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Universal Health Care, American Pragmatism, and the Ethics of Health Policy: Questioning Political Efficacy

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Universal Health Care, American Pragmatism, and the Ethics of Health Policy: Questioning Political Efficacy

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I. INTRODUCTION

This article will explore the conceptual implications of applying ethical critique and analysis to health policy. This is not to imply any reductionist conception of health policy in which ethics is absent. As Deborah Stone and John W. Kingdon both note, policy is fraught with ethical implications, and value prioritization is a *sine qua non* for health policy.¹ Nevertheless, I wish to suggest that there are some conceptually significant distinctions in thinking of the ethics of health policy as opposed to thinking separately about ethics and about health policy. Moreover, these distinctions themselves are of value, both in thinking about some of the most intractable problems of health policy, and in generating health policy that expressly presents its ethical bases, as opposed to masking the value assumptions and beliefs that underpin such policy.

In a purely moral paradigm, the naturalistic fallacy suggests that an important distinction exists between the descriptive and the normative. The mere fact of a phenomenon does not imply its moral goodness. However, while “is” does not imply “ought,” many moral theorists have sug-

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1. DEBORAH STONE, *POLICY PARADOX: THE ART OF POLITICAL DECISION MAKING* 1–14 (W.W. Norton & Co. 2002) (1988); John W. Kingdon, *The Reality of Public Policy Making*, in *ETHICAL DIMENSIONS OF HEALTH POLICY* 97 (Marion Danis et al. eds., 2002).

gested that “ought” implies “can.”² After all, if one cannot do what one ought to do, in what sense is a moral obligation meaningful? The notion that a just social order should endeavor to establish meaningful connections between what a moral agent ought to do and what a moral agent can do is at the core of this article. From an ethics of health policy perspective, if a proposed allocation of health resources is ethically mandatory but practically impossible, it is fair to question whether the proposal is remotely viable as policy, or simply a pious hope.

Bismarck’s dictum—that politics is the art of the possible—is instructive here, especially when one notes that national health insurance took root in Germany under Bismarck.³ And, as Stone argues, if policy is inextricably linked with politics, it is fair to apply the same maxim to policy: if a putative policy is not pragmatic, it is of little use *qua* policy.⁴

I will therefore adopt an ethos of pragmatism in addressing the connection between ethics and health policy. The American pragmatists were in a very real sense responding to the formal, rationalistic traditions of moral theory that dominated Enlightenment and post-Enlightenment thought. While Kant was acutely aware that few agents act in accordance with the moral law, the pragmatists questioned the utility of a moral paradigm that did not actually account for persons’ moral experiences.⁵ This is not to endorse a wholly pragmatic account of morality, as there is real value in conceiving of what one ought to do, even if such acts seem more aspirational than tenable. This is partly why I maintain that ethical theory is integral in thinking about health care.⁶ Nevertheless, purely aspirational objectives are ill-suited for health policy for the simple reason that their aspirational status renders them unavailable as objects of policy. Such aims simply cannot be legislated; while they are not irrelevant policy considerations, they are strategically ineffectual in a policy paradigm precisely because of their aspirational status.

Therefore, any conjunction of ethics with health policy is a non-starter if the policy in question is not pragmatic in some meaningful sense. If

2. See, e.g., DEREK PARFIT, REASONS AND PERSONS 35–37 (Oxford Univ. Press 1991) (1984); John Kekes, *‘Ought Implies Can’ and Two Kinds of Morality*, 34 PHIL. Q. 459, 459 (1984); Elinor Mason, *Consequentialism and the ‘Ought Implies Can’ Principle*, 40(4) AM. PHIL. Q. 319 (2003); Robert Stern, *Does ‘Ought’ Imply ‘Can’? And Did Kant Think It Does?*, 16 UTILITAS 42, 42 (2004).

