

Health, Wealth and Poverty: Why the U.S. Needs Universal Healthcare

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On my honor, I have neither given nor received any unacknowledged aid on this paper.

A handwritten signature in black ink that reads "Lacey R. Thomas". The signature is written in a cursive style with a horizontal line at the end.

Among industrialized nations, twenty-eight of the twenty-nine cited by the World Health Organization have some form of universal healthcare. The exception is the United States. Poor people are the most likely to be uninsured or underinsured in America. Low-income people are more likely to suffer from health problems like cancer, infectious disease, and heart disease than higher income Americans (Handler & Hasenfeld, 133). A significant number of these poor Americans are uninsured and in spite of it, or perhaps because of it, they struggle with more health problems than the average American (Handler & Hasenfeld, 133). Certainly, health is the foremost issue when discussing uninsured persons, but the hazards faced by people without health insurance often extend beyond health risks.

While it is dangerous for uninsured and underinsured people to be deprived of preventive and curative care, there are also dangers linked to the very poverty that leaves them uninsured. For example, while working at Legal Aid in Lexington, Virginia, I became aware of how lack of health insurance can cause a spiral of debt. A client, Mary Host, called to file for bankruptcy because her debt had gotten out of control. This debt began when Mrs. Host had to have surgery for a debilitating back injury. Prior to this injury, Mrs. Host held a steady job that kept her family above the poverty line. Mrs. Host had two children, age ten and eight, whom she supported as her household's sole breadwinner. Although she could make ends meet, Mrs. Host could not afford insurance. Without health insurance, the medical expenses soon became too much for the family to pay and Mrs. Host was, with some embarrassment, now receiving AFDC. Without health insurance, the Host family was unable even to make ends meet and it plummeted into

poverty. “Poor health impacts on the ability to work—both the type of work one can do and the hours that one can work” (Handler & Hasenfeld, 133).

Problems of Inadequate Healthcare

Impoverished Americans suffer deprivations in many aspects of their lives. Inadequate housing, malnutrition, hunger, and inadequate or nonexistent healthcare are some of the problems plaguing the 11.8 percent of Americans who currently fall below the U.S. federal poverty line. The number of poor and working class Americans that struggle without sufficient health insurance is particularly alarming. Over 41 million Americans have little or no access to adequate healthcare (Symposium, Lewis Hall, 3/1/2002). Of those uninsured Americans, approximately two-thirds live in families with incomes below 200 percent of the poverty line; 27 percent actually live below the poverty line (McBride, online).

A common misconception about poor Americans is that they are all granted health insurance under Medicaid. Medicaid actually covers less than half of people that fall below the poverty line and less than 20 percent of people between 100 percent and 133 percent of the poverty line (Handler & Hasenfeld, 134). While new legislation works to insure that Medicaid covers all children under age eighteen, many adults still remain uninsured. Medicaid fully covers all children of families that would have been eligible for the former Temporary Aid to Needy Families (TANF) program. To qualify for Medicaid, the family has to have at least one child below eighteen and fall below a certain income level. One of the child’s parents must be dead, absent, disabled, or unemployed (Va. Medicaid Handbook, 1). States determine individually which family members Medicaid

covers and often only the children receive the healthcare provided by the program (Super, 3/1/2002). Since adults are the household breadwinners, it is essential that they gain the healthcare that they need to remain employed and to care for their families. Medicaid falls short of providing universal care, even for poor persons with families.

Single people and childless couples comprise a large portion of the uninsured and there is no way for them, provided they are not permanently disabled, to receive Medicaid or any other type of health insurance. "Basically, if you are thirty, childless, and not permanently disabled, you are out of luck," states Tracy Treen of Rockbridge County Social Services (Treen, 3/38/2002). Medicaid only covers four basic categories of people, those that meet TANF eligibility, legally blind persons, permanently disabled persons that meet Supplemental Security Income (SSI) requirements, and people over 65 years old (Treen, 3/28/2002). It is impossible for a person to receive any kind of assistance, regardless of income, unless he or she falls into one of these categories.

While Medicaid coverage is indisputably preferable to no coverage at all, problems plague the program. First, coverage and care vary according to state (Handler & Hasenfeld, 134). Medicaid is both a state and a federal program. Connecticut's program differs significantly from Texas'. Most states cover hospital and physician services, care in skilled nursing facilities, diagnostic services, and various screening and treatments for children (Kant, 58). It is optional whether states cover prescription drugs, dental care, and eyeglasses. In Virginia, for example, most, but not all, prescriptions are covered but Medicaid excludes routine dental care and eyeglasses for all persons over age 21 (Virginia Medicaid Handbook, 13). Medicaid coverage also provides rather low reimbursement rates for healthcare providers, discouraging them from accepting the

coverage (Handler & Hasenfeld, 134). Only emergency medical care requires that a physician provide treatment. Finally, a person receiving Medicaid may not combine it with private insurance (Handler & Hasenfeld, 134). This problem is linked to the fact that Medicaid coverage ends as soon as a family moves even one dollar beyond the cutoff point (Handler & Hasenfeld, 134). In Virginia, as soon as Social Services becomes aware that a person or family exceeds the maximum income level to receive Medicaid, they give them ten days' notice that the coverage will end (Treen, 3/28/2002). Since a family cannot gradually increase the amount of private insurance it buys while decreasing reliance on Medicaid, it is left uninsured as soon as it rises above the maximum income level.

