

DEATH PANELS AND DIFFERENCE PRINCIPLES: A RAWLSIAN ANALYSIS OF THE
AFFORDABLE CARE ACT

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I. Introduction

When the Patient Protection and Affordable Care Act (ACA) was signed into law in March 2010, it was supposed to usher in a new era of health care in the United States. From both Democrats and Republicans, we heard that it was going to change the way that Americans think of health insurance—depending on whom one talked to the ACA would finally create a just system of health care in America or usher in a Brave New World of socialized medicine and government takeovers. As the Affordable Care Act begins implementing its signature proposal this year, the so-called individual mandate, its provisions are starting to look more and more like reality. This paper will focus on the ethical ramifications of the Affordable Care Act—specifically, I will examine how the different provisions included in the Affordable Care Act may or may not be justified under the liberal egalitarian system of justice created by John Rawls in the classic book, *A Theory of Justice* (later referred to as *Theory*). In my examination, I will extensively use insights from Norman Daniels’ 2008 book, *Just Health*, which applies Rawls’ system of justice to health and establishes a series of benchmarks for measuring the justness of health sector reforms. Indeed, the discussion and critique of Daniels’ theory forms another main focus of this paper, for it allows for a broader and more nuanced discussion of what comprises health justice.¹

Yet before delving into philosophical theory, I offer a few notes. First, a terminological one: I will refer to this expanded version of Rawls’ system of justice applied to health as the “Rawls-Daniels” theory, and I will use Rawls-Daniels as the philosophical basis on which I evaluate ACA reforms unless otherwise noted. Second, an organizational one: I cover a lot of ground in this paper, so I have divided it into a number of sections. Section II explains in brief

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detail some of the main aspects of the theory of justice as fairness. Those familiar with Rawls may feel free to skim or skip this section. Sections III through VII, which constitute the bulk of this paper, discuss problems specific to health justice, with a primary (but not exclusive) focus on Daniels (I also consider articles by Christopher Boorse and Jerome Wakefield, as well as one of Rawls' later works). In Section VIII, I introduce Daniels' "Benchmarks of Fairness", which I then use to evaluate the American health care system and the reforms in the Affordable Care Act. Section IX uses the framework of the Benchmarks to focus on ethical problems with the American health care system. My discussion in this section focuses exclusively on macro-level problems, as micro-level problems are often too small to evaluate through the lens of political philosophy. In Section X, I evaluate with that same framework where the Affordable Care Act improves the justness of the American health care system, and where it falls short.

Ultimately, I argue that while the Affordable Care Act does make a number of substantive changes that will lead to a more just health care system, it fails to combat the root causes of injustice in the American health sector and opens Americans up to unneeded risk with a smattering of new, unproven experiments. Admittedly, the Affordable Care Act hardly makes unjust changes, and it was perhaps the best that could have been hoped for under political constraints. Yet before delving into how the Affordable Care Act improves and fails to improve the unjust nature of the American health care system, it is necessary to examine what features of the Rawls-Daniels theory cause us to see certain health care systems as just and unjust.

II. Taking a Step Back to Examine Rawlsian Justice as Fairness

Though focused primarily on issues of justice in health care, this essay uses a Rawlsian framework to evaluate the justness of the Affordable Care Act. In this next section, I give the reader a brief sketch of the Rawlsian framework, assuming that she is unfamiliar with Rawls' theory of justice as fairness. Specifically, I will use the theory that Rawls presents in his 1999 revision of *A Theory of Justice* as a basis. It should be noted, however, that this brief discussion cannot explain many of the complexities of *A Theory of Justice*. To engage more deeply with *Theory*, the reader is advised to read Rawls' writings and other academic papers (some of which are found in this bibliography).

Procedural Justice

Rawls' theory of justice as fairness is an ideal conception of justice, i.e. a conception of how the basic structure of a society ought to be ordered under ideal conditions.² Rawls introduces a few key ideas to help us think about justice that lead us to accept the plausibility of his theory. First is the conception of free and equal moral and rational persons. Drawing mainly on Kantian conceptions of the person,³ Rawls accepts that at their base, persons have four main characteristics. They are:

- 1) Free to make their own choices
- 2) Equal to each other (or of equal value)
- 3) Rational

² Rawls defines the basic structure of society as “the way in which major social institutions fit together into one system, and how they assign fundamental rights and duties and shape the division of advantages that arises through social cooperation.” (John Rawls, “The Basic Structure as Subject,” 159.) With this definition, Rawls sets apart the “major institutions”, examples of which include a choice of economic system (laissez-fair capitalism or statism or socialism), a government decision-making model (democracy or one-party state or other), and a system of child-raising (familial or communal). These major institutions contrast with smaller-scale considerations such as individual transactions and specific laws.

³ John Rawls, *A Theory of Justice*, 10–11, 225.

4) Possessing of moral worth.⁴

These four qualities of a “person” guide much of his theory of justice as fairness. Rawls also introduces us to the notion of pure procedural justice, in which the outcome of a fair procedure is just *whatever that outcome may be*. In other words, the makeup of the procedure itself determines if some decision or outcome is just. Rawls uses the example of gambling: given that bets are made freely and fairly, and that no one cheats, etc., it is not a matter of justice that Person A wins and Person B loses, or vice versa.⁵ Though the outcomes are different, they are both equally just because of the way the gambling procedure was set up.

Pure procedural justice underlies Rawls’ formulation of social contract theory. Social contract theory follows in the line of political philosophers such as Thomas Hobbes, John Locke, and Jean-Jacques Rousseau, who argue that the basic structure of a just society is derived from a hypothetical original agreement, or contract. Put another way, as contracts allow the contactors to meet their own interests, a just society should be one that best allows people to meet their interests. The logic underlying the social contract method is that restrictions on natural liberty can be justified if we would have accepted them as a basis for entering into society through unanimous agreement. This original agreement takes place in some type of “initial situation”, or “state of nature”, in which persons who are not involved in a society create an agreement, or contract, for how their society will function.⁶ Rawls’ notion of pure procedural justice distinguishes his social contract method from previous philosophers. For the theory of justice as

⁴ For the theory of justice as fairness, persons have moral worth based on what later becomes known as the “two moral powers”, which are explained below.

1. Persons are capable of understanding, applying, and acting based on principles of political justice.
2. Persons are capable of having a “conception of the good”, a rational plan for a way of life that fulfills one’s unique preferences. (John Rawls, *Justice as Fairness: A Restatement*, 18–19.)

Each person, by virtue of being human, is thought to at least have the capacity to act from principles of justice and to have a “conception of the good”; therefore each person possesses moral worth.

⁵ John Rawls, *A Theory of Justice*, 74–75.

⁶ *Ibid.*, 10–11.

fairness, as long as the original agreement to form a social contract takes place under the conditions of fairness, the outcome of the original agreement (i.e. decisions about the basic structure of society) will be just. Hence the name of “justice as fairness” for Rawls’ theory.

The Original Position

Justice as fairness puts a lot of weight on how the initial situation is conceived, since without a suitable conception of this situation, one cannot invoke pure procedural justice. Rawls creates what he calls the “original position”, which is “the most philosophically favored interpretation of this initial choice situation for the purposes of a theory of justice.”⁷ Importantly, the original position must emphasize the essential characteristics of free and equal moral (and rational) persons but ignore other factors that unfairly influence this original agreement. To facilitate this emphasis on essential characteristics, the original position imposes a constraint on the contractors, what Rawls terms the “veil of ignorance”. The veil of ignorance aims to screen out morally arbitrary facts that may influence a person’s decisions. Some of these morally arbitrary facts are part of the social lottery, whereby persons are born into positions where they have more or less wealth than others, and sometimes more or less liberty than others. Likewise, some of these morally arbitrary facts are part of the natural lottery, whereby some persons are born smarter, or stronger, or with more motivation than others. Some, too, are simply matters of taste, as some persons innately are more willing to take risks, take part in family life, or cultivate new experiences. Since these traits are not our choice, the veil of ignorance considers them morally arbitrary and thus unfit to exist in the original position. Specially, under the veil, no one knows:

- 1) One’s own place in society

⁷ Ibid., 16.

- 2) How one fares in the natural lottery (i.e. no one knows their own intelligence, strength, motivation, etc.)
- 3) One's conception of the good (i.e. the way of life one considers to be best for oneself)
- 4) One's aversion to risk
- 5) The generation of which one is a part (i.e. whether one is part of an undeveloped society still based on subsistence farming, or a highly developed, industrialized society)

Even without this particular knowledge, contractors still know general facts about human society (economic theory, psychology, and sociology). Ultimately, contractors are conceived as perfectly rational persons, and since all contractors are equally rational, each contractor is persuaded by the same arguments. Thus, unanimous decision in the original position is possible.⁸

The Two Principles of Justice

In the original position, contractors compare conceptions of right to find the one that each would prefer, if agreement can in fact be reached.⁹ Contractors most comprehensively compare conceptions of utilitarianism (outside the scope of this essay) to the “two principles of justice” that Rawls introduces and defends. The two principles create a liberal egalitarian conception of the basic structure of society. They are explained below:

- 1) *The first principle (principle of greatest equal liberty)*. Everyone is entitled to the most extensive system of liberties as possible, provided that these liberties are equal and compatible with liberty for all. Liberties include liberty of conscience, freedom of the person (freedom from physical and psychological oppression), right to property, and freedom from arbitrary arrest.
- 2) *The second principle*. Inequalities in wealth and income are to be governed so that they work towards everyone's advantage. This second principle is split further into two principles: the principle of fair equality of opportunity and the difference principle.
 - a. *Principle of fair equality of opportunity*. Under fair equality of opportunity, “those with similar abilities and skills should have similar life chances.”¹⁰ Essentially, fair equality of opportunity requires that no one is prevented from

⁸ Ibid., 118–123.

⁹ Ibid., 106–107.

¹⁰ Ibid., 63.

realizing her skills and abilities because of her disadvantaged place in society relative to others.