3. See, e.g., PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 237 (1982).

4. See STONE, *supra* note 1, at 1–14.

5. See generally William James, *The Present Dilemma in Philosophy*, in WILLIAM JAMES, PRAGMATISM: A NEW NAME FOR SOME OLD WAYS OF THINKING 3–40 (1907). Several scholars, including Glenn McGee and Michele Carter, have urged the systematic application of American pragmatism to bioethics. See Glenn McGee, *Pragmatic Method and Bioethics*, in PRAGMATIC BIOETHICS 24–28 (Glenn McGee ed., 2003); Michele Carter, *A Synthetic Approach to Bioethical Inquiry*, 21 THEORETICAL MED. & BIOETHICS 217, 217 (2000).

6. See Carter, *supra* note 5.

Stone is correct that policy cannot be separated from politics,⁷ it follows that any ethical analysis of health policy must ineluctably supply a political analysis. For the remainder of this essay, I will sketch just such an analysis, combining ethical critique with political assessment in briefly considering one particular means of allocating finite health resources that is as volatile and as contentious today as ever it has been: the prospect of universal health care in the United States. I will analyze the possibility of universal health care in light of the pragmatic ethos that I have described above. First, I will consider the problem of morally justifying policies for universal health care. I submit that this is not nearly as obvious as it is often taken to be, and I say this as someone who unabashedly supports some kind of universal health care policy in the United States. Second, given my commitment to articulating a dialectic model of history,⁸ I will rely on Paul Starr's detailed analysis of the various attempts to implement a policy of universal health care in the United States over the last seventy years.⁹ This analysis delineates the powerful stakeholders whose political and economic interests would be ill-served by virtually any kind of universal health care policy.¹⁰ Consideration of these social forces is integral to analyzing the pragmatic value of universal health care policy in the United States.

II. JUSTIFYING UNIVERSAL HEALTH CARE ON THE BASIS OF NEED

While there is no shortage of philosophical analyses attempting to justify universal health care, it is regrettably common in much of bioethics and health policy scholarship to simply presume its ethical justification.¹¹ This is particularly unfortunate in policy discourse because of Stone's insistence that such discourse is characterized in part by its adversarial nature, insofar as any stakeholder pressing for policy change will virtually

7. See STONE, *supra* note 1, at 6–14.

8. See Daniel S. Goldberg, *The Sole Indexicality of Pain: How Attitudes Towards the Elderly Erect Barriers to Adequate Pain Management*, 12 MICH. ST. J. MED. & L. 51, 58–59 (2008) (applying a dialectic model of history to understanding some of the barriers to adequate treatment of pain in the elderly).

9. See STARR, *supra* note 3. For an extended discussion of the impact of Starr's book, see Keith Wailoo et al., *Professional Sovereignty in a Changing Health Care System: Reflections on Paul Starr's The Social Transformation of American Medicine*, 29 J. HEALTH POL. POL'Y & L. 557 (2004).

10. See STARR, *supra* note 3.

11. See, e.g., Griffin Trotter, *The Illusion of Legitimacy: Two Assumptions that Corrupt Health Policy Deliberation*, 33(5) J. MED. & PHIL. 445, 452 (2008) (noting that appeals to “justice” or “human rights” in health policy discourse are “accompanied by the presumption that the meaning[s] of these terms are settled and well-known”). Trotter also observes that the term “social justice” is “virtually never characterized in its theoretical details or acknowledged in its multiplicity of competing and incompatible forms.” *Id.*

always square off against stakeholders opposing such change.¹² This makes justification indispensable in the political process.

Amy Gutmann and Dennis Thompson concur on the significance of justification in thinking about ethics and health policy, adopting a model of deliberative democracy as a criterion for justice in health care in which “[c]itizens or their accountable representatives seek to give one another morally acceptable reasons to justify the laws and policies they adopt.”¹³ They go on to state that “[b]oth the content of the deliberators’ reasoning and the conditions under which they are deliberating should manifest the aim of justifying the policies in question to the people who are bound by them.”¹⁴ Accordingly, if the ethical basis for universal health care policy is not expounded with maximum clarity, the justification for such policy becomes clouded, and its pragmatic value is arguably lessened.