Both poor and working class Americans fall into the category of "the uninsured." In 1998, only 30 percent of workers in the lowest one-fifth of the wage bracket enjoyed insurance provided by their employers (Boshey, 47). In contrast, eighty-two percent of those in the top one-fifth of wage earners enjoyed this benefit (Boshey, 47). Even when employers make insurance available to the poor and near poor, the co-payments and deductibles are often too high for those with little disposable income (Agency for Healthcare Policy and Research, 1997). Thus, insurance may not be accessible to low-income Americans because of budgetary constraints. The poor and near poor may choose to forgo the purchase of health insurance in favor of purchasing other necessities (McBride, online).

The uninsured fall into two basic categories (Super, 3/1/2002). The first group consists of poor, single adults and childless couples that do not qualify for Medicaid. The second group is people that are above the income cutoff to receive Medicaid. This group

encompasses people that work at low-wage jobs that do not provide employer coverage. This category of people is above the poverty line but often struggles to make ends meet. People in this category cannot afford to pay for private coverage.

Justifying Universal Healthcare

I. Subsistence Healthcare as a Basic Right

If the consequences for being uninsured are so dire, what should be done to correct this national problem? The United States must enact a plan of universal healthcare. Many moral reasons support a policy for universal healthcare. Henry Shue touches on the moral obligation to provide healthcare in *Basic Rights*. In making an argument that subsistence is a basic right, Shue states that it is not unreasonable to require society to provide some form of elementary healthcare to protect people from any fatal or debilitating deficiencies suffered by its citizens (Shue, 25). "No one can fully, if at all, enjoy any right that is supposedly protected by society if he or she lacks the essentials for a reasonably healthy and active life" (Shue, 24). Health care qualifies as a basic right because its absence impedes a person's ability to enjoy all other rights (Shue, 25). To deny people life-saving or preserving healthcare because they are poor violates our belief in an equal right to life.

This argument suggests that the only level of healthcare that is necessary is one that ensures a person's ability to exist in society. To promote the importance of good health goes a step beyond basic subsistence rights and, therefore, beyond the argument that Shue outlines. Shue's theory provides a starting point for justifying national healthcare. It is not enough for our society merely to protect people from grave health

problems; it must provide adequate healthcare for all its citizens regardless of income or wealth. Implementing universal healthcare therefore entails implementing a system that goes beyond fulfilling the role of subsistence to actually improving the life of the person receiving that care.

II. The Intrinsic Value of Health

Amartya Sen suggests that there is more value to a good like healthcare than simply the fact that “it creates utility through consumption” (Sen, 315). Goods have intrinsic value regardless of whether or not a person actually utilizes healthcare or preserves his or her health. Regardless of how a person contributes to society, he or she has a right to good health because of its intrinsic value. Equal access to healthcare ensures that every person has equal capability for a healthy life. Sen’s philosophy extends the justification for healthcare beyond basic subsistence and justifies it as an aid to functioning. It is not enough to merely subsist in America; one must have the capability to actually function. In order to realize this level of functioning a person must have access to an adequate level of healthcare.

Good health has intrinsic value regardless of whether it is used for economic or social functioning. The intrinsic value of good health is generally incommensurable with monetary value. Cass Sunstein recognizes that incommensurability often helps preserve attitudes and values in a society (Sunstein, 85). The social norms that value good health “[are] grounded on the insistence that incommensurability...is desirable as a means of maintaining attitudes and relationships that are part of good lives” (Sunstein, 85). Good health improves people’s mental and physical well being and thus touches every portion of their lives. These benefits should not be denied to anyone. The benefits of good health

are difficult to achieve without preventive care or medical treatment. These services are often beyond the reach of poor, uninsured and underinsured Americans. In order to enjoy good mental and physical health in its own right, the U.S. must provide adequate healthcare to every American.