- b. *The difference principle.* Inequalities in the favor of those who are better situated are just if, and only if, they improve the expectations of the least well off person. If not, then equality must be preserved.¹¹

A further note on the difference principle: it can be thought of as a “maximin” solution, because it maximizes the minimum expectations that one might expect.¹² Expectations, a rather broad term, are determined in reference to primary social goods. Primary social goods (or often, primary goods) include rights, liberties, opportunities, income and wealth, and the social bases of self-respect.¹³ We can determine how “well” someone is situated by appealing to these categories of primary goods, and how much of each primary good that person has.

Finally, the two principles of justice are lexically ordered, meaning that the first condition must be completely satisfied before the second is considered, the second before the third, and so on. The first principle (1) has lexical priority to the second (2), and within the second principle, the principle of fair equality of opportunity (2a) has lexical priority to the difference principle (2b).¹⁴ Thus, liberty must be preserved before opportunity, and opportunity preserved before considering inequalities of wealth and income.

Justification of the Principles of Justice

Rawls argues that the contractors in the original position would choose the two principles over utilitarian theories. Among other reasons, the two principles preserve the liberty of each person to realize her conception of the good, and do not require anyone to sacrifice their own good for the good of others. Moreover, the two principles minimize the risk involved with the

¹¹ Ibid., 65–66.

¹² Ibid., 132–133.

¹³ Ibid., 79, 386.

¹⁴ Ibid., 53–54.

natural and social lottery, because even if one ends up in the “worst” position, that position is the best of all worst positions—she is still better off than the worst position in which one might end up if her society used different principles of justice. Since contractors are operating under a veil of ignorance and are choosing principles that will determine their entire life prospects, it is rational for them to minimize this risk.¹⁵ There are many other given reasons for why the two principles are preferred, but those are beyond the scope of this paper. All that is important for our purposes is that the contractors would, in fact, choose the two principles, and due to the nature of the original position, we can conclude that the two principles should govern the basic structure of society.

¹⁵ Ibid., 130–144.

III. The Philosophical Basis for Evaluating Health Reforms

In *Just Health*, Daniels aims to answer what he terms the “Fundamental Question”: “As a matter of justice, what do we owe each other to promote and protect health in a population and to assist people when they are ill and disabled?” This question, he asserts, breaks down into three ancillary “focal questions”:

- 1) “Is health, and therefore health care and other factors that affect it, of special moral importance?”
- 2) “When are health inequalities unjust?”
- 3) “How can we meet health needs fairly under resource constraints?”¹⁶

The following sections will discuss each of these three questions.

First, a note on method. To answer the focal questions, Daniels uses Rawls’ theory as a background and extends his theory to include claims about health. This extension is important since Rawls assumed (for sake of simplicity) that contractors in his original position could expect to lead healthy, full lives, thereby eliminating possible claims made in the original position on the basis of health inequalities. This assumption by Rawls creates considerable problems for one who tries to apply Rawls’ justice as fairness to health and health care, since that person must alter the main theory in one way without destroying the rest of the whole theory. Daniels tries to do this by relaxing the assumption made about healthy, full lives, which allows for the possibility of unhealthy people making claims of justice based on their health needs.¹⁷ This extension fits Daniels’ characterization of applied ethics, in which we do not merely take moral theories and apply them to relevant situations. Instead, we mold and shape the theories themselves to fit real-world situations even as we shape real-world situations to fit our theories.¹⁸ Daniels’ characterization, what he calls “wide reflective equilibrium” is compatible with (and modeled

¹⁶ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 11.

¹⁷ *Ibid.*, 47.

¹⁸ Norman Daniels, *Justice and Justification*, 11.

after) Rawls' characterization of how we ought to justify our ideal theory of justice. By applying Rawls' theory to health, Daniels tweaks the theory so that it becomes relevant to a practical problem, just as I will undoubtedly tweak Daniels' theory to apply it to a law in practice later in this paper.

The discussion that follows does not solely use, nor does it fully endorse, Daniels' theory of health justice. Yet I still follow the outline of his argument in *Just Health* for sake of simplicity. Once Daniels is able to answer the three focal questions, he is able to completely answer his Fundamental Question, i.e. sketch out a full theory of health justice. Only when the Fundamental Question is answered will we turn to see how Daniels applies his theory of health justice to evaluate health reforms.

IV. Defining Health

Since the act of promoting health factors so heavily into the moral requirements of a just society, we should begin by asking what exactly we mean by “promoting health”. This section is not meant to be a comprehensive discussion on the various ways in which health may be defined, but only an analysis of two main approaches to answering this question

Health Needs

Daniels sees the task of promoting health largely as one of meeting health needs—i.e., if we meet health needs then we promote health (which thereby promotes opportunity, and so on).¹⁹ So then, what does Daniels mean by health needs? Taking first the concept of needs, Daniels differentiates them from preferences, asserting that our needs are what we require for normal species functioning. Since interferences with normal functioning limit a person’s range of opportunities for achieving her life plans, maintaining normal functioning is important for any notion of opportunity governed by the principle of fair equality of opportunity.²⁰

Given this conception of needs, Daniels turns to the concept of health, which he characterizes narrowly as the absence of pathology.²¹ There are two aspects of this definition worth noting: first, the use of “absence,” and second, the definition’s narrow nature. By viewing health as a negative term instead of a positive one,²² we can reach the crucial conclusion that the quality of one’s health cannot be promoted infinitely. When one lacks pathological conditions, her health needs are met. She cannot be made healthier. As such, we do not hold a moral

¹⁹ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 30.

²⁰ *Ibid.*, 31–34.

²¹ Pathology can be defined loosely as a disruption of health, i.e. any significant type of disease, injury, or disorder/disability. The succeeding paragraph explains pathology in more depth.

²² “Negative” and “positive” here are, of course, used descriptively and not normatively.

obligation to enhance her health to further improve her opportunity.²³ Second, the narrowness of the definition means that we are not concerned with an all-inclusive definition of health as complete well-being; we consider only whether one has a pathology and not whether one is generally happy and fulfilled. This narrow definition has the benefit of making the health claims that we will have to make on each other as objective as possible; Daniels notes that claims about health will be “as value-free as the biomedical sciences themselves.”²⁴

Health as Species-Typical Functioning

Of course, the biomedical sciences are not necessarily value-free, and the concept of “pathology” deserves more explanation before being wrapped into a theory about health justice. In *Just Health*, Daniels mainly looks at two analyses of health: the “species-typical functioning” account of Christopher Boorse, and the “harmful dysfunction” account of Jerome Wakefield. For his part, Daniels hesitates to adopt either view fully, claiming that both have their merits and both can be squared with his conception of health justice. While this ambiguity gives more flexibility to his theory of health justice, it fails to treat seriously the complicated notion of pathology inherent in thinking about health justice. A suitable definition is important: we must have a definition that is broad enough to demand that justice cover cases we intuitively agree should fall under the health care system,²⁵ yet we cannot tolerate a definition of health so broad as to demand that the vast swath of society’s resources go to eliminating pathology, when other institutions like schools and transportation infrastructure need adequate funding from society (via

²³ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 152–153.

²⁴ *Ibid.*, 36–38.

²⁵ We might think of various types of cancer, or organ failure, or mental dysfunctions such as severe schizophrenia as paradigm cases. The latter case (and mental dysfunction in general) often leads to larger questions about how to define mental health (and in this sense I beg the question), but still it seems intuitive that a case such as severe schizophrenia would be thought of as something to be treated in the realm of the health care system.

the demands of fair opportunity). In addition, we do not want a theory that classifies conditions as pathologies that, upon reflection, are not pathologies. Wakefield, in his essay “The Concept of Mental Disorder”, gives the historical example of “drapetomania”, the “disease” that caused slaves to run away from their masters.²⁶ A more recent, contentious example might be the “diagnosis” of homosexuality, a case that will be examined later.

To distance himself from these problematic value-laden definitions of pathology, Christopher Boorse argues for a non-normative account of pathology that turns on species typical functioning. Boorse’ view consists of a few main elements:

- 1) An organism is healthy when it is not diseased, or pathological.
- 2) A pathology arises when:
 - a. Some natural function of the organism (natural as related to evolutionary survival or reproductive needs) is interfered with.
 - b. The dysfunction that occurs is not “species-typical,” or if it is typical, it is due to environmental factors.²⁷

This seems to be an attractive and nuanced account of how we think about health. Under this view, we can statistically assess conditions to determine if they are, in fact, atypical enough to be pathological (presumably there would be some threshold for typicality). We can rule out a ridiculous condition like “drapetomania” due to its lack of interference with a natural function and its typicality, and at the same time we can rule out atypical conditions like abnormally high IQ as unhealthy due to its aid, instead of interference with, a natural function.

Health as the Absence of Harmful Dysfunction

²⁶ Jerome C. Wakefield, “The Concept of Mental Disorder: On the Boundary between Biological Facts and Social Values,” 377–380.

²⁷ Christopher Boorse, “What a Theory of Mental Health Should Be,” 62–63.

Wakefield critiques Boorse's argument by pointing to cases that may be pathological but are not thought of as such by the species-typical view. Chronic back pain, even when not species-typical, may not impact one's chances of survival or reproduction, and as such Boorse's account would not treat it as pathological. Yet we intuitively want to view an uncomfortable condition like back pain as a pathology deserving of treatment. Perhaps more disturbing, Boorse's account has an apparent tendency to treat as diseases conditions that we might not consider pathological. Homosexuality comes to mind: it is both statistically uncommon and harmful to reproduction. Boorse may here respond that there is a difference between disease and illness,²⁸ and only illnesses should be treated.²⁹ So though we might view homosexuality as a disease, we need not "treat" it. Yet it may come as little solace to homosexual people to hear that their lifestyle is in fact a disease, but not one worth treating. In light of these problems, Wakefield offers a partly value-based account of pathology, generally known as the "harmful dysfunction" model. Specifically, a condition is pathological if and only if:

- 1) The condition causes a person some type of harm, as judged by that person's culture, and
- 2) The condition is explained by some type of failure of a biological mechanism to perform its "natural function". The natural function is the function that explains (from an evolutionary standpoint) why that mechanism exists.