Thus, in the tradition of some of the late humanists like Montaigne and Erasmus,¹⁵ I adopt a version of Pyrrhonian skepticism in unpacking an ethical commitment to universal health care. That is, I do not presume the ethical justification for universal health care, even though I may personally believe the case for universal health care is compelling. Many accounts of such an ethic, such as Michael Ignatieff’s meditation on *The Needs of Strangers*,¹⁶ connect it to a notion of human and social needs. And there is something appealing about this formulation inasmuch as it seems difficult to contest, at such a level of abstraction, that all or virtually all moral agents have needs. Yet, Ignatieff’s title is significant because of the prepositional phrase—“*of Strangers*.” If his descriptive premise—that all or virtually all have needs—is sound, it follows that those who are strangers to us have such needs. And if such needs are morally compelling, it seems incumbent upon those agents considering said needs to attempt to rank and prioritize the claims. This follows because it has already been posited that all or virtually all strangers have some kind of needs. If all of these strangers’ needs exert claims of equal moral force on us, it is legitimate to wonder what policy initiative could ever satisfy these claims.

12. See STONE, *supra* note 1, at 1–14.

13. Amy Gutmann & Dennis Thompson, *Just Deliberation About Health Care*, in *ETHICAL DIMENSIONS OF HEALTH POLICY* 77 (Marion Danis et al. eds., 2002).

14. *Id.* at 79.

15. See, e.g., GARY REMER, *HUMANISM AND THE RHETORIC OF TOLERATION* 59–61 (1996); Ann Hartle, *Montaigne and Skepticism*, in *THE CAMBRIDGE COMPANION TO MONTAIGNE* 183 (Ulrich Langer ed., 2005). My preference for the intellectual and academic model embodied by the late Renaissance humanists flows from my graduate work in the medical humanities, and is treated in further detail in my forthcoming dissertation.

16. MICHAEL IGNATIEFF, *THE NEEDS OF STRANGERS* 135–42 (1984). Again stressing the links between health policy and politics, in December 2008, Canada’s Liberal Party appointed Ignatieff its interim leader. See Les Whittington, *Ignatieff Warns PM: Fix Economy, or Else*, *TORONTO STAR*, Dec. 11, 2008, at A1.

In other words, the policy value of an ethical claim that all strangers are equally entitled to our efforts to meet their (health) needs is dubious. Of course, the normative value of the ethical claim is not a function of its pragmatic value—to assert as such would be a rank instance of the naturalistic fallacy; but, again, my approach here is to review universal health care policy by wedding the normative with the pragmatic, as virtually any serious ethics of health policy analysis ought to do.¹⁷

Either the premise that all or virtually all humans have needs is itself a morally compelling justification to attempt to satisfy such needs or it is not. If it is, we immediately are presented with the seeming impossibility of crafting policy that instantiates the moral obligation to provide for such needs, and to treat all moral agents equally in setting policy. The pragmatic problems are not the only difficulties of asserting such universal obligations, as asserting the universality of these obligations runs counter to the recent scholarly emphasis on particularism.¹⁸ This scholarship runs across a variety of disciplines, and may constitute something of a revival more than a novel direction insofar as the Medieval and Renaissance humanists were quite sensitive to the importance of the particular in their hopes to translate erudition into local practice.¹⁹

As to ethical theory, for example, an ethic of care emphasizes the particularity and context of our constructed relationships and finds moral value in such phenomena.²⁰ Many theories of virtue ethics similarly emphasize particularity.²¹ And theorists like Jonathan Dancy and Margaret Olivia Little have endorsed the notion of moral particularism, which locates ethi-

17. For further application of this concept, see Daniel S. Goldberg, *In Support of a Broad Model of Public Health: Disparities, Social Epidemiology and Public Health Causation*, 2 *PUB. HEALTH ETHICS* 70, 70–83 (2009), available at <http://phe.oxfordjournals.org/cgi/content/abstract/phn035>.

