off as she could be, without violating others rights)	4 (here, she gets the same as everyone else, but the overall costs to everyone else might be high)
Ben	0 (dead)	7	1	4	4
Claire	0 (dead)	8 (note how well the "middle" people do in util.)	4	4	4
Dennis	1	8	4	6	4
Eileen	1	8	10	6	4
Frank	4 ("king of the jungle", takes things by force)	5 (forced to work nonstop to aid others, and maximize overall wellbeing)	10 (doesn't have to do any work for other adults)	7 (has to do some work for Abby/Ben, but he a baseline of rights that must be respected)	4 (forced to work; may be penalized simply to make things "equal")
TOTAL	6	36 (This is the highest!)	30	30	24
Rights to speech, assembly, religion, etc. protected?	No!	No	Yes	Yes	No

As you can see, each theory has its own "risks"—the utilitarians might kill you "for the greater good", you might end up poor/disabled in the libertarian society, you may be taxed heavily in the liberal egalitarian society, and the Marxist society will take away your rights.

3 IS THERE A MORAL RIGHT TO HEALTH CARE?

Learning Outcomes. In this lesson, you'll learn to:

1. Explain the how the "fair opportunity rule" applies to the rationing and distribution of healthcare.
2. Explain arguments for a "right to a decent minimum of healthcare."
3. Use principles of justice to analyze issues related to biomedical research and medical treatment.

Why Does Fair Opportunity Matter? Nearly all theories of justice require that everyone be given a "fair opportunity" to get access to goods and services. The **fair opportunity rule** asserts that "individuals should not receive social benefits on the basis of undeserved advantageous properties and should not be denied social benefits on the basis of undeserved disadvantageous properties, because they are not responsible for these properties." The idea is that a *just* society is one in which goods and services are NOT distributed according to *luck* (for example, it should not matter "how rich your parents are" or "how good of genes you have"). Of course, it is not possible to eliminate the role of luck entirely (at least if we want to respect peoples' rights); however, we ought to try to distribute benefits and costs in a way that *minimizes* the effects of luck (e.g., by helping those who have been unlucky).[1]

What Does this Mean for Health Care? Before the beginning of the Affordable Care Act ("Obamacare") in 2013, nearly 20% (1 in 5) of the U.S. population was uninsured (no health insurance), and nearly as many were underinsured (they had to pay large portions of their income in out-of-pocket health care expenses). In 2016, Obamacare had reduced the uninsured rate to slightly above 10%, but there are still substantial numbers of uninsured and (especially) underinsured. This is markedly different from nearly every other developed country, where nearly *all* citizens are guaranteed health care. Over the last 30 years, opinion polls have consistently shown that most Americans agree that the health care access should be more "equitable" and "fair"; however, there are large disagreements on how to do this. Until the debate over Obamacare that started in 2010, most scholars of bioethics (including left-wing liberals, right-wing libertarians, and religious thinkers of all types) have argued for a right to a **decent minimum of health care** (where a basic universal plan would cover a set range of preventive measures, surgeries, and treatments; and people could pay more for additional treatments) and

Figure 2 A crowded hospital waiting room (Brendan Shea x Dall-E).

[1] For more details on the healthcare debate as it relates to justice, see Norman Daniels, "Justice and Access to Health Care," in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Winter 2017 (Metaphysics Research Lab, Stanford University, 2017), https://plato.stanford.edu/archives/win2017/entries/justice-healthcareaccess/. Another good (though slightly older) source is Richard Cookson and Paul Dolan, "Principles of Justice in Health Care Rationing," *Journal of Medical Ethics* 26, no. 5 (October 1, 2000): 323–29, https://doi.org/10.1136/jme.26.5.323.

NOT for "equal health care for all" (where the government would try to ensure that *all* health care was distributed equally). The main arguments for this idea are as follows:

- **Argument 1: Analogy with other public services.** Health problems are relevantly similar to the sorts of threats posed by crime, fire, food and drug safety, and pollution. Everyone agrees that these latter sorts of problems should be addressed by government action (and not left entirely to the individual). Consistency requires that we treat health care the same way. So, the government should ensure that each citizen has a decent minimum of health care.
- **Argument 2: Society's past investment argument.** Society as a whole has made huge investments in health care—it subsidizes the training of medical staff, pays for biomedical research, and pays for hospitals and clinics. The common morality thus demands that *all* members of society receive a proportional return on this investment.

In contrast to most other theorists, some libertarians have emphasized that it is essentially *impossible* to ensure perfect equality of opportunity, at least if we care about preserving people's rights to make their own decisions (and so, we shouldn't try). Nevertheless, most participants in the health care debate have agreed that *something* needs to be done to ensure that "unlucky" people (especially those who incur massive medical bills for conditions that they could not prevent) have access to a reasonable level of medical care.

3.1 How Should We Allocate Scarce Health Resources?

Many health care resources (such as organs, hospital beds, and time and attention from medical staff) are **scarce,** in the sense that there are not enough of them to meet everyone's needs. This raises the question: How should we distribute these resources?

- **Is it fair for the rich to get better health care than the poor?** In the U.S., many scarce health care resources (including many surgeries, drugs, and time with specialists) are allocated on *ability to pay*. This raises questions of fairness of opportunity, since (1) people's medical problems are often entirely out of their control and (2) people's wealth is at least somewhat out of their control. In most other rich, capitalist countries (such as Canada, the UK, Germany, and Japan), ability to pay plays far less of a role.
- **Can you forfeit your right to health care by making poor lifestyle choices?** Some ethicists have argued that those who knowingly engage in risky behavior should be treated differently than those who do not. So, for example, they have argued that it would be reasonable for smokers to (1) pay more for their insurance and (2) to be put LOWER on transplant lists for lungs or hearts. The same thing has been argued for liver transplants for heavy drinkers. A problem case: What about *former* smokers or drinkers (e.g., those who quit years ago, but now have health problems because of this).
- **Does citizenship matter?** Some people have argued that health care should be left to *nations* and *states,* and that it is perfectly fair for each political unit to favor its own citizens. So, for example, they argue that U.S. hospitals should give transplant organs to U.S. citizens instead of foreigners (if they are forced to choose). Others (sometimes called **cosmopolitans**) have argued that justice doesn't care about "nationality" at all, and that we have obligations to everyone as "world citizens."

Beauchamp and Childress (2020) argue that purely formal principles of justice commits us to the following goals: (1) provide "unobstructed access to a decent minimum of health care through some form of universal insurance coverage", (2) "develop an acceptable incentives for physicians and consumer-patients" to constrain costs, (3) "construct a fair system of rationing that does not violate the decent minimum standard"

and (4) "implement a system that can be put into effect incrementally, without drastic disruption of basic institutions that finance and deliver health care."

3.2 SOME OTHER ISSUES WITH "FAIR OPPORTUNITY"

The fair opportunity rule (and the principle of justice more generally) also affects other areas of health care policy:

Historically, there have been large disparities in health care based on gender, race, ethnicity (and language), and social status (none of which people "choose"). For example, such people may live in neighborhoods with poorer health care facilities, may lack employer-based health insurance, and may not benefit as much from medical research as other groups. Because of differences in education, they may also be unaware about how to access health care services, and more likely to distrust health care providers.

Differences in inherited income, primary and secondary education, home environment (second-hand smoke, violence, exposure to toxic chemicals, etc.) and genetics also contribute to poor health outcomes, and all of these are out of people's control. For example, because of difference in blood types, people of certain ethnicities been less likely to receive donor organs (because organ-sharing networks have prioritized "having the same blood type" on the grounds that this maximized chance of success). In this case, this policy seems justified on utilitarianism (since it "saved the most lives") but NOT justified according to "fair opportunity."