This part-descriptive, part-normative definition of disease gets away from the more strictly evolutionary advantage/disadvantage notion advocated by Boorse, and it resolves some of the questions raised in preceding paragraphs. First, conditions that we might think of as painful or, in Wakefield's words, "undesirable", may merit treatment regardless of whether they confer evolutionary disadvantage. Second, benign conditions such as homosexuality will not count as

²⁸ Illnesses are diseases that are normatively undesirable. (Ibid., 63.)

²⁹ Ibid.

disorders so long as the culture does not see homosexuality as undesirable (I assume here that one might argue homosexuality involves some dysfunction of a sexual drive, although that argument may be disputed). This definition of pathology has the peculiar (and maybe perverse) effect of allowing society, on some level, to control what is pathological or not, and we can imagine many cultures that might justify treating homosexuality or outspokenness (perhaps a failure of the mechanism of control?) as pathological. This consequence may lead one to accuse Wakefield's approach of a type of medical and moral relativism, as we intuitively do not want to cede our ability to criticize other cultures' stances on conditions such as homosexuality. We might instead criticize the norms that cultures use to define homosexuality as pathological, but more in-depth exploration of that argument unfortunately lies outside the scope of this paper. Indeed, our discussion of Boorse and Wakefield must end without resolving all disputes for either approach. For our purposes, it is important to note that the definitions of pathology and health have both descriptive and normative notions—to ignore the normative notion of desirability when talking about whether or not someone is healthy is to ignore an integral part of what it means to be healthy.

Conclusion

Before transitioning back to Daniels' discussion of health justice, I want to offer two comments on the preceding discussion. The first is a procedural one. My process for determining the adequacy of Wakefield's definition of health justice over that of Boorse followed Daniels' method of justification in applied ethics: we took theories and principles and tested them against real-world scenarios. A similar pattern of discussion will emerge throughout the rest of the paper. Second, by using a "harmful dysfunction" account of health in health justice, we give one's

society even more latitude in determining what a just health system looks like. For (as we will learn later), not only are resource-allocation decisions particular to each society; so too is the very notion of what constitutes pathology (and thus, what may be treated). My health justice rights as a citizen of the United States may look very different than those of a citizen of Finland, or Slovakia, or Zambia. That seems intuitively fair, and (within limits) perhaps empowers different societies to take seriously the interplay between their own norms and how their citizens think of health.

V. Focal Question 1: Is Health of Special Moral Importance?

This section covers a lot of ground, so a roadmap is perhaps merited. The following argument focuses broadly on defining the notion of opportunity in reference to health needs. Daniels' aim here is to show that health is a component of opportunity, and as such, merits a special importance through the principle of fair equality of opportunity. In navigating through this argument, I turn first to evaluate whether health is, in fact, a socially determined good, the lack of which can lead one to a claim upon justice. Here I find that, while health is in large part naturally determined, one's society plays an instrumental role in determining one's health outcomes, meaning that there might be injustice in certain cases in which one is unhealthy. I consider as well the objection that the notion of opportunity that Daniels uses is different from the notion that Rawls uses. I then look into how we can justify considering health as part of one's opportunity, focusing heavily on Daniels' notion of a "normal opportunity range." Finally, I raise some further questions in the form of a case in which the fair equality of opportunity notion of health might fall short, and with the help of Rawls, I suggest an additional method for justifying the importance of health care needs. In this section, I will use a number of cases that I deem to be philosophically relevant, including sickle cell anemia, homosexuality, and HIV/AIDS. My motivation for doing so is to tease out nuances in certain theories, but I readily admit that my grasp on the medical knowledge of these cases is not deep. I hope the reader will be forgiving in my lack of medical details and accept these cases in the form I present them so that deeper philosophical issues can be considered. I do not believe that my simplified cases will invalidate the philosophical points I want to make.

Health as a Part of Fair Equality of Opportunity

Daniels' task in answering the first focal question is complicated by the convoluted nature of health. Quite simply, health does not fit neatly into the category of natural good, nor into the category of social good. When we consider the fact that, by stroke of genetic luck, some are born with genetic disorders that require more extensive health care needs, such as sickle cell anemia, while others are born healthy, health seems to us like a natural good—there is little society could have done to affect the genetic pairing that created sickle cell anemia. Yet as we will explore later, social factors influence our health status to a much greater extent than we might have expected. Indeed, there is reason to suggest that there exists a causal link between low socioeconomic status and poor health status.³⁰ Consider a person who must work two jobs to support her family because her society bars unskilled workers from organizing to demand decent wages. Her immune system may be compromised because of the exhaustion of working two jobs. If that person contracts a serious virus that could have been avoided with a stronger immune system, we have reason to believe that health is a social good as well.

Given that health is, in part, a natural good, Daniels wisely resists the temptation to treat health as some type of primary social good in itself that could be subject to the difference principle. Instead, he argues that promoting health protects opportunity, and consequently promoting health falls under the requirements assigned by Rawls' principles of justice to protect fair equality of opportunity.³¹ Indeed, this seems like a warranted conclusion, since poor health limits the life plans available to us, and our opportunity to choose among them.³² This concept will be explored in more depth later in this section. Daniels explains that tying health to fair opportunity³³ gives greater power to justice as fairness by allowing it to cope with a greater

³⁰ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 79–80.

³¹ *Ibid.*, 29–30.

³² *Ibid.*, 44.

³³ A shortened term for “fair equality of opportunity.” I will use both interchangeably.

variety of competing claims, and by allowing it to respond to criticism that the theory fails to adequately measure what is important to citizens qua free and equal persons with rational plans of life.³⁴ Indeed, Rawls asserts in *Theory* that justice as fairness aims to derive acceptable principles of justice from the weakest possible assumptions, as well as to include the largest possible collision of claims for those principles to resolve.³⁵ Daniels' extension of the theory strengthens justice as fairness on both counts, as it eliminates a rather strong assumption inherent in Rawls' original position (full, healthy lives) and sketches out a method for resolving competing health claims. Also, by tying health needs into fair equality of opportunity instead of the difference principle, Daniels avoids basing his account of health needs on the most controversial part of Rawls' principles of justice; indeed, one who disputes the adequacy of the difference principle may still be able to accept the requirement to meet health needs as a condition of fair opportunity.

Daniels does note that this extension requires a broader justification than the original version of justice as fairness—we no longer use an account of opportunity solely focused on job and career access. Instead, we must incorporate into fair equality of opportunity the notion of a full opportunity range of life plans.³⁶ By the full opportunity range of life plans, Daniels emphasizes the full set of options available to us that help us promote our conception of the good. This notion extends considerably from the narrow notion of an opportunity range used in *Theory*, in which the options available to us are only relevant so far as they concern our ability to broaden our shares of primary social goods, i.e. income, wealth, and the social bases of self-respect. In this sense, the narrow notion of an opportunity range concerns mainly jobs and careers. The distinction is important. If I lose functioning in my legs, my opportunity range will be damaged

³⁴ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 21, 65–67.

³⁵ John Rawls, *A Theory of Justice*, 456–457.

³⁶ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 58–60.

in the narrow sense only in the respect that I may not be able to do certain jobs like working as a summer camp counselor or a lumberjack. Yet in the broader notion of opportunity, my opportunity range will be further narrowed by my not being able to participate in activities like hiking, or running a marathon with friends, or going on political marches. As such, the broader notion of opportunity includes substantially more health conditions under the demands of justice, and it seems to square with our considered judgment that a plan of life is not merely about acquiring the job one needs. As such, the broader notion of opportunity should not give us too much pause.

Justifying Health as Part of Opportunity

To justify health as part of opportunity, we need the help of more terminology to talk about opportunity. We can talk about a “normal opportunity range” (also referred to as a “normal range”), which is the set of life plans that are feasible for reasonable persons to adopt, subject to the constraints of their society. When we know which persons meet the normal range in a society (and which do not), we can determine the extent of fair equality of opportunity in that society. Moreover, how adequately one’s health needs are met affects the share of the normal range open to that person.³⁷ Thus, with the concept of the normal opportunity range we can see how unmet health needs can directly affect one’s opportunity, at least in a weak sense.³⁸ At this point, we must reconsider Rawls’ notion of fair equality of opportunity. Under Rawls’ formulation, fair opportunity demands that those with similar skills and abilities are required to have the same life chances, or opportunities, in jobs and careers. Since we have chosen to expand our notion of

³⁷ Ibid., 43–44.

³⁸ The claim is weak in the sense that it does not tell us anything normative about this lack of opportunity. At this point, we can only describe that failing to meet health needs restricts opportunity. We cannot say that these unmet health needs are *unfair*, or *unjust*. The stronger claim, that unmet health needs affect fair equality of opportunity *for a society* will be discussed shortly.

opportunity, we can say that fair equality of opportunity obtains when those with similar skills and abilities have the same access to the parts of life that one would reasonably need in order to fulfill her life plan (perhaps wealth, free time, family, and so on). In short, fair opportunity obtains when those with similar skills and abilities have access to similar shares of the normal opportunity range. The qualification about “similar skills and abilities” is important here, for it means that not all disparities in opportunity are subject to the constraints of justice. Since skills and abilities are determined naturally, fair opportunity forbids only those disparities in opportunity that result from social conditions. If nature produces disparities among us in regards to opportunity, those disparities might be said to be lucky or unlucky. However, if society produces disparities among us in regards to opportunity, those disparities are unjust.