18. See generally CHALLENGING MORAL PARTICULARISM (Mark Norris Lance et al. eds., 2008); JONATHAN DANCY, *ETHICS WITHOUT PRINCIPLES* (2004); SEAN MCKEEVER & MICHAEL RIDGE, *PRINCIPLED ETHICS: GENERALISM AS A REGULATIVE IDEA* (2006); Margaret Olivia Little, *Wittgensteinian Lessons on Moral Particularism*, in *SLOW CURES AND BAD PHILOSOPHERS: ESSAYS ON WITTGENSTEIN, MEDICINE, AND BIOETHICS* 161–80 (Carl Elliott ed., 2003). In addition, volume 4, issue 1 of the 2007 *Journal of Moral Philosophy* featured a symposium on moral particularism, and I address Dancy's particularism in detail in my forthcoming dissertation.

19. See generally STEPHEN TOULMIN, *COSMOPOLIS: THE HIDDEN AGENDA OF MODERNITY* 28–30 (1990); Ullrich Langer, *Introduction* to *THE CAMBRIDGE COMPANION TO MONTAIGNE* 1 (Ullrich Langer ed., 2005).

20. See, e.g., VIRGINIA HELD, *FEMINIST MORALITY: TRANSFORMING CULTURE, SOCIETY, AND POLITICS* 64–67 (1993); Virginia Held, *Introduction* to *JUSTICE AND CARE: ESSENTIAL READINGS IN FEMINIST ETHICS* 1 (Virginia Held ed., 1995). Other important care theorists include Alison Jaggar, Nel Noddings, and Marilyn Friedman.

21. See, e.g., ALASDAIR MACINTYRE, *AFTER VIRTUE: A STUDY IN MORAL THEORY* 245 (2d ed. 1987) (“I am never able to seek for the good or exercise the virtues only qua individual . . . it is not just that different individuals live in different social circumstances; it is also that we all approach our own circumstances as bearers of a particular social identity.”).

cal significance in the particular and the local, as opposed to the general and the universal.²²

These perspectives attempt to resolve the problem that the seemingly limitless needs of strangers make on us as agents, insofar as they all, at least implicitly, endorse ways of discriminating those whose claims justify more of our attention and efforts (i.e., the needs of intimates over the needs of strangers). Importantly, other theorists reject such an approach, particularly utilitarian scholars like Peter Singer.²³ From Bentham's earliest formulations of the theory, the universe of moral agents whose pleasures and pains are to be considered in the moral calculus are all those who are capable of experiencing pain and suffering.²⁴ Thus, utilitarians typically reject the notion that our intimates have a greater moral claim on us than strangers. This view, if valid, has troubling implications for a pragmatic ethos in the context of satisfying the needs of strangers.

Nevertheless, the moral agent who would argue that the needs of strangers exert a moral pull on those in a position to provide for those needs must, in my opinion, engage the utilitarians and justify affording greater weight to the needs of intimates. The alternative, of course, is simply to contend that the mere fact that most, if not all, humans have needs does not by itself establish any moral obligation to satisfy the needs of strangers. Indeed, this latter line of reasoning is likely more difficult to counter than might seem at first glance.

One of the oldest doctrines in tort law is that individuals have no affirmative duty to rescue.²⁵ Anglo-American law thus expressly rejects the premise that the needs of strangers exert significant ethico-legal claims on those in a position to assist.²⁶ While some jurisdictions have enacted laws that require those properly situated to provide some level of assistance to

22. See JONATHAN DANCY, *ETHICS WITHOUT PRINCIPLES* 1 (2004); Brad Hooker & Margaret Olivia Little, *Introduction to MORAL PARTICULARISM* 1 (Brad Hooker & Margaret Olivia Little eds., 2000); Margaret Olivia Little, *Wittgensteinian Lessons on Moral Particularism*, in *SLOW CURES AND BAD PHILOSOPHERS: ESSAYS ON WITTGENSTEIN, MEDICINE, AND BIOETHICS* 161–64 (Carl Elliott ed., 2001).