The use of (paid) **human research subjects** has also raised concerns. Such people are often poor, and many come from so-called "vulnerable groups" (this term is misleading, since individuals within a group will have varying degrees of vulnerability). On the one hand, if researchers pay these people too little, this amounts to **undue profit**, since it's unfair to ask people to participate in painful, risky research for too little money. However, if too *much* money is offered, this raises issues of **undue inducement**, since such individuals may feel "forced" to take risks they otherwise wouldn't, because of their need for the money. One possibility is that medical research should pay close to minimum wage, to ensure that vulnerable individuals are actually choosing to participate in the research.

3.3 REVIEW QUESTIONS

1. What is the fair opportunity rule? Why do many bioethicists think that this rule requires that this entails a right to a "decent minimum of health care"? Do you agree with their reasons?
2. Do you think it is OK for (government subsidized) health insurance to charge people more based on "life style conditions" (such as smoking and obesity)? Why or why not?
3. Suppose that you are put in charge of determining what counts as a "decent minimum" of health care (remember—this will at least partially be paid for with tax dollars!). Which of the following services would you include? Why?

a. Annual check-ups including physicals and blood tests
b. Preventive care (cholesterol and blood pressure tests and meds, immunizations and flu shots, etc.)
c. Prescription drugs
d. "Normal" hospital services, including surgery, cancer treatment, ER visits, and so on (assume a medium to high benefit-cost ratio).
e. "Extraordinary" hospital services, including surgery, cancer treatment, and so on (assume a low to very low benefit-cost ratio)
f. Transportation (Ambulances, etc.)
g. Prosthetics (artificial limbs)
h. Psychiatric care
i. Experimental treatments, surgeries and drugs
j. Prenatal care and birthing
k. Visits to specialists *without* referrals
l. Fertility treatments (IVF, artificial insemination)
m. Reproductive healthcare *other* than abortion (condoms, birth control drugs)
n. Abortion in the case of rape or threats to the mother's life
o. "Elective" abortions

4. Why is it is so difficult to determine how much to pay research subjects? What is the problem with paying them too little? Too much?

4 How Should we Provide Health Care?

Rich countries have developed a number of different health care models[2]. Here is a brief overview (I have taken the names from TR Reid's *The Healing of America* [3]).

The Beveridge Model. In this system, the government uses tax revenues to build and maintain health facilities (such as hospitals or clinics), and to pay the salaries of the medical staff. There may also be (some) private hospitals and non-government health care workers. Health care is treated in much the same way as the US treats defense, policing, or fire-fighting. This system is named after William Beveridge, who helped found the United Kingdom's National Health Service (NHS). Other "rich" countries (with a per capita GDP comparable to that of the US) that use this system include Spain, Denmark, Norway, New Zealand, and Sweden. This system allows the government considerable control over the prices of drugs and treatments (after all, it purchases nearly all of them!).

The Bismark Model. In this system, every citizen is required to contribute to non-profit insurance companies (or "sickness funds"), which are used to pay for services at privately owned health care facilities. The government maintains strict control over the prices of drugs and medical treatments. This system originated in Germany (Otto van Bismark helped create the modern German state, and helped start this policy), and is also used in France, Japan, and the Netherlands.

Switzerland has adopted a modified version of the Bismark system that requires (for-profit) insurance companies to provide universal access to *basic* plans at cost (they can't make a profit on these plans), but which allows them to sell (and profit from) more comprehensive plans. Obamacare is (partially) modeled after the Swiss model, except that it allows insurers to make (some) profit off of basic health care plans. The US and Switzerland are similar in that they (1) have low tax rates and (2) have very strong insurance sectors

[2] Commonwealth Fund, "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care," accessed June 4, 2019, http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/.
[3] T. R. Reid, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care* (Penguin, 2010).

(both of which make adopting other models politically difficult). However, they also (3) have among the highest costs of health care (considering both private and public spending).

The National Health Insurance Model (NHI). In this system, all citizens are required to pay into government-provided, non-profit health insurance. This is then used to pay private health providers. This system is used in Canada, Australia, South Korea, and Taiwan. Because the government-run insurance program is the largest purchaser of drugs and treatments, they have considerable control over prices. (This is the primary reason why drugs are often cheaper in Canada than in the US).

Singapore has a somewhat unique model of *Medisave* (a mandatory health care saving account for "ordinary" health costs), *Medishield* (a mandatory government insurance plan for catastrophic costs), and *Medifund* (government support for the poor who have exhausted their Medisave/Medishield accounts). Singapore has strict government regulations on different "levels" of care (with citizens choosing between fancy "A" level hospitals or bare bones "C" level hospitals; Medifund will only pay for C-level care). Singapore is often mentioned by reformers because it seems to get decent results despite spending *very* little on health care (less than $3,000 per capita). However, Singapore is also quite a bit different from nearly any other rich nation: it has a small population (of around 5 mil, with a large proportion of recent immigrants from other rich countries) all confined to one small island, and it is governed by a significantly less democratic government. It is unclear whether this system could be implemented in other rich countries, such as the U.S.

The Out-of-Pocket Model (OOP). This system requires that most health care costs be paid for by individuals using private funds. This was the norm in the developed world until the early- to mid-20th century, when nearly all rich countries went to one of the models listed above (the US is a partial exception—see below). It is still widely used in the poorest parts of the world, including much of sub-Saharan Africa and parts of the Indian subcontinent. It is also used in poor, rural areas of middle-income countries, where government health care and/or insurance has traditionally been difficult for residents to access. In recent years, many middle-income countries—especially China, where health coverage for rural residents has quadrupled since the early 2000s—have made substantial improvements.

The US (Mixed) Model. The US has a unique "mixed" model of health care.

- **Veterans Administration.** Health care for many veterans and their families is provided by the Veterans Administration, which is a Beveridge-style system (the staff are US government employees, and the government owns the facilities).
- **Employers/Government.** People who have full-time jobs for mid- or large-sized companies are given coverage by the Bismark system (joint employer-employee contributions, which are subsidized by government tax benefits if the health care plans chosen meet certain minimal requirements).
- **Medicare/Medicaid.** People over 65 and people with low-income are covered by a National Health Insurance system (Medicare and Medicaid); however, the government is not allowed to bargain over drug prices (Americans generally pay 1.5 to 3 times as much for drugs as citizens of other rich countries). Thanks to a law signed by Pres. Biden in Summer 2022, Medicare will be allowed to bargain on a select number of drugs starting in 2026 (though this may change based on the result of the 2024 presidential election).
- **Uninsured/Underinsured.** The out-of-pocket model is used by part-time or self-employed workers who do NOT qualify for Medicare or Medicaid. The Affordable Care Act ("Obamacare") has helped to reduce this somewhat, by creating a system of "exchanges," though recent changes to the healthcare law (in 2017) may increase this number again.

In the U.S., people in the first three categories are generally HAPPY with their own healthcare (which explains why reform is hard). However, people in the last group are NOT happy, and many studies have found that Americans have considerable anxiety regarding the health care system as a whole (often because they are worried they might lose the coverage they have, they dislike the high costs, etc.).