Finally, we are able to derive Daniels’ account of health as being connected to opportunity. Since society in part determines how one’s health needs are met, and meeting those health needs affects our share of the normal range, fair equality of opportunity requires that we meet people’s health needs when possible. Measures such as access to care when we have pathologies, and prevention of those pathologies if possible, protects people’s shares of the normal range, and thus are required by the Rawls-Daniels system of health justice. Yet it is unclear, at least in terms of resources spent for health services, how far we can stretch fair opportunity. To take the previous example of the child born with sickle cell anemia, it is clear that such a child will have worse health outcomes, and thus have her share of the normal range lessened, by sickle cell anemia. Yet it is similarly clear that society is not at fault for that child’s sickle cell anemia. Since the sickle cell anemia is due, at least in this instance, solely to natural factors, it seems as if we are left with two options, neither of which are very attractive for the Rawls-Daniels view. First, we might define Rawls’ “skills and abilities” narrowly, rejecting that

health status falls under skills and abilities. As such, all differential health outcomes become the subject of justice, and society must broadly control them to make sure that everyone is equally healthy. This option, however, requires that the child with sickle cell anemia have the same opportunities as a child without any pathology. Which is to say, this option is practically impossible.

The other option is to say that, at least in these special cases of genetic disorders, society does not have any requirement from justice to care for the child with sickle cell anemia. This too does not seem to square with our considered judgments. If a child were to die because she had a sickle cell crisis and she did not get treated, we would think that unjust. Thus on some level, our moral judgments demand that we treat a child who is sick. It is instructive here to look at *why* that child did not get treated, and how those reasons for lack of treatment impact our considered judgments. If that child was on a camping trip and was too far away from medical help when she needed it, we might think it unlucky, or the fault of the trip organizer, or a cosmic injustice, but not a social injustice. Any child stuck in that situation would probably have reached that same fate. But if the child did not get treated because she could not afford treatment, we think of it as a failure of social justice and of fair opportunity. A person in the same situation *could have* lived had she had access to more wealth. In other words, the disease was not socially caused, but the availability of treatment was, and thus the outcome was as well. From this case, we see that fair equality of opportunity is able to require equal treatment for pathologies, even when those pathologies are not socially caused. Fair opportunity does not tolerate disparities in treatment of a pathological condition, nor does it tolerate disparities in the application of preventative or curative medicine. This interpretation of fair opportunity better captures our considered judgments about health justice, and avoids an impractically broad interpretation of the factors

that might give rise to a claim on justice. Since this notion of fair opportunity demands equal, not just efficient treatment, prevention, and curing in medicine, health is of special moral importance.

Further Questions Beyond Fair Equality of Opportunity

One might still raise the question of what the Rawls-Daniels theory says in cases where a specific pathology affects only one group of people with similar enough social standing that disparities in treatment do not arise. The early years of the AIDS epidemic in the United States stands as an interesting case study here. Simplifying quite a bit, the AIDS epidemic affected mainly gay males in gay communities. This case presents problems for fair opportunity for two reasons. First, while the spread of HIV/AIDS at that point in time affected some of the most marginalized communities in the country, it did not appear to be influenced by any broad societal factors. In short, people did not get the virus *because* they were marginalized. Second (and generalizing a bit) there did not exist groups of people that received better treatment than other groups—no good treatment was available.³⁹ Because the disease occurred without societal influence and society did not favor any one group over another for treatment, it would appear that the United States' delayed response was not unjust. Yet, the medical community's willful ignorance of this epidemic harmed a lot of people, and the case stands as a paradigm example of unjust medical practices.

Turning to Rawls, we can find some perspective on how we are to think about opportunity in this case of medical care. In *Justice as Fairness: A Restatement*, Rawls notes that

³⁹ Again, this is a broad and simplified claim, but it is hard to deny that the medical profession dragged its feet to treat AIDS patients. Daniels notes in a later section of *Just Health* that the American Medical Association allowed physicians *not* to treat AIDS patients until 1987, and a number of physicians still refused to treat patients in 1990. (Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 221.) My point here is not to get into an historical discussion on the state of AIDS treatment. I only want to note that there seem to have been times in recent history in which society's treatment of some pathology has failed not only some but all people with that pathology.

the notion of primary goods protects citizens' ability to be fully cooperating members of society. Further, our index of the primary goods of income and wealth stretches beyond *individual* income and wealth—socially provided medical care (and other social measures that promote individuals' health) can be included in one's income. Thus when providing health care, a just society should devote resources to health care up to the point where the expectations of the least well-off are worsened.⁴⁰ As such, the difference principle provides us with a road map for providing health resources fairly when appeals to fair opportunity cannot be easily invoked. Outside of opportunity, society should spend more on health resources (including pathology research and treatment) until the spending starts to decrease the expectations of the least well off. In the earlier AIDS case, for example, resources should be devoted to AIDS research and treatment as long as devoting those resources increases the expectations of the least well off group in society.

Yet, we should be wary of blindly applying the difference principle to all competing health claims. The difference principle is derived in the original position and intended to introduce additional constraints on a state that already grants full political liberty and fair equality of opportunity. In trying to apply the difference principle to judge real-world situations where there are severely oppressed groups of people, we run the danger of asking too much. We do not know in the original position how *specific* people might need treatment, which individuals will have the lowest expectations, or how individuals might respond to treatments. Rawls acknowledges this problem in *Justice as Fairness: A Restatement*, noting that spending for health resources should be decided by a just state's legislature, as it is out of the realm of the original position.⁴¹ Rawls also notes that the goods that one expects to receive may be very different *ex*

⁴⁰ John Rawls, *Justice as Fairness: A Restatement*, 170–173.

⁴¹ While Rawls does not consider medical care in *Theory*, he does comment on it in later works.

ante than what one actually receives *ex post*, since there are always contingencies affecting the outcome of resource spending.⁴² Daniels, too, acknowledges that the two principles cannot resolve all issues of health justice and shows the need for a method by which a society can justly adjudicate health resource claims.⁴³ Such a system will be discussed in Section VII.

Conclusion

In this section we found that, since health is included in one's normal opportunity range, health has special moral importance via its corollary to fair equality of opportunity. First, we were able to expand Rawls' notion of opportunity to a broader notion that includes health needs. We then used the concept of the normal opportunity range to produce a metric in which pathology can harm one's opportunity. With this metric, we saw that fair opportunity requires that those with similar skills and abilities have access to similar shares of the normal opportunity range, which in turn requires that one's health needs must be met regardless of one's position in society. Finally, we raised some questions as to how broadly fair opportunity might be stretched, and suggested that the difference principle might still be able to guide medical resource allocation in a few circumstances.

⁴² *Ibid.*, 173.

⁴³ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 24–26.

VI. Focal Question 2: When Are Health Inequalities Unjust?

We turn now to Daniels' second focal question of when health inequalities themselves are unjust in some society. In this section, I again follow Daniels' method of argument in *Just Health*. Using Daniels and a study by John Lynch *et al* on inequality, I look at the social factors that lead to health inequalities: namely, access to health services, one's socioeconomic status (SES), and the level of inequality of society as a whole. Ultimately, I agree with Daniels' claim that health inequalities are unjust if, and only if, they result from a non-universal health care system, or from unjust background inequalities (as defined by Rawls' two principles of justice).

Universal Health Care

Our intuitions often suggest that justice requires universal health care, but it will be helpful to spell out how this argument is made under the Rawls-Daniels theory. In the previous section, we saw that the Rawls-Daniels view requires children with sickle cell anemia to have access to the same treatments for their pathology, regardless of their ability to pay. This was because the theory of justice as fairness does not permit opportunity to be tied to wealth, under the principle of fair opportunity. In the sickle cell case, the child's health status, and therefore her opportunity, was limited by her wealth, which constituted an injustice. We can apply this logic more broadly to say that, for all pathologies, the principle of fair opportunity requires that one's access to treatment must not depend on one's wealth. This requirement, therefore, implies that societies must provide universal health care for their citizens.

Both Rawls and Daniels concur on the need for universal health care. Daniels argues that society ought to provide "universal comprehensive health care, including public health, primary

health care, and medical and social support services,”⁴⁴ since these help to meet society’s obligations that it promote population health and reduce health inequalities.⁴⁵ In *Justice as Fairness: A Restatement*, Rawls includes “a basic level of health-care provided for all” among the arrangements necessary in a property-owning democracy.⁴⁶

Other Social Factors Influencing Health Outcomes

Yet accessibility of medical care is not the only factor influencing how healthy we are. People’s health statuses (also referred to as “health outcomes”) are intersectional in nature, meaning that they are influenced by a litany of social factors from different parts of society. One’s health status is determined not only by the amount of health care one has access to, but also one’s socioeconomic status, the presence (or lack thereof) of pollutants or carcinogenic chemicals where one lives, the stress level of one’s work environment, among other factors. On a population level, the health outcomes of a population do not depend solely (or even principally) on its members’ access to health care; instead, factors such as SES, race, and gender have a large influence.⁴⁷

Since the scope of this paper is rather limited, I will focus mainly on the influence on health outcomes obtained by the broad metrics of socioeconomic status and income inequality. As mentioned in the previous section, it has become a well-known fact that people with higher SES have longer, healthier lives, and there is strong evidence to suggest that a low socioeconomic status actually *causes* people to be less healthy (instead of one’s poor health

⁴⁴ This requirement applies mainly to societies that have enough economic resources to support health services. Many countries in today’s world meet and exceed that resource threshold (one need not be a “highly developed” country to meet it), but obviously it would be unreasonable to ask a society with a subsistence economy to provide comprehensive health care.

⁴⁵ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 96.

⁴⁶ John Rawls, *Justice as Fairness: A Restatement*, 176.

⁴⁷ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 5, 79–83.

causing a low SES).⁴⁸ Indeed, the classic Whitehall studies of British civil servants showed that even among a population with completely equal access to health care, one's civil service rank had an enormous impact on one's life expectancy and other health measures.⁴⁹ Since one's civil service rank often parallels one's SES, this finding points to SES being an important determinant of health outcomes.