23. Singer has defended this claim in a number of papers and books. See, e.g., Peter Singer, *Outsiders: Our Obligations to Those Beyond Our Borders*, in *THE ETHICS OF ASSISTANCE: MORALITY AND THE DISTANT NEEDY* 11 (Dean K. Chatterjee ed., 2004). Peter Unger is also famous for arguing that we owe maximal duties to strangers, though Unger is not necessarily a utilitarian. See PETER UNGER, *LIVING HIGH AND LETTING DIE: OUR ILLUSION OF INNOCENCE* (1996). The question of what duties we owe to strangers enjoys extensive treatment in the philosophical literature. See, e.g., Raziel Abelson, *Moral Distance: What do We Owe to Unknown Strangers?*, 36 *PHIL. F.* 31, 34–35 (2005); Barbara Herman, *The Scope of Moral Requirement*, 30 *PHIL. & PUB. AFF.* 227, 228 (2001).

24. MARY ANNE WARREN, *MORAL STATUS* 5 (1997) (noting that “some utilitarians . . . argue[] that all beings that are sentient (that is, capable of experiencing pleasure and pain) are entitled to equal moral consideration, regardless of their species”).

25. See David A. Hyman, *Rescue Without Law: An Empirical Perspective on the Duty to Rescue*, 84 *TEX. L. REV.* 653, 655 (2006).

26. *Id.*

those in need, these jurisdictions remain exceptions to the general rule that there is no duty to rescue.²⁷

Furthermore, in many jurisdictions which do not prescribe an affirmative duty to rescue, once a rescue has been initiated, it must be performed non-negligently, or else the “rescuer” may pursue an action against the putative rescuer for exacerbating the situation through negligence.²⁸ Traditional tort doctrines therefore present disincentives to providing for the needs of strangers. Conversely, there is a well-settled exception to the “no affirmative duty to rescue” doctrine when the potential rescuer has a special relationship with the rescuee, such as a parental or fiduciary relationship.²⁹ In such circumstances, the rescuer may have an affirmative duty to rescue, thereby endorsing the notion that we owe greater efforts in fulfilling the needs of intimates than we do as to strangers.³⁰ Finally, it is an equally well-settled principle of health law that physicians have no affirmative duty to treat anyone, so long as a physician does not abandon a patient (who, by definition, already enjoys a relationship with the physician).³¹

This ethical critique of a needs-based grounding for universal health care is offered to suggest that the moral basis for concluding that persons in our society are entitled to health care simply because they need health care is not self-evident. This, of course, does not imply the invalidity of the conclusion that “universal health care is morally preferable”; the argument is simply meant to problematize the inference that draws this conclusion directly from the premise that most if not all humans have health needs. Further premises would need to be supplied to compel this conclusion.

If the moral case for universal health care policy is not as obvious as it seems, what policy implications does this have? If Stone is correct regarding the need for justification in policy discourse, the difficulty of articulating the ethical rationale for universal health care may weaken the case for such policy, which in turn may complicate universal health care proponents’ ability to convince adverse stakeholders of the need for policy change. Fleshing out the justification for adopting a policy of universal health care is integral to a pragmatic approach. If the needs of strangers are an inadequate or problematic basis for justifying universal health care

27. *Id.* at 683 (explaining that only Vermont, Rhode Island, and Minnesota “have enacted statutory duties to rescue”).

28. *See, e.g.,* Martin Roger Scordato, *Understanding the Absence of a Duty to Reasonably Rescue in American Tort Law*, 82 TUL. L. REV. 1447, 1461–62 (2008) (noting that an individual’s voluntary decision to rescue may give rise to duties to the injured person, and citing cases supporting this).

