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Communications

Healthcare, Foucault, and the Politics of COVID-19

Abstract

As of April 2020, the United States is in a state of complete and utter crisis. This paper seeks to acknowledge and critique the inherent failings present in the neoliberal system of healthcare adopted by the United States. By identifying and criticizing components of insurance, employment, and the fetishization of marketplace competition, I will make a Foucauldian analysis of the flawed power structures existing within a privatized health system. The goal of this article is to articulate and make clear the case for the implementation of a single-payer system in the United States, which would see a much vaster and more equitable breadth of positive health outcomes. New language will be introduced such as the idea of *health outcomes* and *health justice*. Both concepts encompass principles and values that should exist within a progressive healthcare system functioning within the borders of the wealthiest country in world history. The extent to which COVID-19 exposes what this paper considers to be inherent shortcomings and expected failures within the healthcare system is used as further evidence to encourage the reconstruction of the US healthcare system into that of a single payer infrastructure.

Keywords: Un-insurance, State of Exception, Neoliberalism, Healthcare, Markets, Foucauldian, Single-Payer, Health Justice, Subaltern

Power and the Private Sector

In February of 2020, Italian philosopher Giorgio Agamben criticized the Italian government for enacting strict measures of quarantining and social distancing without sufficient evidence that COVID-19 was dangerous enough to warrant such measures (Agamben, 2020). Agamben claimed that these measures created a *state of exception*, a term which refers to a government's ability to transcend the rule of law in the name of public good (Agamben, 2020). With over 10,000 deaths in Italy alone, (Regencia & Alsaafin, 2020) Agamben has likely reconsidered his stance on the severity of COVID-19, but his Foucault inspired arguments citing the *state of exception* deserve a closer look.

What does the *state of exception* represent in a neoliberal state suffering through a pandemic, when government power is indistinguishable from the interests of the private sector? How do we digest the initial hesitation from countries around the world asking their citizens to stay home? What reasons might the western neoliberal powers of the world, such as the United States, have for delaying use of unobstructed absolute power? According to journalist Ani Maitra, the answers to these questions lies within economic ideology. The United States, as well as other participant countries within the global neoliberal economy, view "large-scale restrictions that hinder the movement of capital, labor, and commodities [as] 'counter-growth'" (Maitra, 2020). This distinction and labeling of measures taken to combat the spread of COVID-19 as counter to the main tenants of capitalism and thusly neoliberalism render them ideologically incompatible with neoliberal economics. Maitra notes prominent critique of the European Unions' austere lockdown measures concerning Italy and Spain, the latter country nationalizing all of its private hospitals on March 16th, to be manifestations of the weaknesses inherent to these free market economies. These weaknesses manifest in the forms of overreliance on the private sector and the overwhelming of healthcare systems unfit to manage amongst the chaos. The ultimate consequence being that certain citizens will always be declared as "worth" saving, above those in subaltern groups.

Maitra reaches the conclusion that although the market-first hegemony existent within America continues to be parroted by those in places of wealth-based or political prominence, the people suffering and dying throughout this period of exception may start to challenge this perception. “This state of exception can be an opportunity for change for the people in the US and elsewhere, but only if we mobilize for comprehensive people-centric safety nets and refuse to be content with trickle-down measures and pro-market corporate bailouts” (Maitra, 2020). One of the ultimate goals of any mobilization effort seeking to reject the hegemonic state of healthcare must be to implement a single payer healthcare system. Single-payer means exactly that, in a single payer system, a single public or quasi-public agency organizes healthcare financing and by collecting money from participants, is able to determine rates and payment plans with healthcare providers (Chaufan 2015). A single-payer healthcare system should be implemented in the United States in order to see much more equitable and morally justifiable health outcomes in the pursuit of *health justice*. A term which we will return to further on.

Foucauldian Foundation

Agamben’s initial concern citing the *state of exception* arises from the work of French philosopher Michel Foucault. In identifying the state and presence of government in according to the German *ordoliberal* ideals, Foucault establishes the key difference between these ordoliberals and the traditional concepts of *liberalism*. The ordoliberals flipped the formula of the state supervising the free market as a space of economic freedom, instead wishing for the free market as the “…organizing and regulating principle of the state” (Foucault et al., 2008, p. 116). This state that exists under the supervision of the market is consistent with what we now consider to be one of the dominant overbearing guidelines present within contemporary neoliberalism. This power discrepancy is of course presented and prescribed as the “natural” state of government in the global west. Foucault maintains that this mode of governmentality is not strictly *laissez-faire* however. The first key principle outlined in Foucault’s description of neoliberalism is the false uncoupling of *laissez-faire* from the market economy (Foucault et al., 2008). This uncoupling allows for the *state of exception* to make its appearance. Neoliberalism does not allow for explicit government intervention in the