Looking at income inequality, there is controversial evidence to suggest that the presence of income inequality by itself leads to worse health outcomes, meaning that a society might be damaging its health outcomes merely by maintaining a high level of economic inequality. Daniels cites a study by Lynch *et al* of U.S. metropolitan areas, which suggests that societies with higher income inequality had more deaths *across all income quartiles*—paradoxically, even the richest in unequal societies are made less healthy.⁵⁰ Yet we must be cautious reading too far into these results about income inequality. The study was measuring association, not causation: Lynch *et al* found that, when comparing areas in the United States, those with high income inequality had an “excess of death” equivalent to all deaths due to heart disease. Furthermore, studies from other areas of the world, including studies across OECD countries, did not find the same association between inequality and morbidity. Daniels postulates that this link between inequality and excess morbidity may obtain only across societies that are already highly unequal to begin with, such as the United States.⁵¹

This link between income inequality and health outcomes poses problems for the Rawls-Daniels theory. As a liberal theory, justice as fairness places no upper limit on inequalities—they are allowed so long as they are to everyone's advantage. Yet if inequalities, in and of themselves,

⁴⁸ *Ibid.*, 79–80.

⁴⁹ *Ibid.*, 85.

⁵⁰ John W. Lynch *et al.*, “Income Inequality and Mortality in Metropolitan Areas of the United States,” 1078–1079.

⁵¹ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 87.

make people worse off from a health standpoint, it seems as if a society may have to place a limit on them. However, inequalities do not exist in a vacuum—Daniels reminds us that political, social, and individual mechanisms work to create more equal and unequal distributions, and further that the American states with low levels of income inequality tend to spend more on education and social safety nets.⁵² As such, it may not be the inequalities themselves that produce inferior health outcomes, but instead the policies that allow those inequalities to obtain. Societies looking to promote health may support those services and regulations used by more equal societies to deter inequality, without being forced to limit income inequality itself.

Social Responsibility for Health Inequalities

With a better grasp on the descriptive notion of how SES and levels of inequality influence health outcomes, we now consider the normative question of whether societies are responsible (from the standpoint of justice) for these health outcomes. Going back to our previous question of whether health is a natural or a social good, it seems clear that to some extent, health is a social good. Obviously, the prevalence of income inequality and of groups with low SES in a society is in large part socially determined. Since social policies can act to improve the SES of groups and to reduce income inequality, if these actions improve people's health statuses then we face obligations not only from the distribution of health care in a society but also the distribution of other social goods. Under the theory of justice as fairness, the distribution of these other goods is determined by the difference principle, so if a state's institutions allow inequalities that fail to satisfy the difference principle, these inequalities face criticism from health justice.

⁵² Ibid., 85–87.

Conclusion

To conclude this discussion, there are many ways beyond access to medical care in which society influences one's health status, including one's socioeconomic status and more controversially, the level of income inequality in society. When we incorporate this knowledge into the Rawls-Daniels theory, we see that health inequalities are unjust if they result from not only unequal access to medical care but also unjust background inequalities as determined by the difference principle.

VII. Focal Question 3: Meeting Health Needs under Constraints

Having developed a normative account of how societies ought to govern health inequalities, I now embark on a brief discussion of Daniels' third and final focal question: how a society ought to meet health needs under resource constraints. Here, I agree with Daniels' argument in *Just Health* that an accountable and transparent process is needed to determine decisions about how to allocate medical care.

Even after determining when health inequalities are unjust, Daniels acknowledges that there still exist tough questions about how societies might meet health needs fairly under resource constraints. For example, our theory to this point cannot say whether a society under resource constraints should invest in a treatment that would help a few people who are very unhealthy, or a treatment that would help a lot of people who are slightly unhealthy. It also cannot say how much a society should invest in health care overall, when doing so takes away resources for services like education and a social safety net. On these issues, Daniels maintains that reasonable people may disagree.⁵³

To answer these questions, Daniels turns to the Rawlsian concept of procedural justice.⁵⁴ To find the conditions that should govern a reasonable deliberative procedure, he introduces the concept of Accountability for Reasonableness (AFR), which is based on the notion that “reasons or rationales for important limit-setting decisions should be publicly available.”⁵⁵ AFR has four main conditions: publicity, relevance, revision and appeals, and regulation. Under the Publicity Condition, rationales behind coverage decisions are publicly accessible. Daniels argues that this type of publicity would lead to a type of “case law”, which would help to ensure formal justice in

⁵³ Ibid., 103–106.

⁵⁴ Ibid., 110.

⁵⁵ Ibid., 117.

limit setting where similar cases are treated similarly.⁵⁶ Under the Relevance Condition, health organizations or governments provide a reasonable explanation of how they are providing “value for money” to meet health needs under resource constraints. One important concept in the Relevance Condition is the need for stakeholders to help determine how relevant the reasons chosen by decision makers actually are to the people affected by the limits being set.⁵⁷ Under the Revisability and Appeals Condition, health organizations and governments establish ways to challenge limit-setting decisions, resolve disputes about them, and revise those decisions if need be. This condition gives an extra safeguard against the goal of collective advantage unduly harming individuals. It also allows citizens access to the process of limit setting, even if they were not involved in the original decision.⁵⁸ Finally, the Regulative Condition ensures that the other conditions are met.⁵⁹

Thus, societies with just health systems will allow for a process like AFR to fairly resolve questions about meeting health needs under resource constraints. AFR fills a crucial hole in the Rawls-Daniels theory of health justice, and allows us to better answer some of the sticky disputes about cases previously mentioned in this essay. In the earlier AIDS case, for example, the specific level of funding devoted to HIV/AIDS research need not be determined by the two principles of justice alone; instead, a society may employ AFR to ensure that stakeholders’ needs are being fairly considered. Even if we accept the Rawls-Daniels theory, we may have different value judgments that lead us to prefer different funding levels for this AIDS case, and AFR allows us to reconcile those value judgments without collapsing the theory.

⁵⁶ Ibid., 118–121.

⁵⁷ Ibid., 123–129.

⁵⁸ Ibid., 131–132.

⁵⁹ Ibid., 133.

Before moving on, I want to offer some comments on AFR. First, it must be stressed that AFR need not lead to identical decisions across different societies or different health plans so long as the decisions are reached fairly and reasonably.⁶⁰ As such, two people who have the same pathology, but live in different societies, may be subject to two different treatment decisions. While troubling at first, since it appears to be arbitrary treatment, this outcome of different treatment decisions makes intuitive sense: it is unreasonable to expect the country of Moldova to give its citizens the same medical treatments as might be found in the much richer country of Japan. Second, we find again with AFR the prevalence of non-justice-related value judgments in our theory of health justice. Just as societies may hold different (but reasonable) values about what constitutes pathology (according to Wakefield's view), so too may societies hold different (but reasonable) values about what constitutes adequate treatment and funding. This toleration of differing values gives our theory a considerable measure of flexibility, but it comes at the cost of possibly allowing resource allocation decisions in societies that do not square with our moral intuitions. Finally, Daniels supposes that the transparency central to AFR has the potential to enhance the democratic process, because it empowers citizens in a society to think deliberately about how they ought to allocate health resources.⁶¹ This supposition may or may not prove true, but it is encouraging to think that creating a just health care system could improve the process of democracy itself.

⁶⁰ Ibid., 135–137.

⁶¹ Ibid., 123.

VIII. Benchmarks of Fairness

In the previous three sections, we answered each of Daniels' focal questions, which allows us to answer his Fundamental Question of what we owe each other to “promote and protect health in a population” and assist people who are unhealthy.⁶² We found that health is of special moral importance as a part of fair equality of opportunity, that health inequalities are unjust when resulting from differences in access to medical care and from background inequalities (as measured by the difference principle), and that further allocative disputes can be resolved through the process of Accountability for Reasonableness. So concludes our discussion on the theory of health justice.

Benchmarks of Fairness

We will now establish practical principles that will allow us to evaluate the reforms made under the Affordable Care Act from the standpoint of the Rawls-Daniels theory of health justice. Here, I piggyback on the work of Daniels, who establishes the “Benchmarks of Fairness” for health care system reform in a later section of *Just Health*. The Benchmarks of Fairness are categorized as follows:

Category 1: Equity

- B1: Intersectoral Public Health
- B2: Financial Barriers to Equitable Access
- B3: Nonfinancial Barriers to Access
- B4: Comprehensiveness of Benefits and Tiering
- B5: Equitable Financing

Category 2: Efficiency

- B6: Efficacy, Efficiency, and Quality Improvement
- B7: Administrative Efficiency

Category 3: Accountability

- B8: Democratic Accountability and Empowerment
- B9: Patient and Provider Autonomy

⁶² Ibid., 11.

Before explaining each of them, I offer some of Daniels' comments on how the Benchmarks as a whole lead to just health sector reforms. First, it should be noted that efficiency is pursued because we have obligations to justice outside of the health care system that also require resources. Health systems must be "clinically and administratively effective and efficient" to be just.⁶³ Second, organizations and governments must resist temptations to introduce new, untested reforms aimed at improving health care system efficacy or efficiency. Daniels notes that many of these so-called health sector reforms are essentially social experiments with inadequate scientific and ethical review, giving the example of U.S. insurers who are experimenting with new deductible structures without reviewing the effects of these structures.⁶⁴ Thus, countries need agencies and mechanisms for accountability, as well as adequate scientific/ethical reviews when undertaking health sector reforms.⁶⁵ Finally, Daniels stresses that the Benchmarks do not demand ideal healthy systems, only progress towards the reduction of inequitable access, inefficiency, and unaccountability.⁶⁶

Due to the scope of the ACA, I focus mainly on the Benchmarks relating to equity and efficiency. The relevant Benchmarks (B2-B7) are explicated as follows:

- Equity
 - *Benchmark B2: Financial Barriers to Equitable Access* concentrates on "producing uniform and more adequate benefits across all groups of workers" and ensuring that the health plans by which these workers gain access are compatible with each other.
 - *Benchmark B3: Nonfinancial Barriers to Access* also has two criteria. The first requires that reforms equitably distribute drugs, supplies, facilities, and personnel; the second requires the dismantling of gender barriers.
 - *Benchmark B4: Comprehensiveness of Benefits and Tiering* generally asserts that tiering of benefits reduces the fairness of health systems.⁶⁷

⁶³ Ibid., 246–248.