4.1 WHICH SYSTEM IS CHEAPEST? WHICH GETS THE BEST RESULTS?

A number of large studies have suggested that the US SPENDS MORE per person on health care (including taxes, health insurance, and out of pocket costs) than do other industrial countries and gets WORSE RESULTS. So, for example, here are some recent statistics on health care spending in rich countries taken from the OECD or the World Bank (2019 or most recent available). US citizens also get less face-time with doctors, are discharged from hospitals earlier, and have higher long-term disability rates and pre-term birth rates. Obamacare seems to have helped a bit with cost (in recent years, global healthcare costs continue to increase, but the *rate* of increase has fallen), but given the changes over the past few years, it is difficult to project what exactly will happen.

Country	$/person	Physicians per 1,000	Hospital beds per 1,000	MRI exams per 1 mil	Life expectancy	Infant mortality per 1,000	Overall Tax Rate	Bloomberg Health Ranking*
Italy	$3649	4.0	3.2	28.2	84	2.8	High	2
New Zealand	$3820	3.0	2.7	13.9	83.9	5.7	Avg	18
Finland	$4578	3.2	4.0	25.5	82.5	1.9	High	14
UK	$4653	2.8	2.6	7.2	81.2	3.8	Avg	19
Australia	$5187	3.6	3.8	14.3	84	3.1	Low	7
Japan	$4823	2.4	13.1	51.7	85	2.0	Low	4
Canada	$5155	2.6	2.6	9.5	83.0	4.7	Low-Avg	16
France	$5376	3.1	6.1	13.5	83.1	3.7	High	12
Denmark	$5568	3.7	2.6	…	80.9	3.1	High	25
Sweden	$5782	4.3	2.3	15.7	83.3	2.5	High	6
Germany	$6646	4.2	8.1	34.5	81.2	3.4	High-Avg	23
Netherlands	$5765	3.5	3.6	12.8	82.8	3.5	High	15
Norway	$6647	4.5	3.7	..	82.9	2.2	High-Avg	9
Switzerland	$7732	4.3	4.6	22.3	84.3	3.6	Low	5
US	$11,072	2.6	2.8	36.7	79.1	5.9	Low	35

*The Bloomberg Global Health Index is "calculated taking into account variables such as life expectancy, causes of death, incidence of high blood pressure, high blood glucose, tobacco use, and physical inactivity. Other parameters taken into account are childhood malnutrition, mental health, vaccination coverage, greenhouse gas emissions." The U.S. ranking is brought down by our overweight/obesity rates, among other things.

As you can see, the U.S. has the highest total cost (per person) and the worst life expectancy (and we're actually getting worse here, especially after COVID) and infant mortality rates (we're improving here!). We also have smaller than average numbers of physicians and hospital beds. (Canada and the UK also have low numbers of physicians, which suggests there may be a physician shortage in English-speaking countries, perhaps as a result of the way we set up things like medical education, or the availability of other high-paying careers in law/software engineering.) However, we have very high rates of use of advanced technologies (such as MRI scans and CT scans). The US is the only rich country on the chart that has any *significant* number of uninsured or underinsured people. Weirdly enough, the US government currently spends more *taxpayer*

money on health care per capita than do countries like the UK or Canada. In Commonwealth Fund Surveys (2016), the US had *many* more citizens (23%, vs. an average of around 5%) say the health system needed to be "completely rebuilt" than any other country.

4.2 What Makes Health Care in the US Expensive? Why Do We Get such Poor Results?

Different Populations. The US has more overweight and obese people than do most other rich countries. We also have higher rates of car accidents, illegal drug use, homicide, and suicide. However, we have less smokers, consume less alcohol, and are generally younger. In addition, the US has higher rates of income inequality (more extremely poor and extremely rich) and lower rates of lifetime social mobility (it's much tougher in the US to "work your way to the top"). These all affect things like life expectancy and infant mortality.

Different Use of Health Care Resources. Healthcare providers in the US spend a huge amount of money on complex conditions, such as treating solid-tumor cancers (breast, prostate, and lung), and it shows—the US does better than average in five-year survival rates for nearly all of these cancers. However, these improvements in treatment are very expensive (they involve more MRIs, CT scans, oncologists, surgeons, chemotherapy drugs, white-cell boosting drugs, and so on), and save relatively few years of life. We also have many of the world's top *specialty* hospitals (just in the Midwest, we have Mayo, Cleveland Clinic, and Northwestern Memorial), and Americans generally have shorter waiting times for elective surgeries. By contrast, many other countries focus resources on primary, preventive, and follow-up care, which offer better "returns on investment." However, it is unlikely that these factors (considered by themselves) can account for the large differences in cost, since many countries (e.g., Germany, Japan, and Switzerland) also have comparable number of specialists and uses of high tech equipment, and comparable waiting times to the US.

Administrative Costs. In other rich nations, insurance plans/governments are required to provide coverage for all citizens (and in return, citizens are not allowed to "opt out" of paying for coverage). In the US, insurance companies have historically been allowed to reject people (or charge them different costs) based on things such as age or "pre-existing" conditions. Because of this, US insurance companies spend lots of time and money trying to figure out who to cover (and which claims to deny). Insurance plans in other countries (and Medicare/Medicaid/VA in the US) spend around 1 to 3% of their revenue on administration and billing; while US insurance companies, clinics, and hospitals in the US have historically spent 10 to 20%. The Obamacare "individual mandate" (and the requirement that insurers cover everyone) was projected to address some of these problems (at least for insurance companies). However, this mandate was effectively repealed in 2017, and its unclear how this will affect costs in the long run.

Profits. Certain industries make a lot of money off the current system. The biggest gainers have probably been the multi-national drug and medical technology companies, and the associated pharmacy benefit managers (who have huge profit margins, often above 15%), and private insurance companies (who have smaller profit margins, often below 5%). Physicians (and especially specialists) also earn more in the US than in other rich countries (even after we take into account their more expensive medical schools, longer hours worked, and higher cost of malpractice insurance). Many US providers use a "pay per service" model in which providers are compensated for each procedure they perform, and this may encourage them to give patients expensive and unnecessary (and possibly even harmful) treatments. The Mayo Clinic, among others, has rejected this model (and instead pays staff fixed salaries). Obamacare addresses *some* of these issues (e.g., by mandating insurers spend 85% of their money on patient care, and by changing Medicare payment systems). Other countries avoid this problem by giving the government more power over the rates charged for medical care, which results in lower drug costs, medical equipment costs, and salaries (Japan is especially famous for this).

Costs Due to "Free Riders." People without health insurance (or who are underinsured) pass on considerable costs to tax payers, insurance companies, and health care providers. In particular, because they

are often unable or unwilling to pay for primary or preventive care, they will let preventable conditions become very bad. They will then show up to the emergency room for (very expensive) treatment that will be paid for by the government and/or hospital (after it bankrupts the patient). This does not occur in other countries, since everyone is covered. Fixing this issue was one purpose of Obamacare's **individual mandate,** which requires that most people carry some sort of health insurance, or pay a fine. Again, with the elimination of this mandate in 2017, this will again become a problem (since people will once again have an incentive to forgo having health insurance until they "need" it).

4.3 REVIEW QUESTIONS

1. Describe (in general terms, and in your own words) how the following health care systems differ from the U.S. model.
    a. National Health Insurance (e.g. Canada)
    b. Beveridge (e.g. Britain)
    c. Bismark (Germany, France, Japan or Switzerland.)
2. How does the U.S. compare to other countries in terms of cost? In terms of effectiveness? What are some possible explanations for this?
3. If you had complete freedom to reform the health care system (and didn't need to worry about "politics"), what sort of system would you choose to adopt? Why? Defend your answer using some of the principles we've been studying in class (especially justice and beneficence).