name of concepts such as welfare, as that would go against what Foucault defines as the "…only one true and fundamental social policy: economic growth" (Foucault et al., 2008, p. 116). The *state of exception* refers to the manner in which the government is permitted to interfere in the market, with *exception* referring to the hypocritical manner in which the fallacious *laissez-faire* principle is violated. Foucault notes that interventions present in a neoliberal society exist on behalf of the competitive structures inherent to the market, as opposed to interventions on behalf of the charitable measures mentioned above such as welfare reform (Foucault et al., 2008). Foucault ties this rejection of social policy to the creation of what we might identify as American neoliberalism, as well as a concept uniquely important to our focus; "The privatization of insurance mechanisms, and the idea that…it is up to the individual to protect himself against risks" (Foucault et al., 2008, p. 145). In short, it is this facet of neoliberalism that now oversees the inhumane trend of privatized social policy.

Neoliberal Healthcare as a Subaltern Experience

What does a neoliberal healthcare landscape look like? For answers we should look to Rohit Varman's and Ram Manohar Vikas's 2007 study *Rising Markets and Failing Health: An Inquiry into Subaltern Health Care Consumption under Neoliberalism.* Varman and Vikas sought to illustrate the "fundamental weaknesses of the market-based approach for developing society" (Varman & Vikas, 2007, p. 164). The study was conducted in India, and was primarily concerned with attitudes towards market-based systems as well as the marginalization of lesser-privileged sections of the population. Varman and Vikas note that at the time of the research, India was in the midst of a transition to privatization throughout the economy, providing an excellent avenue for observing the effects of a neoliberal shift. The study was conducted in the city of Kanpur, a city with noted poor health infrastructure, and a poverty rate sitting around 50 percent (Varman & Vikas 2007, p. 162). The research was conducted by interviewing patients, physicians, and sales representatives of pharmaceutical companies, combined with field observations inside clinics/hospitals. Both authors sought to interpret the role of markets in the consumption of healthcare by the marginalized as a *lived experience*. Their findings were remarkably grim. An entire section is provided of stories detailing complete apathy or outright neglect on the part of state physicians and support staff. As

reported by the subaltern persons interviewed, this maltreatment was often seen to be as a result of their lower financial and social status. Respondents specified that "…patients with greater buying power, better clothing, or superior references were given preferential treatment in the hospital" (Varman & Vikas, 2007, p. 167). This concurs with the commonly noted concern of market approaches failing to consider those with the greatest need in favor of those with the higher "purchasing power" (Varman & Vikas, 2007, p. 164). Other interview subjects noted that the reasons for the neglect faced in the state hospital was a direct consequence of the dominance of private clinics throughout the city (Varman & Vikas, 2007, p.167). These private clinics were reported to offer higher salaries when compared to state facilities, but governed by the logic of profit by nature catered to individuals with more purchasing power (Varman & Vikas, 2007, p. 167).

Varman & Vikas's findings cement Foucault's claims concerning both the privatization of insurance mechanisms and shifting of responsibility away from the state, to the individual, in regards to the responsibility of risk protection. Should the burden of protection from risk be placed on the individual, let alone during a pandemic such as COVID-19? The consequences of this transition are likely clearer in the case of India only due to the relative nakedness of social stratification in comparison to a country like the United States, in which the movement to reduce class consciousness has undoubtedly succeeded in obscuring the more overt indications of purchasing power disparity.

Single Payer in America?

Since the Obama administrations successful passing of the Affordable Care Act (ACA), a piece of legislation often fawned over as one of the most significant pieces of health reform legislation since Medicare, Americans have again and again expressed their support for Medicare alongside their disapproval for the ACA (Chaufan, 2015). This contradiction can be explained by the corporate classes' power over both political processes and social institutions, such as the mass media and the judiciary (Chaufan, 2015). With the most expensive healthcare system in the world, how can the United states consistently rank so poorly in international comparisons with other wealthy economies on measures such as access, quality, and equity? The ACA's unfavorable

ratings in public polls likely stems from its inability to combat the measures consistent with what we might consider to be *health justice*. As defined by the San Francisco AIDS Foundation (2020), health justice refers to the "…lessening [of] existing gaps in who has access to health. The health "disparities" that we see for people of color, people with less access to wealth, [and] people who use substances". The lack of the ACA's ability to overcome the aforementioned barriers provides the avenue and potential for building a mass movement coalition alongside those who might be disregarded in the effort for fear of their binary political loyalties.

Since its implementation, the ACA has been the victim of a number of unavoidable issues, the first and most prominent being the problem of access (Chaufan, 2015). Coverage and access are dangerous and misleading words within the realm of healthcare. Neither *access* nor *coverage* guarantees the outcome of *insurance*, in which a body is actually able to redeem the benefits of the health system. After the ACA expanded coverage "as many as 31 million… will remained uninsured by 2024" (Chaufan, 2015, p. 150).

