

Health Care Justice: The Social Insurance Approach

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Abstract There are four basic models for health care systems: the private market insurance model, the national single-payer model, the national health service model, and the social insurance model. The social justice debate over health care usually focuses on the comparative efficiency and quality of competitive private market insurance and the universal coverage and equity of national health care systems. It is a mistake, however, to think that a universal right to health care services requires a single-payer, government-run, national health care system. The social insurance model of Germany, France, Japan, and many other countries, deserves more attention, as it incorporates the strengths of both market models and national health care models.

Keyword Social insurance, health care justice, right to health care, health care financing, health care reform

Introduction

There are four basic models for health care systems: the private market insurance model, the national single-payer model, the national health service model, and the social insurance model. *Private Market Insurance* systems are for-profit, contractual insurance agreements between individuals and private insurance companies, which are often mediated, negotiated, and financed by employers for employees. A *National Single-Payer* model is a national, government-funded, health payment system. This is the dominant system in Canada and Australia, and the definition also fits the national Medicaid and Medicare systems in the United States. A *National Health Service* system is single-payer and also government-run, with public hospitals and clinics, and medical providers as employees of the NHS system. The British NHS is the paradigm case of this model. *Social Insurance* models are the most common and least understood system of universal health care. Most of the European universal health care systems, including the World Health Organization (WHO)'s top-rated French system, are social insurance systems. The Japanese

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health care system, which is rated by the World Health Organization as the best for mortality and morbidity, is a social insurance system as well.

The social justice debate over health care usually focuses on the relative merits of private market insurance versus the nationalization of health care. The social insurance model deserves more attention, as it incorporates the strengths of both market models and national health care models. It is simply a mistake to think that a universal right to health care requires a single-payer, government-run, national health care system. In addition, the distinction between public and private financing of health care insurance needs to be reconceptualized. Indeed, the “public” financing of social insurance is in many ways similar to the financing of a private market system. Specifically, the social insurance model is funded primarily by employer and employee contributions like private markets. Moreover, the social insurance funds are not run by the government, and yet as in nationalized health care, there is still a public guarantee of basic health care for all.

The Right to Health Care

The right to health care raises a complex array of difficult questions. The nature of the right, the content of the right (i.e., the health care services that are due), the financing of the health care services, and the relationship between patients, providers and payers all raise contentious issues. Here we will focus on the nature of the right and the financing of the health care system. The “right to health care” itself is best conceived as a universal human right that requires society to provide secure and reasonable access to basic health care services. This conception of rights follows J.S. Mill’s classic account and Thomas Pogge’s recent expanded conception of human rights.¹

Pogge argues that:

[b]y postulating a human right to X, one is asserting that any society or other social system, insofar as this is reasonably possible, ought to be so (re)organized that all its members have secure access to X ... Avoidable insecurity of access, beyond certain plausibly attainable thresholds, constitutes official disrespect and stains that society’s human-rights record. Human rights are, then, moral claims on the organization of one’s society.

One way to secure a human right is to have a government-based *legal* entitlement. In the case of the retired elderly, for example, a national social security system, with a legal entitlement to a basic income, may help to secure the basic human right to subsistence for all. It is natural to assume that human rights must be secured by legal entitlements. Alternatively, however, in a traditional Confucian culture, the needs of the elderly are secured by a strong sense of *filial piety* and the responsibility that children assume for the care of their parents and elders. A strong sense of filial responsibility and internalized social expectations motivates adult children to

¹J. S. Mill 1979/1861, Chapter 5; and Thomas Pogge 2002, p. 64.

support and care for their parents and relatives.² Indeed, filial responsibility may in fact do a better job than a legal entitlement right in securing adequate social security for the elderly. In most cultures, a sense of *parental responsibility* similarly accounts for the basic needs of almost all young children without any direct state social security support. Direct state action is thus one way to secure a right, but it is not the only way. What is important is that human rights are secured. Whether this is done by direct legal entitlements and protections, or social conventions, or civil society and nonstate actors, is secondary; effectively securing the right is primary.