III. Equality

Equality is an important American and human value. Universal healthcare must be equal for every American citizen in order to preserve this important value. We must promote healthcare policy guaranteeing that all citizens have access to healthcare that is at least equal to that obtained by the American middle class (Einer, 1473). Elauge Einer supports this argument, which requires that universal healthcare be redistributive (Einer, 1473). Universal healthcare entails redistributing resources so that poor Americans have access to as much health care as the middle class (Einer, 1473). This curbs the endless definitions of “adequate healthcare” that often plague real policy. Since universal healthcare requires redistribution, the definition of adequate care hinges on the wealth of the society. It is therefore prudent to choose the middle class of society as the group whose healthcare can be considered adequate.

A plan to raise every American to the level of middle class healthcare outlines a daunting and expensive task. Americans often support plans that define adequate healthcare only in terms of preventive medicine because this type of care supposedly saves money. Regardless of whether such plans actually cost less, these, and any similar arguments, are secondary to the obligation to provide adequate healthcare. Sunstein expresses this by arguing that we cannot measure human life [and its experiences] on a single metric. In this case, the metric is money and it is simply inappropriate to value

human health only monetarily. As a society, we must be willing to spend enough money to obtain an equal, middle class level of healthcare for all people because there is an intrinsic value in good health and equality (Einer, 1463).

III. Rationing Healthcare

Difficulty arises in rationing healthcare. Sunstein warns us that it is dangerous to take a moral absolutist position that obligates us to even marginally improve the health of every person (Sunstein, 100). Einer agrees with Sunstein's positions, suggesting that the United States could devote 100 percent of its GNP to healthcare without providing all possible services of some health benefit (Einer, 1459). This would be a poor decision because there are other services that U.S. citizens need. It is therefore an untenable policy to require that we devote all possible resources to providing U.S. citizens with healthcare.

Every healthcare system must address the issue of rationing. The major question in this realm is how to balance market and government rationing. Currently, "the American desire for more medical services, together with an ingrained suspicion of government, continues to trump concerns over high costs and the embarrassing lack of access to medical services for the working poor" (Churchill, 6). Americans are therefore dedicated to a market system of rationing. The market rations according to wealth. Those that have the highest level of wealth receive the largest or most valuable proportion of healthcare. The market then distributes limited healthcare resources to those who are poor. Wealth determines a person's level of healthcare and limits that healthcare according to one's ability to purchase it. The market system, by determining monetarily how much healthcare people have, rations.

This method denies healthcare, and thus both subsistence and the benefits of health, to those too poor to participate in the market. A universal, state-run system must be instituted to provide the healthcare that our current system rations unfairly (Churchill, 12). Because the state can promote equality in healthcare distribution, it must have a hand in running the U.S. healthcare system. State rationing would allocate equal resources to every American, regardless of income and, thus, minimize the inequalities produced by the market economy. Some elements of the market economy should, however, be preserved in universal healthcare because of the value they have to the American people. Americans value freedom and choice. An ideal system would be one in which the government distributes healthcare payments according to need, rather than wealth, but in which citizens remain free to choose their healthcare providers. In such a system, the details of which are discussed later, market choice would force healthcare providers to be responsive to patients in order to remain in practice. Government rationing would ensure that care is equally available.

Types of State-Run Care

The U.S. could adopt any of a number of forms of state-run health insurance. A single-payer system would mean that a single entity, like the government, would use tax revenues to pay for health expenses for all citizens. A multi-payer system builds on the single-payer system; people may opt to purchase private insurance in addition to their universal coverage. An alternative to the “payer” systems is a tax credit system in which the government provides tax credits to individuals who purchase private insurance. There are positive and negative aspects to each of these plans. In order to better evaluate such proposals, it is best to evaluate how such systems work in practice.

I. The Canadian System

In creating a universal healthcare system for the United States, it is helpful to examine the various strengths and weaknesses of other state-run healthcare systems. Canada offers a commonly used comparison and an example of the single-payer system. Canada shares a similar culture and medical tradition (Huefner & Battin, 97). Like, the U.S., this country has historically run its healthcare according to physician choice and fee-for-service reimbursement (Huefner & Battin, 97). Canada retains these traditions in its current healthcare system and can therefore be used as a possible model for instituting universal healthcare in the United States.

Fully adopted in 1971, Canadian healthcare runs as a single-payer system in which the provincial governments use tax revenues to pay healthcare fees (Powell & Wesson, 115). There are six basic tenets of the Canadian healthcare system: “Universal health insurance for all citizens, government funding from general tax revenues and government or non-profit administration of the plan, no point-of-service charges, no private insurance coverage for universal medical benefits, central control of budget levels but discretion for institutions for how to spend within overall budgets, and central control and dissemination of technology” (Powell & Wesson, 153).

The goal of the Canadian system is to provide “publicly financed healthcare services for all medically necessary services” (Graig, 121). The provinces individually define “medically necessary.” In most provinces this entails making a list of those procedures that would be deemed medically necessary. While Canadians may purchase private insurance in addition to their other coverage, this private insurance is prohibited from covering any of the services covered under the state’s plan (Graig, 121). This

prohibition ensures that every citizen receives essentially equal medical treatment at the level that is deemed medically necessary. Despite what critics may deem “lack of freedom” in choosing the level of medical care, patients remain free to choose their own physician and hospital and physicians remain free to choose where they practice (Graig, 127).