5 THE AFFORDABLE CARE ACT (ACA – "OBAMACARE")

What exactly was/is "Obamacare", or the "Affordable Care Act (ACA)? What has been the big fight about it? Debates about US Healthcare for the last decade have often been expressed in terms of reactions to "Obamacare," which was a major healthcare reform passed in 2010, with the two main goals of (1) expanding coverage and (2) keeping costs down. (As we've discussed previously, the US has healthcare that is more expensive, and arguably less effective, than any other rich country). The ACA is a lengthy bill, but it had four major impacts on US healthcare[4].

1. **Expansion of Medicaid.** The single biggest impact of the law has probably been the expansion of federally-funded Medicaid benefits to families making 133% of the federal poverty line (around $30,000 for a family of four). Around 15 million people have gained coverage because of this. However, because of a Supreme Court ruling, the various states can choose to allow this or not. This has led to a dramatic increase in insurance rates in the 38+ states (& DC) that have chosen to do so, but doesn't affect the people living in the other states at all. These states are generally in the South or Mountain West, with Wisconsin being a notable exception.
2. **Coverage of young adults to age 26.** Young adults were allowed to stay on their parent's insurance plans until age 26. (These plans are largely from the parents' employers, and as such, are supported by tax breaks). Around 3 million people have gained coverage through this.
3. **The "Employer Mandate."** Medium- and large employers were given a variety of incentives to offer insurance to full-time employees (tax breaks for coverage, penalties for not expanding coverage). This coverage had to meet certain minimal conditions.

[4] For a recent analysis of how the ACA and subsequent legislation has effected US healthcare, see Rachel Garfield et al., "The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act - Introduction," *The Henry J. Kaiser Family Foundation* (blog), January 25, 2019, https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-introduction/.

4. **The exchanges.** For people who couldn't get coverage through any of the above (or the VA, or Medicare), a system of federally funded exchanges was created). More on this below…

Why were the exchanges created? Before the ACA exchanges were created, a large number of people found it difficult or impossible to get health insurance, on the basis of their age or pre-existing health conditions. Insurance companies were also free to drop them when they got ill, or to raise their premiums by arbitrarily large amounts. Moreover, the health insurance they *could* buy was often inadequate, as it came with lifetime caps, after which the insurance companies would refuse to pay. While these people could seek care from the emergency room, etc., this simply shifted costs onto the government, hospitals, insurance companies, etc. So, the creation of the exchanged had two motives: (1) to make sure these people could get adequate health care and (2) to get more control over health-care costs paid by individual, insurance companies, and the government. It was widely agreed that the U.S. needed to do something with regards to these issues, given the fact that it has consistently spent more on health care than any other nation, while achieving subpar results.

Who buys insurance on the exchanges? The ACA exchanges are meant to provide a way for people to buy insurance who wouldn't otherwise be able to get it. These people are (1) too young to receive Medicare, (2) make too much money to qualify for Medicaid (or live in a state that hasn't expanded Medicaid), and (3) fail to qualify for employer-based health insurance. This may be because they don't work enough hours, are self-employed, or work for a small business. Even if these people don't log on to the official "exchanges" to buy insurance, they are subject to many of the rules governing these exchanges (governing the costs of the plans, the type of plans offered, etc.).

What role DID the "individual mandate" play? It's important to remember that the *reason* insurance companies were refusing to cover these people was that they cost a lot of money. If the ACA had simply required that the insurance companies cover these patients (without making any other changes), this may have led to the insurance companies going bankrupt, which would have led to a whole-sale collapse of health care financing in the U.S. So, for example, this would have led to a case where people could simply wait until they were sick, log online to buy insurance, have the insurance company pay their bills, and then cancel the insurance. In order to make sure the insurance companies could remain solvent, policy makers needed to ensure that *healthy customers also signed up.*

In 2017, the individual mandate was repealed as part of a tax bill. Health care economists have predicted this will have two major effects (though they may take a while to show up, since it only took effect in 2019): (1) it will lead to an increase in the price of health insurance (for those buying it on the exchanges), and (2) it will lead to a significant reduction in the amount of people who are covered by health insurance (because they can't afford it, choose not to buy it, etc.). In 2021 (after the election of Joe Biden), however, the government began providing additional financial support for people looking to buy plans. As of early 2022, this seems to have increased overall enrollment in ACA health care plans. (However, it's very likely that COVID made people more likely to sign up for health insurance!).

6 IS HEALTH CARE A RIGHT? (BY ATUL GAWANDE)[5]

[Brendan's Note: This is one of the longer readings of the semester. However, Atul Gawande is a very good writer, and I think you'll find it pretty interesting. He's written a number of best-selling books about medicine and healthcare, and I'd encourage you to look them up if you are interested.]

The United States remains the only developed country in the world unable to come to agreement on an answer. Earlier this year, I was visiting Athens, Ohio, the town in the Appalachian foothills where I grew up. The battle over whether to repeal, replace, or repair the Affordable Care Act raged then, as it continues to rage now. So I began asking people whether they thought that health care was a right. The responses were always interesting.

6.1 MARIA AND JOE DUTTON

A friend had put me in touch with a forty-seven-year-old woman I'll call Maria Dutton. She lived with her husband, Joe, down a long gravel driveway that snaked into the woods off a rural road. "You may feel like you are in the movie 'Deliverance,' " she said, but it wasn't like that at all. They had a tidy, double-wide modular home with flowered wallpaper, family pictures on every surface, a vase of cut roses on a sideboard, and an absurdly friendly hound in the yard. Maria told me her story sitting at the kitchen table with Joe.

She had joined the Army out of high school and married her recruiter—Joe is eleven years older—but after a year she had to take a medical discharge. She had developed severe fatigue, double vision, joint and neck pains, and muscle weakness. At first, doctors thought that she had multiple sclerosis. When that was ruled out, they were at a loss. After Joe left the military, he found steady, secure work as an electrical technician at an industrial plant nearby. Maria did secretarial and office-manager jobs and had a daughter. But her condition worsened, and soon she became too ill to work.

"I didn't even have enough energy to fry a pound of hamburger," she said. "I'd have to fry half of it and then sit down, rest, and get up and fry the rest. I didn't have enough energy to vacuum one room of the house." Eventually, she was diagnosed with chronic-fatigue syndrome and depression. She became addicted to the opioids prescribed for her joint pains and was started on methadone. Her liver began to fail. In 2014, she was sent two hundred miles away to the Cleveland Clinic for a liver-transplant evaluation. There, after more than two decades of Maria's deteriorating health, doctors figured out what the problem was: sarcoidosis, an inflammatory condition that produces hardened nodules in organs throughout the body. The doctors gave her immunosuppressive medication, and the nodules shrank away. Within a year, she had weaned herself off the methadone.

"It was miraculous," she said. In middle age, with her daughter grown up and in the Army Reserves herself, Maria got her life back and returned to school. All along, she'd had coverage through her husband's work. "They have amazing insurance," she said. "I think one year the insurance paid out two hundred thousand dollars. But we paid out, too."

This was an understatement. Between a six-thousand-dollar deductible and hefty co-pays and premiums, the Duttons' annual costs reached fifteen thousand dollars. They were barely getting by. Then one day in 2001 Joe blacked out, for no apparent reason, at a Girl Scout meeting for their daughter and fell down two flights of stairs, resulting in a severe concussion. It put him out of work for six months. Given the health-care costs and his loss of income, the couple ran out of money.

[5] Atul Gawande, "Is Health Care a Right?," *The New Yorker*, September 25, 2017, https://www.newyorker.com/magazine/2017/10/02/is-health-care-a-right.