⁶⁴ Ibid., 244–245.

⁶⁵ Ibid., 269–272.

⁶⁶ Ibid., 251.

⁶⁷ However, if "a small but wealthy group does better than the others" and the "others" still have access to an adequate benefit package, a tiered system might be justifiable.

- *Benchmark B5: Equitable Financing* requires that medical services be financed by persons' ability to pay.⁶⁸
- Efficiency
 - *Benchmark B6: Efficacy, Efficiency, and Quality Improvement* promotes evidence-based practice for providing and reforming health services.
 - *Benchmark B7: Administrative Efficiency* requires controls for overhead, cost of purchasing, and system abuse.⁶⁹

Conclusion

This concludes our discussion of Norman Daniels' book, *Just Health*. With these practical principles in place, we are in a position now to analyze to what extent the Affordable Care Act meets the requirements of our theory of health justice in reforming the American health care system. Such an analysis will be the focus of the next few sections of this paper.

⁶⁸ Generally, tax-based systems are more equitable than premium-based systems, provided that the taxes are progressive in nature. Premium-based systems are more equitable if premiums are community-rated rather than risk-rated, meaning that one does not pay more for being more prone to getting sick.

⁶⁹ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 257–261.

IX. Problems with the American Health Care System

Before I delve into the specific policies enacted by the Affordable Care Act, some context is necessary. This next section will focus on the American health care system pre-ACA and the ethical problems that arise from it. Specifically, I look into problems associated with Benchmarks B2 through B7: access, financing equity, and efficiency. Using accounts by journalists, policy analysts, economists, and others, I find that the pre-ACA American health care system is indeed guilty of deep and systemic problems relating to these Benchmarks, and more broadly, to the Rawls-Daniels theory of health justice.

Steven Brill, writing for *Time* magazine, sums up these problems as succinctly as possible in his report on medical costs,

“Unless you are protected by Medicare,⁷⁰ the health care market is not a market at all. It’s a crapshoot. People fare differently according to circumstances they can neither control nor predict. They may have no insurance. They may have insurance, but their employer chooses their insurance plan and it may have a payout limit or not cover a drug of treatment they need... They have little choice of hospitals or the services they are billed for, even if they somehow know the prices before they get billed for the services. They have no idea what their bills mean, and those who maintain the chargemasters⁷¹ couldn’t explain them if they wanted to... They have no choice of the drugs they have to buy or the lab tests or the CT scans that they have to get, and they would not know what to do if they did have a choice. They are powerless buyers in a seller’s market where the only sure thing is the profit of the sellers.”⁷²

Brill’s comments echo those by economist Uwe Reinhardt, who characterizes the American health care system as a “moral morass” by referencing the low payment rates of Medicaid (the publicly-funded health insurance program for low-income Americans) that treat those in poverty as if their lives have less value. He also laments the lack of coverage for undocumented immigrants, as well as the fact that 18,000 Americans die every year because they lack health

⁷⁰ The government-run insurance program for citizens over age 65.

⁷¹ Brill’s term for the seemingly arbitrary pricing system used by hospitals. See footnote 82 on p.43 for a more complete discussion.

⁷² Steven Brill, “Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care,” 54.

insurance and fail to get treated for preventable conditions.⁷³ These critiques of the American health care system point out a few essential truths of the system that concern us morally. On the access front a significant portion of the population lacks insurance coverage, and even among those who have coverage, problems of access remain. A significant portion lacks *adequate* coverage, and both those who have coverage and those who lack it are unable in many circumstances to choose their hospital or treatment plan. On the financing equity front, the uninsured and underinsured sick finance a greater proportion of the country's medical costs than we would consider equitable. On the efficiency front, the United States quite simply overpays for inefficient health care.

Problems of Access

On the critique of lack of coverage, a number of concerns jump out fairly quickly. The Congressional Budget Office reports that 53 million Americans lacked insurance in 2012; with pre-ACA rules this number would have been 56 million.⁷⁴ We recall that justice requires “universal comprehensive health care, including public health, primary health care, and medical and social support services.”⁷⁵ A lack of health insurance clearly undermines fair opportunity in because of its detrimental effect on health outcomes and limiting of choices for the uninsured.

Yet barriers to access in the pre-ACA American system are not only financial. Barriers to access obtain with many groups of people; in particular, women and Medicaid recipients stand out as two groups facing steep barriers. For women, less-than-comprehensive benefit packages prevent equity in access, in violation of Benchmark B3. Importantly, there has been a pervasive

⁷³ Uwe Reinhardt and Tsung-mei Cheng, *Sick Around the World*.

⁷⁴ *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, 19.

⁷⁵ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 96.

refusal among insurers to cover maternity care: before the ACA, 62% of women in non-employer insurance plans lacked have maternity coverage.⁷⁶ This lack of coverage creates both unequal access for those unable to pay out-of-pocket costs or more comprehensive benefit packages, and it creates a gender disparity: quite simply, many women cannot meet their health needs.

For those on Medicaid, problems arise from the low reimbursement rates that Medicaid pays. Doctors are allowed to decide which patients to treat based on one's insurance plan, regardless of whether that person is on the public systems of Medicare or Medicaid.⁷⁷ As Reinhardt pointed out, in practice Medicaid's low reimbursement rates limit those on Medicaid to accessing certain doctors and hospitals.⁷⁸ Thus, even though Medicaid recipients are able to bypass many financial barriers with coverage, they still may not be able to access the doctors and providers that they need. Thus, the American system allows the poorest among us to go without treatment and to be treated by only certain doctors, a clear inequity of access.

Problems of Equitable Financing

Yet perhaps an even more pervasive problem in the pre-ACA health care system is its inequitable financing structure. Of prime importance is the health care system's tendency to burden the sick with undue costs. In the realm of premiums (the monthly rate paid by those insured to their insurance company, regardless of whether health benefits are used), the pre-ACA insurance market for individuals was "actuarially fair", meaning that insurance companies would determine an individual's premium based on how much the insurance company would expect to pay in health benefits for that individual. This actuarial fairness makes sense when insurance is

⁷⁶ Elisabeth Rosenthal, "American Way of Birth, Costliest in the World."

⁷⁷ Norman Daniels, *Just Health: Meeting Health Needs Fairly*, 232.

⁷⁸ Uwe Reinhardt and Tsung-mei Cheng, *Sick Around the World*.

only used as a way to pool risk, but given the special importance of health, health insurance is often a way for society to support those who have greater health needs. Uwe Reinhardt explains that before the Affordable Care Act, the price of an individual's premium could be represented by the equation $P_i = (1 + L)X_i$, where P is the price of the premium, X is the expected outlay for the insurance company (i.e. how much coverage for an individual will cost the company), and L is the markup percentage (to cover overhead and profit).⁷⁹ The more pre-existing pathologies an individual has, the higher her premium. Yet the Rawls-Daniels theory, evidenced by Benchmark B5, requires that health spending be financed by ability to pay instead of expected costs per person. Since health needs are part of our opportunity, it is inequitable to leave their financing to market forces.

Likewise, in the realm of benefit payouts many insurance plans still leave patients responsible for health costs after a certain point by imposing annual and lifetime benefit caps. This and other practices lead millions to be categorized as having health insurance even as they lacked adequate coverage.⁸⁰ These inadequate benefits mean that the sickest among us often shoulder the biggest burden, an ostensibly inequitable outcome. Moreover, these financing inequities in health can spill over to lack of opportunity outside of the health sector—a 2009 study found that medical bills had contributed in some way to 62% of American personal bankruptcies.⁸¹ Thus, even Rawls' narrow account of opportunity in career/economic prospects would advocate for more equitable health sector financing, since the American system impacts citizens' economic opportunity in important ways. Finally, due to bargaining agreements, hospitals and medical providers charge uninsured persons more for medical procedures than insurance companies, which have pre-negotiated prices. Hospitals are able to bill the uninsured

⁷⁹ Uwe Reinhardt, "Premium Shock' and 'Premium Joy' Under the Affordable Care Act."

⁸⁰ Steven Brill, "Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care," 32–33.

⁸¹ David U. Himmelstein et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," 742.

on what Brill refers to as “chargemaster” prices,⁸² which Brill asserts do not “seem to be based on anything objective – like cost”.⁸³ Though some uninsured individuals may be able to get discounts, many do not, leaving the low-income people who do not qualify for Medicaid but cannot afford adequate insurance to pay the most expensive medical bills.⁸⁴ Benchmark B5 requires that medical costs be distributed by ability to pay, and yet the American system nearly produces the opposite of this requirement—individuals with lower incomes face more expensive bills than individuals with higher incomes. This outcome should strike us as highly inequitable.

Problems of Efficiency

Finally, the American health care system fails because it is grossly inefficient. In 2009, the United States led the OECD in health sector spending as a share of GDP with a 17.4% share; the closest country was the Netherlands with a 12.0% share and the OECD average was a 9.6% share.⁸⁵ Even adjusted for the United States’ high GDP per capita, the United States spends 27% more on health care than other OECD countries. Americans were expected to spend \$2.8 trillion on health care in 2013; a 27% overspending is equivalent to \$750 billion.⁸⁶ This overspending is not only frustrating for Americans as citizens and taxpayers, but also a violation of Benchmark B7 and therefore unjust. Indeed, this overspending should concern us deeply as a matter of justice—that \$750 billion could be going to other sectors like education or environmental

⁸² The list of Chargemaster prices described by Brill seemed Kafkaesque—some of them included a charge of \$1.50 for an acetaminophen (Tylenol) pill (anyone can buy 100 pills for \$1.49), \$15,000 for blood work and lab tests (Medicare, using a cost-based pricing system, pays well less than \$1000), \$7 for an alcohol prep pad (anyone can buy 200 for \$1.91), and \$14,000 for dose of cancer drug that likely cost the hospital \$3000 to \$3500. It should also be noted that every hospital studied by Brill was a non-profit hospital.

⁸³ Steven Brill, “Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care,” 22–23.