While Canadian health insurance aims to offer, at the most basic level, equal healthcare to its citizens, there are valid critiques of the system. Wide differences continue to exist between different demographic groups regarding the type and dollar-value of the care received (Powell & Wesson, 140). “A substantial and growing body of research indicates that despite national health insurance programs, social class differences still persist” (Powell & Wesson, 141). Inequalities arise partially because the program is not federally run. The provinces run the healthcare system with a combination of federal and provincial funds. This method means that provinces have different amounts of funding depending on their tax bases (a particular difficulty in those dominated by poorer, rural populations). Provinces also choose to cover different medical procedures according to their individual definitions of “medically necessary” (Graig, 131). There is no federally defined standard of healthcare. Although Canadian healthcare is universal, unequal funding and differing definitions mean that it is not equal. This problem would certainly be magnified in the American setting, which would have fifty states imposing fifty different healthcare systems.

One advantage that could arise from transplanting Canadian health insurance to the U.S. deals with a different problem of equality pertinent to the American setting. Urban and rural poor alike currently face a lack of access to healthcare providers in the

U.S. (Randall, 3/1/2002). One difficulty for poor populations is that “there is a shortage of physicians in both the inner cities and rural areas, and preventive health care for the poor is declining” (Handler & Hasenfeld, 133). Hospitals and physicians in the United States work for profit and, therefore, locate among those citizens that can afford their services. A single-payer system could potentially encourage more physicians to locate among poorer populations, receiving their fee regardless of the area’s demographic composition. While the poor would be unable to pay for additional procedures not deemed “medically necessary,” wealthier populations could choose to undergo these procedures. This type of inequality is tolerable. The achievement of universal healthcare does not hinge on an impossible-to-achieve ideal of equality. The inequalities of the Canadian system are therefore negligible when one observes that every Canadian citizen receives a minimum level of adequate healthcare.

A final critique of the Canadian system stems from the ambiguous definition of “medically necessary.” In the Canadian system, virtually all hospital and physician services are covered by the healthcare program (Graig, 127). Nevertheless, each province has a “master list” of what constitutes necessary medical care. Clearly, some medical procedures are more important than others are to sustaining a person’s life and are therefore medically necessary. Other cases are ambiguous, particularly those that deal with terminal illness. America’s Medicaid system demonstrates the problem of defining medical necessity. As noted, Virginia Medicaid does not pay for eyeglasses for persons over 21 years old. It impedes functioning when one cannot receive correctional treatment for a condition, like poor eyesight, that affects daily living. Understanding “medically necessary” should therefore be within the context of middle-class functioning. This

provides a general solution to defining medical treatment for people with terminal diseases. Treatment that prolongs life without improving a person's functioning should therefore be excluded from a definition of "medically necessary." Meanwhile, treatments that seem trivial, like dentistry, but which can significantly improve one's ability to function in society, should be deemed medically necessary.

In the U.S., imposing a standard of healthcare would have to have a clearer definition than "medically necessary." I suggest that the goal of universal healthcare should be to provide everyone with the same healthcare enjoyed by the middle class. This level of healthcare would offer the care required by the middle class to function at a middle class level. This is a shifting definition that varies according to the level of functioning that the middle class actually experiences in society. Middle-class care is synonymous with middle-class functioning.

II. The Dutch System

The Netherlands operates under a system of managed competition. It is founded on the principles of social democracy (Goodin, 247). Social equality is one of the most fundamental elements of social democratic ideals (Goodin, 247). In the interest of social equality, most social democracies provide their citizens with a variety of services that are universal, substantial, equal, and redistributive (Goodin, 251). These programs particularly address education, poverty, and healthcare. In the realm of healthcare, the Netherlands embraces the policies of a social democracy. The nation's Sickness Funds ensure that healthcare is universally distributed to the population, that it is substantial enough to cover most illness, and that it is equal to everyone. The healthcare system is also founded on a redistributive method of funding in which people pay a graduated

premium based on their salary. Thus, while wealthier people could normally afford to purchase more healthcare services, they are taxed according to their wealth, leaving care available for poorer people, who pay a smaller proportion of their incomes toward their Sickness Fund premiums. Unlike in the U.S. market economy, “healthcare is allocated instead as a state benefit and its distribution is no longer dictated by the underlying distribution of income and wealth within the community” (Goodin, 49).