"We had to file for bankruptcy," Joe said. He told me this reluctantly. It took them more than five years to dig out of the hole. He considered the bankruptcy "pretty shameful," he said, and had told almost no one about it, not even his family. (This was why they didn't want me to use their names.) He saw it as a personal failure—not the government's. In fact, the whole idea that government would get involved in the financing of health care bothered him. One person's right to health care becomes another person's burden to pay for it, he said. Taking other people's money had to be justified, and he didn't see how it could be in cases like this.

"Everybody has a right to access health care," he allowed, "but they should be contributing to the cost." He pointed out that anyone could walk into a hospital with an emergency condition, get treated, and be billed afterward. "Yes, they may have collectors coming after them," he said. "But I believe everybody should contribute for the treatment they receive."

Like her husband, Maria leans conservative. In the 2016 election, Joe voted for Donald Trump. Maria voted for Gary Johnson, the Libertarian candidate. But on health care she was torn. Joe wanted Obamacare repealed. She didn't.

"I am becoming more liberal," she said. "I believe that people should be judged by how they treat the least of our society." At her sickest, she had been one of them. But she was reluctant to say that health care is a right. "There's where the conservative side comes in and says, 'You know what? I work really hard. I deserve a little more than the guy who sits around.' "

A right makes no distinction between the deserving and the undeserving, and that felt perverse to Maria and Joe. They both told me about people they know who don't work and yet get Medicaid coverage with no premiums, no deductibles, no co-pays, no costs at all—coverage that the Duttons couldn't dream of.

"I see people on the same road I live on who have never worked a lick in their life," Joe said, his voice rising. "They're living on disability incomes, and they're healthier than I am." Maria described a relative who got disability payments and a Medicaid card for a supposedly bad back, while taking off-the-books roofing jobs.

"Frankly, it annoys the crap out of me—they're nothing but grasshoppers in the system," Joe said, recalling the fable about the thriftless grasshopper and the provident ant.

The Duttons were doing all they could to earn a living and pay their taxes—taxes that helped provide free health care for people who did nothing to earn it. Meanwhile, they faced thousands of dollars in medical bills themselves. That seemed wrong. And in their view government involvement had only made matters worse.

"My personal opinion is that anytime the government steps in and says, 'You must do this,' it's overstepping its boundaries," Joe said. "A father, mother, two kids working their asses off—they're making minimum wage and are barely getting by—I have no problem helping them. If I have someone who's spent his whole life a drunk and a wastrel, no, I have no desire to help. That's just the basics."

Such feelings are widely shared. They're what brought the country within a single vote of repealing major parts of President Obama's expansion of health-care coverage. Some people see rights as protections provided by government. But others, like the Duttons, see rights as protections from government.

[Brendan's Question: What are your thoughts? Is health care a "right"? What might be some reasons for or against this?]

6.2 TIM AND MONNA

Tim Williams, one of my closest childhood friends, disagreed with the Duttons. Tim is a quiet fifty-two-year-old with the physique of a bodybuilder—he once bench-pressed me when we were in high school—and

tightly cropped gray hair that used to be flame red. He survived metastatic melanoma, in the nineties, and losing his job selling motorcycles, during the great recession. He went through a year of chemotherapy and, later, three years without a job. He can figure out how to fix and build almost anything, but, without a college degree, he had few employment options. Hundreds of job applications later, though, he was hired as an operator at our town's water-treatment plant, where I visited him.

The plant was built in the nineteen-fifties. We walked among giant pipes and valves and consoles that controlled the flow of water from local ground wells through a series of huge pools for filtration, softening, and chlorination, and out to the water towers on the tallest ridges surrounding the town. The low hum of the pump motors churned in the background.

People don't think about their water, Tim said, but we can't live without it. It is not a luxury; it's a necessity of human existence. An essential function of government, therefore, is to insure that people have clean water. And that's the way he sees health care. Joe wanted government to step back; Tim wanted government to step up. The divide seemed unbridgeable. Yet the concerns that came with each viewpoint were understandable, and I wondered if there were places where those concerns might come together.

Before I entered the field of public health, where it's a given that health care is a right and not a privilege, I had grown up steeped in a set of core Midwestern beliefs: that you can't get something for nothing, and that you should be reluctant to impose on others and, likewise, to be imposed upon. Here self-reliance is a totemic value. Athens, Ohio, is a place where people brew their own beer, shoot their own deer, fix their own cars (also grow their own weed, fight their own fights, get their own revenge). People here are survivors.

Monna French was one. She was fifty-three years old and the librarian at Athens Middle School. She'd been through a lot in life. She had started a local taxi company with her first husband, but they couldn't afford health insurance. When she gave birth to her daughter Maggie and then to her son, Mac, the couple had to pay cash, pray that there'd be no unaffordable complications, and try to leave the hospital the next morning to avoid extra charges. When Monna and her husband divorced, litigation over the business left her with no income or assets.

"I had twenty-six dollars, two kids, and a cat," she said.

She held down five part-time jobs, working as a teaching assistant for three different schools during the day, bartending at night, and selling furniture at Odd Lots department store on weekends, while her parents helped with the kids. Finally, she got the librarian job. It was classified as clerical work and didn't pay well. But it meant that her family had health insurance, and a roof over their heads. She also met Larry, an iron worker and Vietnam veteran, who became her second husband. He had two children, but he was older and they were grown. Together, Monna and Larry had a child of their own, named Macie. Then, thirteen years ago, Maggie, at age sixteen, was killed in a car accident. Seven years ago, Larry's son, Eric, who had spina bifida and multiple medical needs, died suddenly in his sleep, at the age of forty.

After twenty-two years as a librarian, Monna still makes only sixteen dollars and fifty cents an hour. Her take-home pay is less than a thousand dollars a month, after taxes and health-insurance contributions. Her annual deductible is three thousand dollars. Larry, now seventy-four, has retired, and his pension, military benefits, and Medicare helped keep them afloat.

For all her struggles, though, Monna is the kind of person who is always ready to offer a helping hand. When I visited her, there were stacks of posters on her porch, printed for a fund-raiser she was organizing for her daughter's high-school marching band. She raised money for her township's volunteer fire brigade. She was the vice-president of her local union, one of the largest in the county, which represents school-bus drivers,

clerical staff, custodians, and other non-certified workers. She'd been deeply involved in contract negotiations to try to hold on to their wages and health benefits in the face of cutbacks.

"I don't know anything about health care," she protested when I asked her for her thoughts on the subject. In fact, she knew a lot. And, as she spoke, I thought I glimpsed a place where the health-care divide might just allow a bridge.

Monna considered herself a conservative. The notion of health care as a right struck her as another way of undermining work and responsibility: "Would I love to have health insurance provided to me and be able to stay home?" Of course, she said. "But I guess I'm going to be honest and tell you that I'm old school, and I'm not really good at accepting anything I don't work for."

She could quit her job and get Medicaid free, she pointed out, just as some of her neighbors had. "They have a card that comes in the mail, and they get everything they need!" she said. "Where does it end? I mean, how much responsibility do tax-paying people like me have? How much is too much?" She went on, "I understand that there's going to be a percentage of the population that we are going to have to provide for." When she was a young mother with two children and no home, she'd had to fall back on welfare and Medicaid for three months. Her stepson, Eric, had been on Medicaid and Social Security Disability Insurance before he died. Her eighty-three-year-old mother, who has dementia and requires twenty-four-hour care, was also on Medicaid. "If you're disabled, if you're mentally ill, fine, I get it," Monna said. "But I know so many folks on Medicaid that just don't work. They're lazy." Like the Duttons, she felt that those people didn't deserve what they were getting.