29. RESTATEMENT (SECOND) OF TORTS § 323 (1965).

30. *See id.*

31. *See* HEALTH CARE LAW AND ETHICS 113–50 (Mark A. Hall et al. eds., 7th ed. 2007).

policy, it would seem inadvisable for proponents of universal health care to continue to articulate such grounds as moral impetus for universal health care policy. In short, rhetoric that connects the justification for universal health care policy to the needs of strangers may lack political efficacy if connected to an inadequate or at least under-theorized moral grounding.

Rhetoric is nothing if not strategic, and is therefore peculiarly suited to the arts of politics and policy. It is no accident that Western history's arguably greatest orator was also a Senator.³² Given the problems involved in justifying universal health care based on the needs of strangers—which, again, is not to suggest either that universal health care is not morally preferable or that the problems are insurmountable—it may well be the case that talk of an individual right to health care on the basis of the individual need for health care may be unlikely to persuade. I am questioning here how pragmatic the rhetoric of rights talk based on a theory of need is in convincing opponents in policy discourse who are disinclined to support a policy of universal health care.

While it would be unwise to reduce politics or policy to an adversarial contest, it seems equally unwise to discount the existence of a significant adversarial component to policy discourse.³³ Starr traces such a contest in the mid-to-late nineteenth century, when the newly formed American Medical Association (AMA) devoted much of its energies to suppressing the competing healing traditions of the Thomsonian herbalists and the homeopathic practitioners.³⁴ The AMA adopted aggressive policy initiatives, including pressing for legislative reforms (primarily by way of licensing requirements) and exerting influence through local medical societies.³⁵ Though these examples are not directly applicable to a policy proposal for universal health care, they do demonstrate the significance of market share—in terms of patient base—for those whose interests are affected by such markets. Of course, cultural authority is not simply a function of market power, but such power cannot be discounted inasmuch as it remains an end to which the medical profession's enlarged sovereignty was and continues to be directed.

32. I speak, of course, of Cicero.

33. See JOHN W. KINGDON, *AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES* (Addison-Wesley Educ. Pub. 2003) (1984); STONE, *supra* note 1; Kingdon, *supra* note 1, at 98–102.

34. See STARR, *supra* note 3, at 79–144.

35. See *id.*

III. ENTRENCHED INTERESTS AND THE DEFEAT OF UNIVERSAL HEALTH CARE POLICY

Starr's treatise is nothing if not an account of the power such interests exert in the context of health care policy.³⁶ Book Two of his treatise is a painstaking account of the ways in which those with interests in the status quo worked to prevent policy change.³⁷ Though the identities of the interest groups and stakeholders changed over the course of the twentieth century, the AMA, along with business interests such as insurance and pharmaceutical companies, consistently formed strategic alliances designed to derail various attempts to instantiate a policy of universal health care.³⁸ Along the way, such stakeholders were sometimes joined by "strange bedfellows," such as organized labor during the 1920s and 1930s, who were not opposed to universal health care so much as they were opposed to any attempt to usurp the unions' power by stumping for universal health care outside of the unions' prerogative to acquire it on behalf of their constituents.³⁹

Those interests arrayed against a policy of universal health care have typically employed effective rhetoric, taking advantage of the Red Scare of the 1920s and the Cold War to paint universal health care policies as Bolshevik attempts to alter the individualist, capitalist ethos of U.S. society.⁴⁰ Such poetics are particularly likely to be effective insofar as they tap in to deeply-rooted perceptions in the fabric of American political culture (individualism and capitalism).⁴¹

Regardless of one's views on the merits of a culture which seems to celebrate private consumption and material gain,⁴² it seems difficult to overestimate the awesome social power of market forces. The primary mode of critiquing such power, whether Rawlsian or Marxist, takes the scope of such power as a given, and emphasizes the need for political and regulatory correction of the policy results of unrestrained capitalism.⁴³ Starr's analysis definitively demonstrates the extent of such power in the

36. See generally *id.*

37. *Id.* at 235–89.