There are three ways that people can be covered. A civil servant enjoys mandatory coverage (Graig, 74). The one-third of the population that earns more than the government-set income limit of \$34,000 a year must attain private insurance (Graig, 74). Although private insurance is optional, only about one percent of the population remains uninsured. The two-thirds of the population that falls below this income cut-off receives coverage from mandatory Sickness Funds (Graig, 74). The Dutch system guarantees that every citizen enjoys health insurance while a market system provides each patient with a choice for which Sickness Fund to choose. This unique combination allows Dutch citizens the freedom to enjoy healthcare and to choose the type of healthcare they receive.

When Holland reformed its healthcare, the Dutch instituted a governmental agency to determine which health services would be covered by Sickness Funds. This council did not compose a list of covered services but guidelines for determining coverage (Graig, 78). The tests for coverage are whether the service is necessary to allow the individual to function in society; whether the treatment requested is effective; whether the treatment is efficient; and whether the patient could pay for the service (Graig, 78). The provision that the treatment should be necessary for a person to function in society certainly addresses an important goal of any medical care. Additionally, it agrees with

Shue's theory that everyone has a right to a level of care that allows him or her to subsist. These policies, combined with the fact that care of the terminally or long-term ill is covered separately in a catastrophic coverage fund, mean that most illnesses are adequately covered by Sickness Funds.

When a person suffers from illness, he or she receives treatment from a general practitioner that has a contract with the Sickness Fund covering that individual (Graig, 81). Sickness Funds compete on a national level. Every two years a person has the option to renew or change the Sickness Fund that provides his coverage. This arrangement encourages competition between Sickness Funds on the basis of patient care, responsiveness, and flat rate fees (Graig, 87). Patient choice ensures that the quality of care does not decline due to lack of competition and addresses two arguments often posed against universal healthcare in the United States. The first argument is that universal healthcare compromises both patient and physician choice (Huefner & Battin, 82). The second argument contends that the trust inherent in a physician-patient relationship is undermined by state-run healthcare (Huefner & Battin, 82). These arguments address moral issues of freedom and choice. They are important American values that should be considered in healthcare reform. While these arguments address issues that are secondary to actually instituting a universal system of national healthcare, a plan that, like the Dutch system, accounts for them would enjoy greater political success and preserve important cultural values.

The other appeal of the Dutch system is that the government is not actually an agent in paying for the Sickness Funds. This would be an advantage to introducing a similar system to Americans, who tend to be wary of any programs that increases the

power and responsibilities of the government (Churchill, 6). The employer and employee share payment for the premiums. The premiums are removed from the employee's earnings as a percentage of his or her income. The employee contributes slightly more than 7 percent of his salary to paying premiums for the Sickness Funds (Graig, 80). Employers are required to contribute to Sickness Funds and are enticed by large governmental incentives to pay the bulk of insurance (Cook, 9). Employers contribute a larger percentage than the employees to the covered insurance premiums (Graig, 80). In addition to paying premiums, all adults pay a flat, \$175 a year to the Sickness Fund (Graig, 85). This flat rate was instituted during healthcare reform as a means of demonstrating the high costs of health care to the population (Graig, 80). It is conceivable that in cases where a person is unable to pay the flat rate, they would be able to apply for a waiver of this fee.

Components of the Dutch healthcare system address the goals of U.S. healthcare reform. Sickness Funds ensure that every citizen has access to healthcare. Although the Sickness Funds do not have a specific list of covered services, they consider whether care is necessary to allow the individual to function in society. As noted, Canada's definition of adequate care as "medically necessary" is too ambiguous; Holland's standard clarifies adequate care without resorting to simply listing covered services. It sets a precedent for defining America's healthcare according to a standard of middle-class functioning by stating that healthcare should allow a person to function in society.

The fact that Sickness Funds compete for consumers ensures that they provide adequate and generally equal care. This is an excellent model of how to combine government and market rationing. The Dutch system, in which patients choose their

Sickness Funds and physicians, contains elements of the market economy. The government also acts as a rationing agent by offering a sliding scale of payment to the Sickness Funds. The system is thus redistributive, ensuring that citizens have access to healthcare regardless of income while preserving market choice. This model should be considered in the U.S. as an alternative to the single-payer system because it offers a good definition of adequate medical care and preserves American values like freedom and choice while rationing care equally.

III. The British System

It is generally acknowledged that the British healthcare system, known as NHS, would never be adopted in the United States (Graig, 153). Americans are wary of British-style socialized medicine in which the federal government actually runs the healthcare system. Socialized medicine, in which physicians are salaried government employees, is contrary to the American interpretation of freedom. It would be easier to adopt a single-payer, rather than a socialized system in the U.S. The British system, however, shares many characteristics with Canada's single-payer system (which *is* a viable option for the U.S.), thus making it valuable to observe how the British healthcare system functions. "NHS is the most centrally managed and financed healthcare system in the world" (Graig, 153).