But then we talked about Medicare, which provided much of her husband's health care and would one day provide hers. That was different, Monna told me. Liberals often say that conservative voters who oppose government-guaranteed health care and yet support Medicare are either hypocrites or dunces. But Monna, like almost everyone I spoke to, understood perfectly well what Medicare was and was glad to have it.

I asked her what made it different.

"We all pay in for that," she pointed out, "and we all benefit." That made all the difference in the world. From the moment we earn an income, we all contribute to Medicare, and, in return, when we reach sixty-five we can all count on it, regardless of our circumstances. There is genuine reciprocity. You don't know whether you'll need more health care than you pay for or less. Her husband thus far has needed much less than he's paid for. Others need more. But we all get the same deal, and, she felt, that's what makes it O.K.

"I believe one hundred per cent that Medicare needs to exist the way it does," she said. This was how almost everyone I spoke to saw it. To them, Medicare was less about a universal right than about a universal agreement on how much we give and how much we get.

Understanding this seems key to breaking the current political impasse. The deal we each get on health care has a profound impact on our lives—on our savings, on our well-being, on our life expectancy. In the American health-care system, however, different people get astonishingly different deals. That disparity is having a corrosive effect on how we view our country, our government, and one another.

[Brendan's Question: Why do you think there is such a big difference between the way people view Medicaid, which provides medical insurance to the poor, with Medicare, which provides health insurance to the old?]

6.3 SOME IDEAS FROM HENRY SHUE

The Oxford political philosopher Henry Shue observed that our typical way of looking at rights is incomplete. People are used to thinking of rights as moral trump cards, near-absolute requirements that all of us can demand. But, Shue argued, rights are as much about our duties as about our freedoms. Even the basic right to physical security—to be free of threats or harm—has no meaning without a vast system of police departments, courts, and prisons, a system that requires extracting large amounts of money and effort from others. Once costs and mechanisms of implementation enter the picture, things get complicated. Trade-offs now have to be considered. And saying that something is a basic right starts to seem the equivalent of saying only, "It is very, very important."

Shue held that what we really mean by **"basic rights**" are those which are necessary in order for us to enjoy any rights or privileges at all. In his analysis, basic rights include physical security, water, shelter, and health care. Meeting these basics is, he maintained, among government's highest purposes and priorities. But how much aid and protection a society should provide, given the costs, is ultimately a complex choice for democracies. Debate often becomes focussed on the scale of the benefits conferred and the costs extracted. Yet the critical question may be how widely shared these benefits and costs are.

6.4 ARNOLD JONAS

Arnold Jonas is another childhood friend of mine. Blond, ruddy-faced, and sporting a paunch at fifty-two, he has rarely had a nine-to-five job and isn't looking for one. The work he loves is in art and design—he once designed a project for the Smithsonian—but what usually pays the bills is physical labor or mechanical work. He lives from paycheck to paycheck. ("Retirement savings? Ha! You're funny, Atul.") Still, he has always known how to take care of himself. "I own my house," he told me. "I have no debts."

This is a guy who's so handy that the cars he drives are rehabbed wrecks rebuilt from spare parts—including the old Volvo that he drove to the strip-mall Mexican restaurant near my family's house, where we were catching up. But when I asked him about health care he could only shake his head.

"I just try not to think about it," he said. He hadn't seen a doctor in at least a decade. He got a health-care plan through an insurance-agent friend, but could only afford one with minimal benefits. He wasn't sure whether he'd got an Obamacare subsidy. "I don't read the fine print, because it's going to be completely confusing anyway." All he knew was that the plan cost him a hundred and ten dollars a month, and the high deductible (however many thousands of dollars it was, it was well beyond his savings account) made doctors' visits almost out of the question.

"I am lucky I can get my teeth looked at because I'm dating a dental hygienist. But"—here he showed me his white-toothed grin—"I can't date a dental hygienist *and* a cardiologist."

Arnold, with his code of self-reliance, had eliminated nearly all sources of insecurity from his life. But here was one that was beyond his control. "The biggest worry I have would be some sort of health-care need," he said. A serious medical issue would cost him his income. As an independent contractor, he isn't eligible for unemployment benefits. And, having passed the age of fifty, he was just waiting for some health problem to happen.

So did he feel that he had a right to health care? No. "I never thought about it as a matter of rights," he said. "A lot of these things we think are rights, we actually end up paying for." He thinks that the left typically plays down the reality of the costs, which drives him crazy. But the right typically plays down the reality of the needs, which drives him crazy, too.

In his view, everyone has certain needs that neither self-reliance nor the free market can meet. He can fix his house, but he needs the help of others if it catches fire. He can keep his car running, but he needs the help of others to pave and maintain the roads. And, whatever he does to look after himself, he will eventually need the help of others for his medical care.

"I think the goal should be security," he said of health care. "Not just financial security but mental security—knowing that, no matter how bad things get, this shouldn't be what you worry about. We don't worry about the Fire Department, or the police. We don't worry about the roads we travel on. And it's not, like, 'Here's the traffic lane for the ones who did well and saved money, and you poor people, you have to drive over here.' " He went on, "Somebody I know said to me, 'If we give everybody health care, it'll be abused.' I told her that's a risk we take. The roads are abused. A lot of things are abused. It's part of the deal."

He told me about a friend who'd undergone an emergency appendectomy. "She panicked when she woke up in the hospital realizing it would cost her a fortune," he said. "Think about that. A lot of people will take a crappy job just to get the health benefits rather than start an entrepreneurial idea. If we're talking about tax breaks for rich people to create jobs and entrepreneurialism, why not health care to allow regular people to do the same thing?"

[Brendan's Question: What do you think about this idea—that the need to keep health insurance in American society can stop people from being "entrepreneurs"? To what extent would universal healthcare solve this problem?]

As he saw it, government existed to provide basic services like trash pickup, a sewer system, roadways, police and fire protection, schools, and health care. Do people have a *right* to trash pickup? It seemed odd to say so, and largely irrelevant. The key point was that these necessities can be provided only through collective effort and shared costs. When people get very different deals on these things, the pact breaks down. And that's what has happened with American health care.

6.5 HISTORY OF US HEALTHCARE

The reason goes back to a seemingly innocuous decision made during the Second World War, when a huge part of the workforce was sent off to fight. To keep labor costs from skyrocketing, the Roosevelt Administration imposed a wage freeze. Employers and unions wanted some flexibility, in order to attract desired employees, so the Administration permitted increases in health-insurance benefits, and made them tax-exempt. It didn't seem a big thing. But, ever since, we've been trying to figure out how to cover the vast portion of the country that doesn't have employer-provided health insurance: low-wage workers, children, retirees, the unemployed, small-business owners, the self-employed, the disabled. We've had to stitch together different rules and systems for each of these categories, and the result is an unholy, expensive mess that leaves millions unprotected.

No other country in the world has built its health-care system this way, and, in the era of the gig economy, it's becoming only more problematic. Between 2005 and 2015, according to analysis by the economists Alan Krueger and Lawrence Katz, ninety-four per cent of net job growth has been in "alternative work arrangements"—freelancing, independent contracting, temping, and the like—which typically offer no health benefits. And we've all found ourselves battling over who deserves less and who deserves more.

[Brendan's Question: How might American Health Care have been different if it hadn't been built around "employers" providing tax-exempt health benefits?]