38. See *id.* For a timely and particularly insightful examination of the close alliance between American physicians and the pharmaceutical industry during the middle decades of the twentieth century, see Dominique A. Tobbell, *Allied Against Reform: Pharmaceutical Industry-Academic Physician Relations in the United States, 1945–1970*, 82(4) BULL. HIST. MED. 878 (2008).

39. See STARR, *supra* note 3, at 249.

40. *Id.* at 254.

41. See Kingdon, *supra* note 1, at 105–07; see also DANIEL MILLER, CONSUMPTION: CRITICAL CONCEPTS IN THE SOCIAL SCIENCES (2001); DAVID E. SHI, THE SIMPLE LIFE: PLAIN LIVING AND HIGH THINKING IN AMERICAN CULTURE (2001).

42. See STONE, *supra* note 1, at 134.

43. See generally JONATHAN COHN, SICK (2007).

context of health care policy, and specifically as to a policy of universal health care. Given the current status quo, for example, it seems difficult to deny that the insurance industry and pharmaceutical companies have rational economic reasons to militate against a policy of universal health care.

This follows because it is difficult to conceive of any universal health care program in which some kind of government influence fails to exert downward pressure on prices. In the private insurance market, large firms that furnish commercial insurers with hundreds or thousands of subscribers (by virtue of employment) enjoy significant bargaining power in negotiating prices with insurers.⁴⁴ Conversely, individuals who enter the private market without any such leverage face dramatically higher premiums and preexisting condition exclusions if they are fortunate enough to find coverage at all.⁴⁵ If, for example, the federal government sponsored universal health care, even in a cooperative that utilized commercial insurers to provide access to care, the government could exert tremendous economic and political downward power on prices. For similar reasons, the government would enjoy tremendous leverage in negotiating prices with pharmaceutical and medical device companies for all manner of drugs and biologics.⁴⁶

We have, therefore, a particularly vicious commons problem, in which major stakeholders' private interests seem adverse to public interests—

44. See, e.g., Oliver Fein & Leonard Rodberg, *U.S. Health Care Reform and the Candidates*, 13(3) J. HEALTH SERV. RES. & POL'Y 131, 131 (2008) ("Individuals buying insurance on their own do not have the bargaining power of an employer group and pay more or accept shrunken benefits.").

45. See *id.*

46. This explains why the pharmaceutical industry in particular vigorously (and successfully) lobbied for the enactment of a Medicare prescription drug benefit that specifically prohibited Congress from granting any agency authority to use its purchasing power to negotiate drug prices directly with manufacturers or similarly situated interests. See Marcia Angell, *Excess in the Pharmaceutical Industry*, 171(12) CANADIAN MED. ASS'N J. 1451, 1453 (2004). Angell, it must be noted, is a particularly vehement critic of the pharmaceutical industry, but to the best of my knowledge there is little dispute as to the pharmaceutical industry's interest and involvement in shaping the Medicare prescription drug benefit so as to preclude the exercise of federal purchasing power as to drug prices. See Jonathan Oberlander, *Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act*, 32 J. HEALTH POL. POL'Y & L. 187, 195–200 (2007) ("[T]he [Medicare Modernization Act of 2003] embodied a bizarre benefit design, lacked a sustainable funding source and direct cost controls, provided incomplete coverage to its intended beneficiaries, was disliked by both liberals and conservatives, and failed to generate strong support among Medicare enrollees or the public."). Compare Louise M. Slaughter, *Medicare Part D—The Product of a Broken Process*, 354 N. ENG. J. MED. 2314, 2314 (2006) (declaring, in an article authored by a Democratic member of the U.S. House of Representatives, that "[t]he political process used to pass Part D was the worst abuse of the legislative process I have seen during my 20 years in Congress" and decrying the pharmaceutical lobby's extensive role in its passage), with Peter B. Bach & Mark B. McClellan, *The First Months of the Prescription-Drug Benefit—A CMS Update*, 354 N. ENG. J. MED. 2312, 2313 (2006) ("[Medicare] plans have achieved their low prices without such [price] restrictions because of their other sources of pricing leverage.").

presuming universal health care is in the public interest.⁴⁷ In the context of the pragmatic approach that informs my analysis, there are reasons to question the political efficacy of any universal health care policy insofar as it is difficult to conceive of any such policy that would not be adverse to politically and economically powerful entrenched interests. Arrayed with such compelling reasons for opposing a policy for universal health care, what rhetoric might be effective?