Although the NHS has undergone reform during the 1990s, the way that care is funded and enjoyed by the population remains basically the same. This continuity exists because there are four basic, unchanging principles under which the system operates. These principles dictate that healthcare should be universal, comprehensive, free upon point-of-service, and financed by general tax revenues (Graig, 156). Despite flaws like

long waiting lists for certain procedures, NHS delivers decent, comprehensive health services to the entire United Kingdom (Graig, 281).

Every citizen and resident immigrant may register with a general practitioner. The general practitioner provides the patient with primary medical care and makes any necessary referrals to specialists. One cannot receive treatment from a specialist through NHS without receiving a referral from the general practitioner. Under the recent reforms, the GP also functions as the purchaser of medical treatments. Each GP is assigned a budget that he or she can use to purchase certain non-emergency services for patients (Graig, 167). The GPs essentially function as mini-HMOs that purchase care for patients, regulate visits to specialists, and treat non-emergency patients. Physicians' income comes from a variety of sources. The British government pays the salary and fees. Under recent reforms, 60 percent (rather than the previous less-than-50 percent) of income is based on the number of patients treated (with a limit of 5,000) (Graig, 161). The government instituted capitation (income based on number of patients) as a major source of income to encourage physicians to provide improved care (Graig, 167).

All citizens and residents have access to NHS as their source of healthcare but they are not required, as in the Canadian system, to receive their care through NHS. Instead, citizens can opt for private insurance that may be offered by employers. While about 12 percent of the population has some form of private insurance, it is not generally used for basic care, but as a means of reducing wait-time for elective surgery (Graig, 163). There is little incentive to opt-out of the national healthcare system because one must continue to pay taxes toward NHS (Graig, 163).

Like the Canadian healthcare system, the NHS's finances come almost entirely from tax revenues (Graig, 157). Approximately 2 percent of the budget derives from patients payments for dental work, eyeglasses, vision exams, and some prescription drugs not covered under NHS (Graig, 157). In the UK, however, the budget is formed and healthcare administered on the national level. While reforms have created Primary Care Groups (PCGs) to treat a certain region's population, the PCGs have no regional administrators and rely solely on the federal government for their budget (Graig, 170). This method of administration is an advantage in the British system. While inequalities would persist as far as the actual care received and the physical access a patient had to healthcare, federal administration ensures that healthcare means the same thing in every region.

Current American Proposals for Reform

I. Plans to Expand Current Programs

Proposals for reforming U.S. healthcare are basically interested in expanding programs that already exist to relieve some members of the uninsured population. The first such suggestion is to expand the State Children's Health Insurance Program (SCHIP) to include the parents of those children (Davis, online). Proponents of this proposal note that SCHIP successfully covers low-income children and has been expanded in some states to cover parents. The second suggestion for reform is to expand Medicaid to cover low-income parents (those below 200 percent of the Federal Poverty Line), singles, and childless couples (Davis, online). The third category of proposals includes a variety of plans that involve individual states providing insurance programs that would be funded by the federal government (Davis, online).

These proposals are interested in incremental changes that expand existing programs to include a larger number of poor, uninsured Americans. Certainly any reform that can actually be instituted to expand health insurance to more Americans should not be rejected. I assert, however, that these reforms are inadequate because they do not result in a universal healthcare system. Universal healthcare would not only expand health insurance, it could also minimize inequality in the care received. It is not just lack of insurance, but also unequal care and coverage that plagues the U.S. healthcare system and proposals to expand existing “safety nets” do not solve these problems. A universal, single-payer system could, however, ensure both that people receive healthcare and that it is basically equal for all Americans.

Not only am I not convinced that these programs will be adequate, but I also think that there is a moral argument to be made in favor of a federal, single-payer program funded by an income-based tax. Every American has an obligation to alleviate poverty. One of the ways that poverty most often manifests itself is in the poor health of the uninsured and underinsured American. It is therefore obligatory that every American contribute an amount proportional to his wealth to funding a national healthcare system. While any expansion-based reform would certainly receive funding from federal and state budgets, I think it is necessary for the funds to be clearly identifiable as tax revenue.

II. Plans for Universal Healthcare

There are three basic proposals that go beyond expanding social welfare programs to reforming health insurance on every level in the United States. The first such proposal presents universal healthcare as a voluntary, followed by a mandatory process in which individual states would implement health insurance systems (AMSA.org). During the

voluntary phase, participating states would receive federal matching funds to design a healthcare system meeting residents' needs (AMSA.org). During the universal phase, states would be required to provide universal healthcare for all residents, remaining free to choose a single-payer system of some other option (AMSA.org). In the interest of assuring quality care to those that receive their care through this universal system, the state would ensure that coverage would be equivalent to the Federal Employees Health Benefit Program (AMSA.org).