⁸⁴ *Ibid.*, 24.

⁸⁵ OECD, *Health at a Glance 2011*, 150.

⁸⁶ Steven Brill, “Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care,” 20.

regulation that protect other notions of fair opportunity and preserve justice across generations.⁸⁷ Moreover, this overspending does not seem to lead to better health outcomes—the United States performed worse than the OECD average in most measures of health status, including critical measures such as life expectancy at birth, potential years of life lost, heart disease mortality rate, and infant mortality rate.⁸⁸

There are several factors in this high cost of health care in the United States, but I can only focus on a few here. To the extent that one can pinpoint a central reason for the high cost of American healthcare, things tend to center on unrestrained pricing by medical providers. Since the United States does not set prices for medical devices and services, but instead has allowed providers to base their prices on market forces,⁸⁹ the same medical devices and services are more expensive in the United States compared to other developed countries. *New York Times* journalist Elisabeth Rosenthal notes that other nations pay about a third of what Americans do for both conventional birth deliveries and Caesarean sections,⁹⁰ and joint replacements that cost upwards of \$130,000 at American hospitals can cost less than \$14,000 in Europe.⁹¹

Tied in with this notion of overpayment is the problem of treatment effectiveness. Many systems, like the United Kingdom's National Institute for Health and Clinical Excellence (NICE), make coverage decisions based on cost effectiveness and treatment effectiveness.⁹² Yet in the United States, law prohibits Medicare from using even treatment effectiveness in its decisions

⁸⁷ For a sense of what American citizens could do with that \$750 billion, consider this: Jordan Weissman, in a somewhat cheeky article in *The Atlantic*, estimated that the U.S. government could make tuition at public colleges and universities free if it spent \$62.6 billion more on education funding. Jordan Weissman, "Here's Exactly How Much the Government Would Have to Spend to Make Public College Tuition-Free." Thus, the United States could eliminate undergraduate debt from public universities (ostensibly a great injustice) with less than a tenth of the money it overspends on health care.

⁸⁸ OECD, *Health at a Glance 2011*, 25–37.

⁸⁹ Jonathan Oberlander, "Throwing Darts: Americans' Elusive Search for Health Care Cost Control," 481.

⁹⁰ Elisabeth Rosenthal, "American Way of Birth, Costliest in the World."

⁹¹ Elisabeth Rosenthal, "In Need of a New Hip, but Priced Out of the U.S."

⁹² Nigel Hawkes, *Sick Around the World*.

over what to cover—it must reimburse patients for most drugs approved by the Food and Drug Administration. Many private insurers have followed suit.⁹³ Thus, Americans on the whole pay more than necessary for many bad treatments, worsening health outcomes and increasing inefficiencies.

Conclusion

The obvious conclusion here is that the American health care system before the Affordable Care Act is unjust. It failed each of the Benchmarks set out in the previous section, as shown by different cases. Millions lack access to basic health services because they are not covered by insurance, and millions more are either underinsured or insured by Medicaid, and as such, restricted to certain doctors and hospitals. Individuals with lower SES often pay more for the same services than do individuals with higher SES. Largely due to pricing practices for medical services and devices, the health care system overspends close to a trillion dollars every year, money that could be spent to advance justice in other ways. Its barriers to access, financing inequity, and inefficiencies are severe and systemic. It is in this context that we can properly evaluate the changes proposed by the Affordable Care Act. As an act that ostensibly set out to limit the injustice of the system of health care in the United States, we are finally in a position to evaluate where it succeeded and where it failed.

⁹³ Steven Brill, “Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care,” 46.

X. Evaluating the Affordable Care Act in Regards to Justice

Having detailed where the American health care system pre-ACA fell short in regards to the Rawls-Daniels theory of health justice, we can now examine how the ACA addresses those shortcomings. In this section, I look at a number of effects of the Affordable Care Act, focusing on the ACA's methods of cost control, insurance coverage expansion, community rating, social experimentation, accessibility to underserved populations, shifting of costs, and its reliance on Medicare and Medicaid. This section will use the framework of the Benchmarks and progress through the categories identified in the previous section (access, equity, and efficiency) to look into first the improvements, and then the shortcomings of the Affordable Care Act. Though not covered in the previous section, I will also briefly discuss how the ACA improves upon (and damages) the accountability of the American health care system. It should be noted as well that this section will evaluate the Affordable Care Act as an instrument of policy, and not as a political document. Obviously, there were many political compromises made so that the ACA could be passed into law, but to try to ferret out those compromises and determine what the maximally just health care system reform law that could have been passed given the political climate of the United States is surely Sisyphean (or at least, a task for a political scientist).

Improvements to Access, Equity, Accountability, and Efficiency

The Affordable Care Act succeeds, at least in part, in expanding access. The ACA expands Medicaid to all children and adults with incomes up to 133% of the Federal Poverty Level, grants subsidies to individuals with incomes up to 400% of that level, creates tax incentives (and penalties) for businesses to cover employees, and imposes fines on citizens and

documented residents who are not covered under health insurance.⁹⁴ These changes mean that by the end of the decade, the ACA is projected to expand coverage to 30 million individuals who would not have otherwise been covered.⁹⁵ For those who lacked coverage before and now find themselves able to obtain insurance, access to health services will clearly improve. This expansion of coverage also moves the United States towards universal comprehensive insurance coverage, something that Daniels and Rawls require of a society governed by justice as fairness in health. The ACA also expands access to the millions of underinsured Americans by regulating benefit packages more strictly. The Affordable Care Act prohibits insurers from denying coverage to individuals who have pre-existing pathologies, and insurers can no longer set annual and lifetime caps beyond which individuals must pay in full for health services.⁹⁶ Moreover, it sets an “essential health benefits package” and requires all new health insurance plans to meet these requirements.⁹⁷ Benefits required in this package stand to be more generous than benefits offered in many existing plans.⁹⁸ The package also includes maternity care, thereby dismantling one of the main nonfinancial barriers to access in the current American health system.⁹⁹ Thus, by decreasing the number of uninsured and underinsured individuals, changes set forth in the ACA will improve access to health services for many, and even out access across gender.

The Affordable Care Act also cuts down on the financing inequity inherent in the system. The previously mentioned expansion of Medicaid and subsidies for low-earning individuals move the American system closer to a system where costs are assigned by ability to pay, and the smaller uninsured population means that fewer people in lower SES groups will be billed

⁹⁴ *Summary of the Affordable Care Act*, 1–3.

⁹⁵ *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*.

⁹⁶ *Summary of the Affordable Care Act*, 6.

⁹⁷ *Ibid.*

⁹⁸ Uwe Reinhardt, “Confusing the Public on the Affordable Care Act.”

⁹⁹ *Impact of Health Reform on Women’s Access to Coverage and Care*, 2–3.

undiscounted, “chargemaster” prices. The ACA also takes a big step in financing equity by moving past the system of actuarial fairness to a community-rated system for the individual insurance market. If we remember the equation for the price of insurance premiums, $P_i = (1 + L)X_i$, the X_i term, which stands for the expected outlay of an insured individual, will now represent the average outlay per person in the community (i.e. every person that the insurance company covers).¹⁰⁰ People with pathologies will pay the same in premiums as people without them, a requirement of Daniels’ Benchmark B5 about equitable financing.

While I did not discuss problems of accountability in my analysis of the problems of the American health care system, it should be noted that the Affordable Care Act’s new health insurance exchanges help to improve the sector’s transparency, and bring it closer to an Accountability for Reasonableness model. The exchanges create four benefit tiers (platinum, gold, silver, and bronze) and allow consumers to compare plans with relative ease and clarity about what is being covered and what costs are entailed.¹⁰¹ Although nothing like the robust AFR (with appeals processes and community input for tough decisions) has been reached, the exchanges do promote accountability in the individual insurance market by providing more information to consumers. The exchanges also promote equity in financing by lowering costs for consumers on the individual insurance market for many Americans. Insurers must devote at least 75% of their revenues to health benefits,¹⁰² and premiums in the New York insurance exchanges are expected to fall by an average of 50% in 2014.¹⁰³ Thus, by opening up these exchanges, the ACA allows Americans on the individual insurance market, many of whom are among the

¹⁰⁰ Uwe Reinhardt, “‘Premium Shock’ and ‘Premium Joy’ Under the Affordable Care Act.”

¹⁰¹ *Summary of the Affordable Care Act*, 5.

¹⁰² Uwe Reinhardt, “‘Premium Shock’ and ‘Premium Joy’ Under the Affordable Care Act.”

¹⁰³ Roni Caryn Rabin and Reed Abelson, “Health Plan Cost for New Yorkers Set to Fall 50%.”

poorest and sickest in society,¹⁰⁴ not only to take more control over choosing their insurance coverage, but also to choose among more affordable options. The ACA, then, promotes accountability and equity in this context.

Some changes in the ACA also promote efficiency by limiting how much we spend in the health care system to some degree. The Affordable Care Act will save \$600 billion over the next decade, due mostly to savings from changes in Medicare in how they pay providers and from the health exchanges' focus on increased competition for insurers.¹⁰⁵ While these cost controls are far from comprehensive, they do help to slow the growth of health sector. Thus, the Affordable Care Act takes steps towards meeting some of Daniels' Benchmarks of Fairness for its expansion of health insurance to millions of Americans, its focus on community-rated health insurance premiums, its establishment of clearer and less expensive health insurance exchanges, and its modest attempt to make the health care system more efficient through lowering expenditures.

Shortcomings in Access, Equity, Efficiency, and Accountability

Yet the Affordable Care Act is also notable for what it does not do—it leaves much to be desired in its attempt to make the American health system more accessible, equitable, efficient, and accountable. To start, the law will still leave 29 million Americans uninsured even by 2020,¹⁰⁶ with the uninsured population consisting mostly of undocumented immigrants, people who earn too much income to qualify for Medicaid but still cannot afford to purchase subsidized insurance,¹⁰⁷ and people who could buy insurance but choose to pay the fine instead.¹⁰⁸ Thus, the

¹⁰⁴ Jonathan Oberlander and Theodore R. Marmor, “The Health Bill Explained at Last,” 5.