One response is simply to assert an ethical obligation for universal health care, that because we ought to provide universal health care, that obligation should be reflected in policy. A paradox exists here because, on the one hand, Gutmann and Thompson appropriately warn of the naturalistic fallacy when thinking of the power of market interests from a pragmatic view:

The trouble with prudential reasoning as a criterion for public decision making is that some people have far greater bargaining power than others, and prudence authorizes them to use that power in a self-interested, or group-interested, way to gain still more benefits for themselves or their group.⁴⁸

This is simply another way of suggesting that the raw exercise of capital does not by itself establish ethical propriety. On the other hand, this article is committed to an emphasis on the pragmatic in an ethics of health policy analysis. Assuming, without argument, that universal health care is a morally preferable health policy, the paradox is that what seems practically possible may not be ethically optimal, but what seems ethically optimal may not be practically possible.

IV. CONCLUSION

Unfortunately, I am unaware of any viable resolution to this quandary. Perhaps a particularly strategic rhetoric may be used to disabuse the powerful interests opposed to universal health care policies, and perhaps a powerful alliance can shape policy even in the face of staunch opposition. Sadly, Starr's narrative does not justify optimism, as the United States seemed poised on several occasions between 1915 and the present to enact some kind of single-payer health care, but opposing interests and ill luck

47. For more on the concept of the commons as it pertains to health care, see Nancy S. Jecker & Albert R. Jonsen, *Healthcare as a Commons*, 4 CAMBRIDGE Q. HEALTHCARE ETHICS 207 (1995).

48. Gutmann & Thompson, *supra* note 13, at 85.

conspired to prevent such policy enactment.⁴⁹ Similarly, Allen Buchanan warns of the error of presuming that private market forces will produce a just allocation of health care resources.⁵⁰ As Buchanan points out, the principal architects of managed care organizations (MCOs) never imagined they would be tools for the just allocation of scarce health resources justly,⁵¹ nor is there justification to expect for-profit MCOs to diminish dividends for their stockholders in the interests of social justice.⁵² Again, this is not to assert that the MCOs' rent-seeking behavior is ethically preferable, but simply that given MCOs' involvement, no intelligent observer should be surprised that health care dollars in the United States do not seem to be allocated according to many persons' sense of justice, under which all would be guaranteed some minimal level of health care.

Nevertheless, for those who endorse a policy of universal health care, there seems little alternative other than to seek to forge alliances and unearth rhetoric sufficient to bring about the desired changes. The clash of opposing forces that characterizes the dialectic model of history posits few other political mechanisms for facilitating a policy synthesis. As such, it is unsurprising to hear the words of Harry H. Moore, a staff director of the Committee on the Costs of Medical Care, on the state of American health care over eighty years ago: "What exists is not so much a system as a lack of a system."⁵³

Buchanan is persuasive when he contends that U.S. society has not come to any policy commitment on how to dispense health care justly.⁵⁴ Whether such agreement is possible remains questionable. But for those who seek such a commitment, what policy alternative exists?

49. See STARR, *supra* note 3, at 235–449. Book Two of Starr's analysis is devoted to explaining this point.

50. Allen Buchanan, *Rationing Without Justice, But Not Unjustly*, 23(4) J. HEALTH POL. POL'Y & L. 617 (1998).

51. See *id.* at 619–21.

52. See *id.* at 621–24.

53. See STARR, *supra* note 3, at 262.

54. See Buchanan, *supra* note 50, at 632–33.