There are positive aspects to this plan. First, it offers a good blueprint for phasing in a universal healthcare system. By offering a voluntary phase, states could experiment to find the most effective healthcare plan. The second advantage is state control over administration, which would promote a system responsive to its consumer population. This plan presents a good example for a minimum standard of healthcare but does not ensure that every state provides equal care; it does not advocate set federal standards, only a federal minimum of healthcare. Since it does not require that everyone use the state's healthcare, inequalities would persist.

A second proposal suggests progressive, federal tax credits that would provide large enough tax credits for people to buy private insurance (AMSA.org). This plan would also encourage more people to buy private health insurance, attempting to decrease reliance on employer-provided insurance (AMSA.org). People will remain free to choose the type of coverage that they purchase with this tax credit (AMSA.org). Although this plan would preserve patient choice, tax credits would not reduce inequality or ensure that every American has health insurance coverage. A universal healthcare system should address both of these points, criteria that this plan fails to meet.

A third proposal is actually an expansion of employer-based insurance and federal coverage programs to ensure access to health insurance for all Americans. Employees would be automatically enrolled in any employer-offered plans (AMSA.org). They could, however, choose to opt out of the plan (AMSA.org). Workers not offered employer coverage could enroll in the Federal Employees Health Benefits Plan (AMSA.org). In addition, the plan would expand Medicaid and CHIP to include all individuals up to 100 percent of the poverty line (AMSA.org). Individuals could also choose to retain their private insurance. This plan is inadequate because the important issue in any reform is not making health *insurance* but *healthcare* more accessible. This plan fails to ensure that every American has healthcare because people can opt out of employer plans and the working poor would still be ineligible for Medicaid and possibly unable to procure private insurance.

The American Medical Student Association (AMSA) and Physicians for a National Health Program support a single-payer system run by the federal and state governments (AMSA.org). These groups advocate adopting a system similar to Canada's (AMSA.org). Their proposal meshes with my own recommendations for adopting universal healthcare in the United States. It includes a health package funded by a federal tax and administered by the states (AMSA.org). The state would negotiate the fee schedule with physicians but would not actually employ the physicians (AMSA.org). Unfortunately, state administration in this case would encounter the same inequalities of Canada's provincial administration. The plan lacks a federal standard of care. Supporters of the plan suggest that healthcare should be free upon point-of-service; another point at which I diverge from this reform. Because this plan provides healthcare, rather than

health insurance, it is the best of current proposed options for adopting healthcare reform in the United States.

My Proposal for Healthcare Reform

The best way to ensure that people receive healthcare equal to that of the American middle class would be to adopt a system like Canada's. By denying anyone, regardless of income, the ability to receive basic healthcare outside the state's plan, the plan avoids the danger of developing a tiered system. Universal, mandatory health insurance prevents different classes of citizens receiving different care depending on whether they opt out of the state program. If everyone were covered by the same policy, the procedures that would be covered would necessarily be both extensive and exhaustive according to the definitions of "middle class."

The standard of care in the U.S. should be the level that the middle class enjoys, understanding that this level of care covers procedures that ensure a middle-class level of functioning. This would obviously exclude procedures like cosmetic surgery. The middle-class standard would perhaps include dental procedures or podiatry, which are not "medically necessary" by the Canadian standard, but that help middle-class Americans function. A middle-class American would expect these treatments to be a part of his or her healthcare. If every citizen must use a state healthcare plan, then the wealthiest citizens will have just as much of an incentive as the poorest citizens to insist that this middle class standard of coverage be adequate coverage.

Unlike the British, socialized, system, the Canadian system is a single-payer system. Under socialized medicine, the physician is a salaried government employee. Meanwhile, physicians in a single-payer system are not government employees; the

government only distributes funds paid into the collective healthcare budget. While the federal and provincial governments manage the funds in Canada, they do not actually have a hand in medical care other than regulation. In contrast, the British government actually runs the hospitals and employs the physicians. This makes the British system an untenable one for the U.S. because citizens are wary of any overarching federal programs. Medicine run by the federal government incites fears about inadequate care and excessive bureaucracy. A single-payer system avoids this problem.

The federal government would regulate the treatments and procedures covered. In order to achieve the most beneficial and equal healthcare system and avoid some of the problems that the Canadian system faces with provincial inequalities, it would have to be regulated by the federal government. The federal government would define the minimum level of healthcare and this definition would not be open to states' interpretations.

A graduated income tax and co-payments on any services or prescriptions that a person receives should fund the plan. Funding would come through federal taxes granted to the states according to the characteristics of its population. This avoids the Canadian problem where provinces derive healthcare funds from their own tax bases and, therefore, provide unequal care. Instead, the federal government would ensure that every state had enough funding to meet a middle-class standard of care for every citizen. The states would play a role as the single-payer, implementing the system and paying physicians from the federal grants. States would have the opportunity, if desired, to spend their own budget according to their residents' needs. Federal funds could encourage states to run pilot or test programs for providing the federal standard of care (using federal dollars) while being responsive to a specific population.