The Berkeley sociologist Arlie Russell Hochschild spent five years listening to Tea Party supporters in Louisiana, and in her masterly book "Strangers in Their Own Land" she identifies what she calls the deep

story that they lived and felt. Visualize a long line of people snaking up a hill, she says. Just over the hill is the American Dream. You are somewhere in the middle of that line. But instead of moving forward you find that you are falling back. Ahead of you, people are cutting in line. You see immigrants and shirkers among them. It's not hard to imagine how infuriating this could be to some, how it could fuel an America First ideal, aiming to give pride of place to "real" Americans and demoting those who would undermine that identity—foreigners, Muslims, Black Lives Matter supporters, feminists, "snowflakes."

Our political debates seem to focus on what the rules should be for our place in line. Should the most highly educated get to move up to the front? The most talented? Does seniority matter? What about people whose ancestors were cheated and mistreated?

The mistake is accepting the line, and its dismal conception of life as a zero-sum proposition. It gives up on the more encompassing possibilities of shared belonging, mutual loyalty, and collective gains. America's founders believed these possibilities to be fundamental. They held life, liberty, and the pursuit of happiness to be "unalienable rights" possessed equally by all members of their new nation. The terms of membership have had to be rewritten a few times since, sometimes in blood. But the aspiration has endured, even as what we need to fulfill it has changed.

When the new country embarked on its experiment in democracy, health care was too primitive to matter to life or liberty. The average citizen was a hardscrabble rural farmer who lived just forty years. People mainly needed government to insure physical security and the rule of law. Knowledge and technology, however, expanded the prospects of life and liberty, and, accordingly, the requirements of government. During the next two centuries, we relied on government to establish a system of compulsory public education, infrastructure for everything from running water to the electric grid, and old-age pensions, along with tax systems to pay for it all. As in other countries, these programs were designed to be universal. For the most part, we didn't divide families between those who qualified and those who didn't, between participants and patrons. This inclusiveness is likely a major reason that these policies have garnered such enduring support.

Health care has been the cavernous exception. Medical discoveries have enabled the average American to live eighty years or longer, and with a higher quality of life than ever before. Achieving this requires access not only to emergency care but also, crucially, to routine care and medicines, which is how we stave off and manage the series of chronic health issues that accumulate with long life. We get high blood pressure and hepatitis, diabetes and depression, cholesterol problems and colon cancer. Those who can't afford the requisite care get sicker and die sooner. Yet, in a country where pretty much everyone has trash pickup and K-12 schooling for the kids, we've been reluctant to address our Second World War mistake and establish a basic system of health-care coverage that's open to all. Some even argue that such a system is un-American, stepping beyond the powers the Founders envisioned for our government.

In fact, in a largely forgotten episode in American history, Thomas Jefferson found himself confronting this very matter, shortly after his Inauguration as our third President, in 1801. Edward Jenner, in England, had recently developed a smallpox vaccine—a momentous medical breakthrough. Investigating the lore that milkmaids never got smallpox, he discovered that material from scabs produced by cowpox, a similar condition that afflicts cattle, induced a mild illness in people that left them immune to smallpox. Smallpox epidemics came with a mortality rate of thirty per cent or higher, and wiped out upward of five per cent of the population of cities like Boston and New York. Jefferson read Jenner's report and arranged for the vaccination of two hundred relatives, neighbors, and slaves at Monticello. The President soon became vaccination's preëminent American champion.

But supplies were difficult to produce, and the market price was beyond the means of most families. Jefferson, along with his successor, James Madison, believed in a limited role for the federal government. They did not take expanding its power and its commitments lightly. By the time Jefferson finished his two

terms as President, however, city and state governments had almost entirely failed to establish programs to provide vaccines for their citizens. Thousands of lives continued to be lost to smallpox outbreaks. Meanwhile, vaccination programs in England, France, and Denmark had dramatically curbed the disease and measurably raised the national life expectancy. So, at Jefferson's prompting, and with Madison's unhesitating support, Congress passed the Vaccine Act of 1813 with virtually no opposition. A National Vaccine Agent was appointed to maintain stocks of vaccine and supply it to any American who requested it. The government was soon providing free vaccine for tens of thousands of people each year. It was the country's first health-care entitlement for the general population. And its passage wasn't in the least controversial.

[Brendan's Note: Smallpox was one of the first illnesses for which we had effective vaccines. However, it took a long, long time to get enough people vaccinated to eliminate the virus—almost 200 years! Why do you think was? You'll find out one reason a bit later in the essay…]

Two centuries later, the Affordable Care Act was passed to serve a similar purpose: to provide all Americans with access to the life-preserving breakthroughs of our own generation. The law narrowed the yawning disparities in access to care, levied the taxes needed to pay for it, and measurably improved the health of tens of millions. But, to win passage, the A.C.A. postponed reckoning with our generations-old error of yoking health care to our jobs—an error that has made it disastrously difficult to discipline costs and insure quality, while severing care from our foundational agreement that, when it comes to the most basic needs and burdens of life and liberty, all lives have equal worth. The prospects and costs for health care in America still vary wildly, and incomprehensibly, according to your job, your state, your age, your income, your marital status, your gender, and your medical history, not to mention your ability to read fine print.

Few want the system we have, but many fear losing what we've got. And we disagree profoundly about where we want to go. Do we want a single, nationwide payer of care (Medicare for all), each state to have its own payer of care (Medicaid for all), a nationwide marketplace where we all choose among a selection of health plans (Healthcare.gov for all), or personal accounts that we can use to pay directly for health care (Health Savings Accounts for all)? Any of these can work. Each has been made to work universally somewhere in the world. They all have their supporters and their opponents. We disagree about which benefits should be covered, how generous the financial protection should be, and how we should pay for it. We disagree, as well, about the trade-offs we will accept: for instance, between increasing simplicity and increasing choice; or between advancing innovation and reducing costs.

What we agree on, broadly, is that the rules should apply to everyone. But we've yet to put this moral principle into practice. The challenge for any plan is to avoid the political perils of a big, overnight switch that could leave many people with higher costs and lower benefits. There are, however, many options for a gradual transition. Just this June, the Nevada legislature passed a bill that would have allowed residents to buy into the state's Medicaid plan—if the governor hadn't vetoed it. A similar bill to allow people to buy into Medicare was recently introduced in Congress. We need to push such options forward. Maintaining the link between health coverage and jobs is growing increasingly difficult, expensive, and self-defeating. But deciding to build on what's currently working requires overcoming a well of mistrust about whether such investments will really serve a shared benefit.

6.6 BETSY AND MARK

My friend Betsy Anderson, who taught eighth-grade English at Athens Middle School for fifteen years, told me something that made me see how deep that well is. When she first started out as a teacher, she said, her most satisfying experiences came from working with eager, talented kids who were hungry for her help in preparing them for a path to college and success. But she soon realized that her class, like America as a whole, would see fewer than half of its students earn a bachelor's degree. Her job was therefore to try to help all of

her students reach their potential—to contribute in their own way and to pursue happiness on their own terms.

But, she said, by eighth grade profound divisions had already been cemented. The honors kids—the Hillary Clintons and Mitt Romneys of the school—sat at the top of the meritocratic heap, getting attention and encouragement. The kids with the greatest needs had special-education support. But, across America, the large mass of kids in the middle—the ones without money, book smarts, or athletic prowess—were outsiders in their own schools. Few others cared about what they felt or believed or experienced. They were the unspecial and unpromising, looked down upon by and almost completely separated from the college-bound crowd. Life was already understood to be a game of winners and losers; they were the designated losers, and they resented it. The most consistent message these students had received was that their lives were of less value than others'. Is it so surprising that some of them find satisfaction in a politics that says, essentially, Screw 'em all?