¹⁰⁵ Jonathan Oberlander, “Throwing Darts: Americans’ Elusive Search for Health Care Cost Control,” 478, 481.

¹⁰⁶ *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*.

¹⁰⁷ This problem of people not qualifying for insurance under Medicaid existed even before the 2012 Supreme Court ruling that allowed states to opt out of expanding Medicaid. The Supreme Court ruling worsened this problem by allowing states to deny access to Medicaid to even more individuals with even lower incomes. As of January 2014,

Affordable Care Act deliberately excludes one of the most marginalized groups in the population, undocumented immigrants, from accessing health services and writes them out of the national narrative of universal health insurance. For undocumented immigrants, the changes in the ACA certainly do not expand opportunity; in fact, they may restrict it.

Questions may also be raised about the essential benefits package outlined by the ACA. Insurers are only required to cover 60% of costs, and grandfathered insurance plans may cover less than that.¹⁰⁹ While this requirement is a marked improvement from some current practices, it still appears to leave individuals covered by the lowest tier plans on the hook for a very significant portion of their health costs. This high co-payment amount will certainly make health services inaccessible for many who do not have the means to afford high co-payments for expensive procedures, thereby limiting access under Benchmark B2. In addition, Benchmark B5 requires that medical services be financed by one's ability to pay, and having 40% of one's medical costs coming from out-of-pocket surely fails to meet this requirement. We should also view the expansion of Medicaid with a skeptical eye, given the problems of access that it engenders. Thus, though millions of Americans will gain insurance through the Medicaid expansion, many of those Americans will be subject to a "lower class" of medical care, where low payout rates will limit their access to many doctors and hospitals.

As far as problems with equity are concerned, the costs of the new law are in part financed by a new tax on so-called "Cadillac" insurance plans, which have the potential to harm sicker individuals. Specifically, the "Cadillac tax" works by identifying employer-sponsored

only 25 states (and DC) have chosen to expand Medicaid, with debate ongoing for another 6 states. ("State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, 2014.")

¹⁰⁸ Jonathan Oberlander and Theodore R. Marmor, "The Health Bill Explained at Last," 4.

¹⁰⁹ *Summary of the Affordable Care Act*, 6.

insurance plans that offer benefits exceeding a cost limit,¹¹⁰ and then imposing an excise tax of 40% for over-limit costs on the firm who issues the insurance policy (either the plan administrator or the employer herself).¹¹¹ Though partly a cost-control tactic, this new “Cadillac tax” could possibly harm sicker individuals whose plans would be so expensive not because they want frivolous health services, but because it is expensive to meet their health needs.¹¹² So while the ACA makes great strides to not penalize individuals with pathologies in how much they pay for premiums, it may punish the insurance plans that cover those very individuals, bringing the American health care system farther away from a truly community-rated system.

In terms of efficiency, the ACA stopped well short of any real cost control. As shown earlier, there seems to be no shortage of inefficiencies to iron out in the American health system, yet no serious proposal for reining in these inefficiencies. As Jonathan Oberlander notes, a real effort to control costs in the health sector requires concentrated purchasing, budgeting and regulation¹¹³—essentially governments or other actors must step in to negotiate or set prices for medical products and services that can be applied regardless of how one is insured. Many other countries have used this approach very successfully, notably Japan, whose per capita spending on health is just over a third of what it is in the United States despite Japan having the longest life expectancy in the world.¹¹⁴ The United States uses this price-setting tactic (for medical services) in its Medicare system,¹¹⁵ yet no attempt to expand Medicare or create a Medicare-based public insurance option was included in the Affordable Care Act. In effect, the ACA

¹¹⁰ Plans exceeding that limit were defined in 2013 as plans whose aggregate values exceeded \$10,200 for individual coverage and \$27,500 for family coverage. (*Ibid.*, 3.)

¹¹¹ *Ibid.*

¹¹² Jonathan Oberlander, “Throwing Darts: Americans’ Elusive Search for Health Care Cost Control,” 480.

¹¹³ *Ibid.*, 481.

¹¹⁴ OECD, *Health at a Glance 2011*, 27, 149.

¹¹⁵ Steven Brill, “Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care,” 22.

sacrificed real cost cutting and attempts at efficiency for cosmetic programs that marginally cut costs while keeping the main system in place.

Finally, the Affordable Care Act fails to make the American health care system significantly more accountable. While individual insurance markets will become more transparent due to the exchanges, the ACA largely avoided any decisions about rationing in the face of resource constraints. No binding decisions about the comparative effectiveness of drugs and treatments have been implemented,¹¹⁶ leaving resource rationing to be determined largely on ability to pay and contingencies about certain situations. In addition, in the absence of systemic change, the cost cutting measures included in the ACA amounted to a grab-bag of recommendations by health economists.¹¹⁷ While many of these recommendations have good theoretical backing, they seem to closely parallel the type of social experiments that Daniels warns us as being inherently unaccountable. These experiments might cause real harm in terms of decreased access, and there is reason to worry that the United States lacks sufficient institutional procedures and protections to evaluate and, if need be, cease these new practices.

The grab-bag approach seems especially culpable in regards to justice because of the abundance of alternative models for health care systems that, by almost any measure, work better than the ACA could ever hope to work. Oberlander and Theodor Marmor note that when it came to cost-cutting, health policy researchers for the ACA paid little attention to international experience.¹¹⁸ As noted before, the United States health system is strikingly more expensive, covers fewer people, and produces worse outcomes than many other countries, and the cost-cutting experiments of the ACA, even if wildly successful, will not change that reality. The United States could have, for example, adopted the Swiss model of health insurance. Like the

¹¹⁶ Ibid., 46.

¹¹⁷ Jonathan Oberlander, "Throwing Darts: Americans' Elusive Search for Health Care Cost Control," 477.

¹¹⁸ Jonathan Oberlander and Theodore R. Marmor, "The Health Bill Explained at Last," 6.

United States, Switzerland has a high level of economic development, a capitalist economic system, a long history of private insurance, and large, powerful pharmaceutical companies.¹¹⁹ The Swiss health care system is based largely on an ACA-type requirement for everyone to have insurance, and with the government subsidizing low-income people.¹²⁰ Everyone is covered, no one goes bankrupt from medical costs, and insurance costs are kept low (less than 12% of GDP) by the aforementioned tactic of concentrated purchasing and regulation—insurance companies are forbidden to make a profit off of the basic health plan.¹²¹ The quality of the Swiss health care system also gets high marks: not only do the Swiss have some of the best health outcomes in the world, but also the average wait times in 2010 for elective surgery and specialist appointments in Switzerland were at or below wait times for Americans.¹²²

No two societies are identical, but it seems that Swiss and American societies are similar enough that the Swiss model could be adopted in the United States with largely similar results without much risk of spectacular failure (assuming, of course, that there would be political will to do so). Given that the Swiss model outperforms the American model, even with the addition of the ACA, spurning the Swiss model and its concentrated purchasing for the cost-cutting experiments outlined in the ACA creates not only a failure of reason, but also a failure of justice. Benchmark B6 requires evidence-based practices for reforming health services, and to put Americans at risk of possibly decreased access to care under cost-cutting measures while overlooking other, less risky options is not evidence-based, and therefore unjust. While the grab

¹¹⁹ Pascal Couchepin, *Sick Around The World*.

¹²⁰ One might point out that there are more equitable, efficient systems in the world—Germany, Japan, and the United Kingdom come to mind—and that the Swiss system itself ought to be reformed to one of those systems. This judgment may be true, but it does not undermine the argument I make here—all that is needed is for the Swiss system to be somewhat superior to the American system in each relevant category.

¹²¹ Pascal Couchepin, *Sick Around The World*.

¹²² OECD, *Health at a Glance 2011*, 144.

bag approach of the ACA might have been politically necessary, the political necessity cannot excuse the risk of decreased access.

Conclusion

Using Daniels' Benchmarks of Fairness to evaluate the changes made to the American health care system under the Affordable Care Act, we've seen that some of those changes have led to a more just system, while some have not. Specifically, the ACA promotes justice by expanding access to medical care for many low-income Americans and Americans with pre-existing pathologies, by making payment more equitable for those with pre-existing pathologies, by increasing the efficiency of the Medicare payment system, and by improving the accountability and transparency of the individual health insurance market. The ACA fails to promote justice by leaving undocumented immigrants and some low-income individuals still without health insurance, by continuing to condone insurance plans with large out-of-pocket costs that leave citizens on the hook for their health needs, by allowing the basic health care system structure to remain grossly inefficient, and by opening up Americans to the risk of not having access to medical care in the name of cost-cutting experiments.

On the whole, we can say that the Affordable Care Act makes the American health care system more just by getting closer to fair equality of opportunity, on the Rawls-Daniels view. And yet, there remain many ways in which this law falls short on expanding opportunity, and in the case of undocumented immigrants, it may possibly restrict opportunity. A truly just health care system will require a deep, systemic change in how Americans receive, pay for, and think about health products and services, and the ACA simply does not make that kind of deep, systemic change.

Defenders of the Affordable Care Act may chide this analysis for being unrealistic about American political structures. They may argue that the ACA was the best that could have been done under the political circumstances, and in establishing (mostly) universal health insurance Americans take one big step closer to a more fair health care system. I find myself sympathetic to that argument. Indeed, Oberlander posits that, by giving the public a greater stake in funding the health care system, public pressure might mount towards making the system more efficient.¹²³ From the standpoint of justice, one must remember that the Affordable Care Act is a step—a big one, but just a step nonetheless—towards creating a just health care system that affirms citizens’ rights to fair equality of opportunity. Now that the main policies of the Affordable Care Act have been implemented, Americans should work on taking that next step.

¹²³ Jonathan Oberlander, “Throwing Darts: Americans’ Elusive Search for Health Care Cost Control,” 482.

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