Although the government would be rationing healthcare at the largest level, there needs to be some rationing at the individual, patient level as well. Co-payments would reduce the number of people that overuse health services by requiring a point-of-service payment. The fee should be nominal but significant enough to reduce the possibility that a patient will frequent a general practitioner simply because it is “free.” Introducing co-payments to U.S. healthcare reform would remind Americans of the great costs associated with providing health services.

The Canadian healthcare system also makes a good example of how to ensure that physicians respond to patients. Canadian physicians are paid on a fee-for-service basis. It is therefore advantageous for a Canadian physician to retain patients and continue receiving the fees for their care. Physicians would receive fees for curative treatment as well as vaccinations, screenings, and immunizations, providing monetary incentive for both curative and preventive healthcare. By being responsive and providing good care, Canadian physicians can retain patients and gain new patients, thus increasing their income.

Recent reforms ensure that there are monetary incentives for practicing good preventive medicine in the UK, and also for locating in medically impoverished areas. Access to medical care is a problem in both the U.S. and Canada. Canadian patients must sometimes travel outside their province to receive treatments not available in their area (Graig, 132). In the UK, physicians receive a special “deprivation payment” for locating in undesirable areas and, additionally, receive a larger bonus when they meet “targets” for immunizing, screening and vaccinating these difficult, often mobile, populations. These incentives could be adapted to American healthcare reform. Although under the

single-payer system, physicians could not receive salary bonuses, the government could provide tax breaks or some other viable financial incentive to physicians who locate in an underserved area.

While a single-payer system offers the most desirable plan for adopting universal healthcare in the U.S., the Dutch system is a good and more politically popular alternative. The system is viable because it ensures that every citizen has health insurance and, thus access to healthcare. Citizens are not able to opt out of health insurance, but are able to choose private insurers. Although Dutch healthcare does not ensure that every citizen receives equal healthcare, it's competitive, market system encourages competition. Since Americans consider market competition an essential component in ensuring quality, the Dutch system, wherein Sickness Funds compete for consumers, would preserve this valued component of the American system. Competition would benefit consumers and possibly ensure a good standard of medical care without imposing federal guidelines.

The final acceptable proposal is one being currently proposed in the American political arena. A program that phases-in state-run healthcare in a voluntary, then mandatory format would ensure universal coverage. A health package funded by taxes would be administered by the states (AMSA.org). Again, this type of system does not ensure equality. Like the inequalities in state-run welfare programs, state-run healthcare would vary greatly from state-to-state. A federal minimum of care would ensure some level of care, but not an equal level of care. It is, however, a plan for every American, regardless of income, to have access to a minimum level of healthcare. This is the first

step toward universal healthcare. In fact, this method may be the first, short-term means to achieving implementation of the Canadian-like system in the long run.

Healthcare and Poverty

Theoretical and practical arguments support the adoption of a single-payer, state-run system. The two primary goals of any healthcare system should be security and solidarity (Churchill, 29). Security speaks to the issue already discussed that argues that every citizen has the right “to live without fear that basic health concerns will go unattended” (Churchill, 29). Mandatory universal coverage would certainly ensure that every citizen could receive medical care, regardless of income. Poor Americans would not suffer, wondering how bad their condition had to be before they could visit the emergency room. All Americans would enjoy the peace of mind that accompanies guaranteed healthcare.

Solidarity is the “sense of community that emerges from acknowledgment of shared benefits and burdens” (Churchill, 29). The benefits of a single-payer system clarify the importance of solidarity. Solidarity will only exist if everyone receives the same healthcare. The population then shares the incentive to promote the best possible healthcare because everyone recognizes that he or she cannot be any better off than anyone else in terms of basic healthcare. Solidarity in healthcare helps avoid the inequalities that arise when a rich and powerful class of people paternalistically determines what is best for the poorer, powerless classes.

Class and power should not determine access to healthcare. Under a universal healthcare system, the large medical bills that plagued Mrs. Host would have been nonexistent. She would not have been pushed into poverty and reliance on AFDC by

huge and necessary medical expenses. Second, and equally as important, she would have had full access to care, allowing her to reach an adequate level of health capability. Finally, and most simply, Mrs. Host would have enjoyed the intrinsic value in the opportunity for healthcare because she would have access to preventive care and treatment. She would not have had to suffer with a back injury until the pain became so unbearable as to force her to seek surgical attention. Although poor Americans suffer many inequalities and deprivations, universal healthcare would both reduce these deprivations and alleviate poverty. Universal healthcare addresses pressing issues of both poverty and health and, therefore, must be adopted in the United States.

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