I met with Mark, a friend of Arnold's, at the Union Street Diner, uptown near the campus of Ohio University, which makes Athens its home. The diner was a low-key place that stayed open twenty-four hours, with Formica tables and plastic cups, and a late-night clientele that was a mixture of townies and drunken students. I ordered a cheeseburger and onion rings. Mark ordered something healthier. (He asked me not to use his last name.) The son of a state highway patrolman, he had graduated from Athens High School five years ahead of me. Afterward, he worked as a cable installer, and got married at twenty-three. His wife worked at the Super Duper grocery store. Their pay was meagre and they were at the mercy of their bosses. So, the next year, they decided to buy a convenience store on the edge of town.

Mark's father-in-law was a builder, and he helped them secure a bank loan. They manned the register day and night, and figured out how to make a decent living. It was never a lot of money, but over time they built up the business, opening gas pumps, and hiring college students to work the counter part time. They were able to make a life of it.

They adopted a child, a boy who was now a twenty-five-year-old graduate of the local university. Mark turned fifty-seven and remained a lifelong conservative. In general, he didn't trust politicians. But he felt that Democrats in particular didn't seem to recognize when they were pushing taxes and regulations too far. Health-care reform was a prime example. "It's just the whole time they were coming up with this idea from copying some European model," he said. "And I'm going, 'Oh shit. This is not going to end up good for Mark.' " (Yes, he sometimes talks about himself in the third person.)

For his health coverage, Mark trusted his insurance agent, whom he'd known for decades, more than he trusted the government. He'd always chosen the minimum necessary, a bare-bones, high-deductible plan. He and his wife weren't able to conceive, so they didn't have to buy maternity or contraceptive coverage. With Obamacare, though, he felt forced to pay extra to help others get benefits that he'd never had or needed. "I thought, Well, here we go, I guess I'm now kicking in for Bill Gates's daughter's pregnancy, too." He wanted to keep government small and taxes low. He was opposed to Obamacare.

Then, one morning a year ago, Mark's back started to hurt. "It was a workday. I grabbed a Tylenol and I go, 'No, this isn't going to work, the pain's too weird.' " It got worse, and when the pain began to affect his breathing he asked his wife to drive him to the emergency room.

"They put me in a bed, and eight minutes later I'm out," he recalled. "I'm dying." Someone started chest compressions. A defibrillator was wheeled in, and his heart was given a series of shocks. When he woke up, he learned that he'd suffered cardiac arrest. "They said, 'Well, you're going to Riverside' "—a larger hospital, in Columbus, eighty miles away. "And I went back out again."

He'd had a second cardiac arrest, but doctors were able to shock him back to life once more. An electrocardiogram showed that he'd had a massive heart attack. If he was going to survive, he needed to get to Columbus immediately for emergency cardiac catheterization. The hospital got him a life-flight helicopter, but high winds made it unsafe to fly. So they took him by ground as fast as an ambulance could go. On the procedure table, a cardiologist found a blockage in the left main artery to his heart—a "widow-maker," doctors call it—and stented it open.

"The medicine is just crazy good," Mark said. "By twelve-thirty, I was fixed."

After that, he needed five days in the hospital and several weeks at home to recover. Although he had to take a pile of drugs to reduce the chance of a recurrence, he got his strength back. He was able to resume work, hang out with his buddies, live his life.

It was only after this experience that Mark realized what the A.C.A. had given him. Like twenty-seven per cent of adults under sixty-five, he now had a preëxisting condition that would have made him uninsurable on the individual market before health-care reform went into effect. But the A.C.A. requires insurers to accept everyone, regardless of health history, and to charge the healthy and the less healthy the same community rate.

"This would have been a bad story for Mark," he said. "Because the same time you're being life-flighted is the same time you lose value to an employer. Your income is done."

He no longer opposed the requirement that people get insurance coverage. Fire insurance wouldn't work if people paid for it only when their house was on fire, and health insurance wouldn't work if people bought it only when they needed it. He was no longer interested in repealing protections for people like him.

[Brendan's Question: What do you think about the idea that health insurance should be required? This was a central piece of the ACA, and of basically every universal healthcare program that relies on "private" insurance.]

In this, he was like a lot of others. In 2013, before the implementation of the A.C.A., Americans were asked whether it was the government's responsibility to make sure that everyone had health-care coverage, and fifty-six per cent said no. Four years after implementation, sixty per cent say yes.

"But that doesn't mean I have to sign on for full-blown socialism—cradle-to-grave everything," Mark said. "It's a balance." Our willingness to trust in efforts like health reform can be built on experience, as happened with Mark, though we must recognize how tenuous that trust remains. Two sets of values are in tension. We want to reward work, ingenuity, self-reliance. And we want to protect the weak and the vulnerable—not least because, over time, we all become the weak and vulnerable, unable to get by without the help of others. Finding the balance is not a matter of achieving policy perfection; whatever program we devise, some people will put in more and some will take out more. Progress ultimately depends on whether we can build and sustain the belief that collective action genuinely results in collective benefit. No policy will be possible otherwise.

Eight years after the passage of the Vaccine Act of 1813, a terrible mistake occurred. The Agent accidentally sent to North Carolina samples containing smallpox, instead of cowpox, causing an outbreak around the town of Tarboro that, in the next few months, claimed ten lives. The outrage over the "Tarboro Tragedy" spurred Congress to repeal the program, rather than to repair it, despite its considerable success. As a consequence, the United States probably lost hundreds of thousands of lives to a disease that several European programs had made vanishingly rare. It was eighty years before Congress again acted to insure safe, effective supplies of smallpox vaccine.

When I told this story to people in Athens, everyone took the repeal to be a clear mistake. But some could understand how such things happen. One conservative thought that the people in North Carolina might wonder whether the reports of lives saved by the vaccine were fake news. They saw the lives lost from the supposed accident. They knew the victims' names. As for the lives supposedly saved because of outbreaks that didn't occur—if you don't trust the government's vaccines, you don't necessarily trust the government's statistics, either.

These days, trust in our major professions—in politicians, journalists, business leaders—is at a low ebb. Members of the medical profession are an exception; they still command relatively high levels of trust. It does not seem a coincidence that medical centers are commonly the most culturally, politically, economically, and racially diverse institutions you will find in a community. These are places devoted to making sure that all lives have equal worth. But they also pride themselves on having some of the hardest-working, best-trained, and most innovative people in society. This isn't to say that doctors, nurses, and others in health care fully live up to the values they profess. We can be condescending and heedless of the costs we impose on patients' lives and bank accounts. We still often fail in our commitment to treating equally everyone who comes through our doors. But we're embarrassed by this. We are expected to do better every day.

The repeal of the Vaccine Act of 1813 represented a basic failure of government to deliver on its duty to protect the life and liberty of all. But the fact that public vaccination programs eventually became ubiquitous (even if it took generations) might tell us something about the ultimate direction of our history—the direction in which we are still slowly, fitfully creeping.

On Mark's last day in the hospital, the whole team came in to see him. He thanked them. "But I didn't thank them for taking care of me," he said. "I thanked them for when I was smoking, drinking, and eating chicken wings. They were all here working and studying, and I appreciated it."

"That's what you thanked them for?"

"Yeah," he said. "Because if Mark wasn't going to stop this, they were going to have to keep working hard. Something had to happen because Mark was clogging up." And those people did keep working hard. They were there getting ready for Mark, regardless of who he would turn out to be—rich or poor, spendthrift or provident, wise or foolish. "I said, I am glad they do this every day, but I'm hoping to do it only once." ♦