This conception of rights, including the right to health care, leaves open the particular means of securing the right. In principle, if not in actual practice, a market system that in fact provided health insurance at an affordable price could secure the right to health care. In practice, of course, a private market system must be supplemented with alternative funding, or free care, for individuals without adequate wealth or income. A market-based system can also use tax policy in the form of tax deductions and/or tax credits as a supplement and incentive to make health care and private health insurance affordable for the working poor and middle class. In addition to private markets, however, government-based systems like Medicaid and Medicare are usually necessary to provide secure access to health care services for the many who otherwise simply could not afford it.

In the United States, 47 million people, or 14% of the population, do not have health insurance. The uninsured are defined as individuals without any health insurance for the entire year. In addition, even more people, an additional 15–20 million, lack insurance coverage for part of a year. Since the poor and elderly have Medicaid and Medicare insurance provided by the government, the real health insurance crisis is faced by the near-poor and lower-middle class. Of those with household incomes under \$25,000, 24% or 14.6 million are uninsured. These families really cannot afford private health insurance and so government programs must be expanded to provide or subsidize insurance for this income group. (In 2003, the average premium for individual health insurance coverage was \$148 per month and family premiums were \$240–489 per month depending on the region.)³ Another 15 million households earning between \$25,000 and \$50,000, or 21%, are also uninsured. These families often could buy insurance but it would involve significant financial sacrifice to do so. Proposals to provide tax breaks or other assistance to help finance health care for this income group may also be appropriate. Surprisingly, however, 8.3 million households earning between \$50,000 and \$75,000, and 8.7 million earning \$75,000 or more are also uninsured. More households earning over \$50,000 (17 million) are uninsured than poorer households earning under \$25,000 (14.6 million).⁴ For these families, the decision not to have health insurance is more of a choice; they have the means to buy

²On Confucian ethics and rights, see Ihara (2004) and Cumiskey (2006).

³Kaiser Family Foundation, Update on Individual Health Insurance, August 2004 <http://www.kff.org/insurance/upload/Update-on-Individual-Health-Insurance.pdf>.

⁴United States, 2005 Census: <http://aspe.hhs.gov/health/reports/05/uninsured-cps/index.htm#fig2>; and *New York Times*, Magazine, June 10th, 2007, p. 69.

insurance and decide to spend their money on something else that they believe is more important. Since United States hospitals must by law provide emergency room care without regard for ability to pay, and since routine health care is less expensive than health insurance, this choice not to have insurance often is rational for the healthy individual. The overall social consequence, however, is that too much routine care is provided by hospitals and cost-effective preventive care is too often neglected. Consequently, the cost of health care for all is thus substantially higher.

Household Incomes of the Uninsured in the USA

Under \$25,000: 14.6 million

\$25,000–50,000: 15 million

\$50,000–75,000: 8.3 million

\$75,000 or more: 8.7 million

Households earning over \$50,000: 17 million uninsured

As these income statistics suggest, most of the uninsured are also employed. In 2004, in the United States, 46% of the uninsured had full-time jobs and 28% had part-time jobs. Of the uninsured, only 26% are unemployed. For the most part, uninsured workers work for smaller employers, with 26% working in firms with 10 or fewer employees and another 21% in companies with fewer than 100 employees.⁵ The United States problem of the uninsured is not simply a problem of health insurance for the unemployed and poor. If all employee benefit packages included health insurance, the problem of the uninsured would be three quarters solved. Unlike nationalized health care, the social insurance model (explained below) uses mandatory employment-based insurance as the core of universal coverage.

The United States already incorporates a diverse array of health care insurance into a complex system that blends private for-profit markets, nonprofit insurance organizations, and the national, single-payer, Medicaid and Medicare system. The Federal Employees Health Benefits Plan and the State Children Health Insurance Program (SCHIP) are additional government-based health plans. The United States also has the (more NHS-style) Veterans Health Administration with government-run hospitals.