Secondly, the ACA also failed to significantly reduce financial barriers to receiving care (Chaufan, 2015). The United States has the equally ironic and unfortunate issue of seeing many of its medical bankruptcies predominantly afflicting those who *actually possess health insurance* (Chaufan, 2015). Consistent with what Varman and Vikas explored in India, in a neoliberal health system, individuals with a high amount of wealth and subsequent purchasing power can navigate this paradox. Those in subaltern groups however, cannot even afford to *use* the policies that they *can* afford to purchase. In 2012, 80 million people reporting that they did not go to the doctor when sick or in need of care solely due to the cost of care, 75 million people reported problems paying for their care, and 28 million people reported spending their entire savings just to pay off medical bills (Chaufan, 2015) The cost of care was a significant barrier to entry before the ACA, and remains a significant barrier hereafter.

Lastly, the ACA has no way of dealing with the spiraling costs of health care, costs that are not explained by "inflation, age structure, health status, above-average utilization, or medical technologies" (Chaufan, 2015, p. 151). It goes without saying the ACA does not account for the breakout of a disease on the scale of COVID-19, even if

people are privileged enough to have comprehensive coverage, there is no guarantee that they can afford to use their insurance, nor that a care facility in their provider's network is in proximity to where they might be sheltering-in-place.

Under the Expanded and Improved Medicare for All ACT, (also known as HR 676) an American single-payer health insurance system would be established. All residents, regardless of documentation status, would be covered for all medically necessary services including but not limited to services such as doctor visits, mental health, dental, and preventative care (Chaufan, 2015). HR 676 also seeks to eliminate the wasteful paper pushing associated with the current system, which in the case of a pandemic would drastically worsen the speed and quality of care afforded to participants. This wasteful paper pushing comes from three sources as identified by Chaufan (2015), the need of insurers to market plans to profitable customers and make a profit, the care providers' need to screen patients' coverage and file claims to multiple insurers to receive payment, and the need of participants to juggle all of the above with an already ponderous system of navigators, plans, providers, and services (Chaufan, 2015).

Not only would HR 676 save time and stress (even more prescient during a period such as the current COVID pandemic) it would save an enormous amount of money. Friedman (2013) concludes that single-payer would cover more and cost less than the current American neoliberal system for up to 95% of Americans. Noting that the current system is regressive and by placing the burden on the individual, the costs weigh heaviest on the poor, working class, and already sick, Friedman (2013) contends that by use of a progressive payroll tax, revenues would exceed expenditures by as much as $154 billion in the first year alone. Due to the erasures of "out of pocket" costs via the implementation of single-payer, and the administration of a highly progressive *Robin Hood* tax, only the top 5% of households would see a cost increase under HR 676, which would mean savings for Americans earning incomes of up to and well above as high as $200,000 (Friedman 2013).

The single-payer system's merits are even more prevalent in the wake of COVID-19, with the tedious nature of the current health system already responsible for an

untold amount of pain and suffering, the weaknesses of neoliberal health administrations are being further exposed during this period of global health insecurity.

Navigating American Health During the COVID-19 Crisis

The American system of health is not prepared and not capable of handling an outbreak on the scale of COVID-19. According to Seervai, et al. (2020) as many as 30 million citizens remain uninsured, with a further 44 million falling into the category of *underinsured*, meaning that they have coverage that they cannot afford to utilize. With a total population of 328.2 million as of 2019 (United States Census Bureau), you're looking at over 20% of people in the United States who are conditioned to avoid seeking care because they either don't have insurance or cannot afford either the out of pocket costs or deductibles associated with the American insurance system. The financial disparities within the American health system are not randomly distributed, they are disproportionately Hispanic, young, and of lower incomes (Seervai, et al., 2020). State cuts to Medicaid, Medicare, and other public have only worsened the issues of avoidance to medical care, meaning that the arbitrary financial barriers associated with American healthcare are responsible for driving those afflicted with COVID-19 away from seeking help, with residents forced to sit and watch as avoidable deaths continue to pile up in the wealthiest country in the history of the world. A single-payer public health infrastructure would offer the security, morality, and equity necessary to combat medical inequality even in the wake of a global outbreak. I sincerely hope that in the future we can afford the basic right of receiving adequate healthcare to all of those present in the United States, and that until we do, neoliberal practices will continue to abate and be directly responsible for needless death and suffering at an extreme and tragically apathetic level. As seen in the study by Varman & Vikas, and in real time watching the number of active American cases of COVID-19, the lived consequences of these austere and inhumane privatized social policies will perpetuate the system of purchasing power, and by consequence, healthcare disparities active through neoliberal statehood.

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