As an alternative to introducing social insurance, as proposed below, it is possible that simply expanding federal health insurance programs and mandating employment-based insurance could go far toward solving the problem of the uninsured without fundamentally altering the private insurance market. In this way, universal access to affordable insurance for all can be addressed by a mixed market system. This is the approach favored by Democratic presidential candidates in the 2008 election. This is also the approach the United States' States of Oregon and Massachusetts have taken towards universal coverage. Republican proposals, on the other hand, emphasize tax deductions, tax credits, and market mechanisms to expand access to health insurance. Both types of proposals have promise, and, in a mixed system, there is no reason why both expanded government-based plans and increased market/tax incentives cannot coexist.

⁵United States, 2005 Census.

On the other hand, a national system of free public health care that is radically underfunded, seriously understaffed, and lacks an adequate health care infrastructure clearly will not secure access to basic health care services. For example, India offers a government-based legal right to health care for all, but the government program finances only 17% of health care expenditures and private insurance makes up the remaining 83% of expenditures. This statistic strongly suggests that the legal entitlement does not adequately secure the right. Although a nationalized single-payer health care system provides a legal right to health care services, laws alone do not secure rights.

It is simply a mistake to equate a right to universal access to health care services with a requirement to have a nationalized, single-payer health care system. Indeed, social insurance may be a better alternative for building an *additional* health care financing system in both the United States and in developing countries that have an inadequate public health care sector.

The Social Insurance Model

In addition to private insurance markets and government-based national health services, we have to add the extremely successful social insurance systems. The social insurance model originated in Germany with the formation of employment and union-based sickness insurance funds. Although first set up by workers, employers soon joined in the financing of these funds. Over time, the funds grew and spread across Germany. Starting in 1883 under Chancellor Bismarck's rule, these funds were shaped into a broad and increasingly universal system of health insurance that included regional, territorial funds. The social insurance model is thus often called the Bismarckian model. Nationalized systems are called Beveridge systems and are named after the United Kingdom's Beveridge Report (1942) that led to the British National Health Service in 1948. The alternative Bismarckian model of social health insurance is found in much of Europe, including Austria, Belgium, France, Luxembourg, the Netherlands, Switzerland, as well as in Japan. Both France and Japan have some of the best health indicators in the world. France was rated the best health care system by the World Health Organization and Japan has the highest life expectancy and the lowest infant mortality rate in the world. Health care justice may be best served by the third way of social insurance.

The particular characteristics of social insurance systems vary from country to country. In broad terms, social insurance systems typically involve the following nine characteristics:

1. **Multiple Health Insurance Funds.** Often called "sickness funds," these are nonprofit, quasi-public but independent (nongovernment) organizations, which collect revenues and pay health care providers.
2. **Fund Membership.** Funds were originally occupation-based but now include regional funds, such as funds for small businesses and the self-employed. Membership is based either on type of occupation or geographical region.

3. **Choice.** Social insurance systems may include choice in fund membership and it may include complete choice of providers.
4. **Control.** Representatives of employees and employers are responsible for managing the funds within the constraints of general government mandates, which include basic coverage standards.
5. **Financing.** The health (sickness) funds are financed primarily by employer and employee contributions. Employee contributions are based on ability to pay through a percentage of wages or income, which is set nationally by the funds and/or the government. Employer contribution levels are set nationally by the funds and/or the government.
6. **Risk-Pooling.** Social insurance systems provide insurance to all eligible persons without regard to risk or previous health status. Social insurance always includes a system of risk-pooling, and/or general government contributions, to promote risk-based equity across funds.
7. **Mandatory.** Health insurance is (typically) compulsory for all either through the social insurance funds or individual private insurance. Employment-based funds include all dependent family members.
8. **National Fund.** The employment-based social insurance systems must be supplemented by a general government fund (or funds) for the poor, unemployed, and retired. General government funds also often subsidize co-pays and deductibles for low-income workers.
9. **Private Market.** A private for-profit insurance market provides additional complementary and/or supplemental coverage of services and/or co-pays and deductibles.

Social insurance systems achieve *universal coverage* without a single-payer national government-based health system. Social insurance health care systems are *nonprofit* systems and the fund managers are focused on *balancing costs and care* in the interests of patients/payers. The patients pay for the system in a more direct fashion than in an NHS or single-payer system, and thus efficiency and costs are more directly relevant to patients. In practice, since social insurance fund managers represent patients, the funds can be *more responsive* and more efficient than nationalized health systems. Since social insurance is not a single-payer system, equity across funds is achieved by *risk-pooling*. One of the most bizarre aspects of private for-profit health insurance is its business imperative to sell insurance to those most likely not to need it. Unlike for-profit markets, health funds do not strive to deny health care coverage to the sick. Enrollment in social insurance funds is open to all and coverage cannot be denied based on risk assessment. In short, the funding of the health care system is more direct than in a nationalized health system, the system is more responsive, universal coverage is required, and the balancing of cost and care is more immediate. It is thus not surprising that patient satisfaction is high.

Norman Daniels has argued that for physicians and providers, saying “No” to patients in a private market system of health care is harder to justify than in a national health care system (Daniels 1986). The first reason for this difference is that market insurance systems are built on profit and so are not “closed systems.” A denial of expensive, marginally beneficial care to one person does not have any

clear impact on health care costs, access or quality for others. In a market, micro-decisions that limit care for cost-benefit reasons are just as likely to simply increase corporate profits. In a closed system, on the other hand, limiting access to marginal services for the sake of providing other more beneficial, more cost-effective services provides a more reasonable basis for allocation decisions. Second, in a private market there is no public system for setting priorities and balancing considerations of cost, quality, and access. In a government-run system, especially in democracies, the health care system must be publicly defensible and is thus more likely to be responsive to citizen interests as payers and patients.

Social insurance systems are also closed systems with public accountability, and on both counts are indeed preferable to the nationalized models. Since national government systems are funded by general taxation, they compete with all other government services. Health care cost savings might go to better or cheaper health care, but it could just as easily go to any other government program. As a patient I have no reason to assume that cost savings will go to more efficient care or even lower taxes for all, as opposed to increased funding for defense or corporate tax breaks. In a social insurance system the funding of health care is direct and thus the link between cost and benefits is even clearer than in a nationalized system. In addition, politicians and government officials have many responsibilities, concerns, and constituencies. There is no reason to assume that benefit packages and services will be very responsive to the overall best interest of the people. Social insurance fund managers are more directly representative of payers and patients, and they are clearly responsible for the costs and quality of the health care system. Social insurance systems are thus likely to be more deliberative, responsive, and transparent than both for-profit markets and national health services.

David Eddy has provided an interesting analysis and reconceptualization of the alleged conflict between the individual and society in allocating health care services (Eddy 1991). When health care allocation decisions are made in response to sick patients, more cost-effective care, especially preventive care, is often neglected. From the perspective of the ill patient, the preventive care is obviously too late. If, however, allocation decisions are made from the perspective of a healthy person deciding on a health care insurance plan, the benefit of more cost-effective care is obvious. The conflict is not between sick individuals and society; it is between the position of a healthy person insuring against illness and the position of perhaps even the same person when they are already ill.

To sharpen the point, consider Eddy's example of funding increased preventive screening for breast cancer as opposed to funding high-dose chemotherapy with autologous bone marrow transplant (HDC-ABMT). For the sake of analysis, assume that HDC-ABMT costs \$150,000 and that this treatment offers a 5% chance of a complete cure of an otherwise terminal condition. For a 50-year-old woman who is likely to live 30 more years, this treatment would increase life expectancy by 1.5 years (30×0.05). Alternatively, suppose that this \$150,000 was used for breast cancer screening, at \$100 per screening, for women between 50 and 60 years old. This would amount to 10 years of mammograms for 150 women. On the reasonable assumption that annual screening for this age group can reduce mortality

rates by 40%, this results in an increase of 12 person years of life. Screening as opposed to HDC-ABMT has eight times (800%) increased efficacy, which is of course an 800% increase for the lives of real individual people. If you are a 50-year-old contemplating whether your health insurance policy should cover either screening or HDC-ABMT, it is clearly rational to choose screening. It is only when health care decisions are made at the bedside, when someone already has cancer, that a person would choose to fund HDC-ABMT instead of screening; once you have cancer, early detection screening provides no benefit. The advantage of a closed financing system and open deliberations is that allocation decisions are made from the perspective of a person deciding what to cover as insurance against illness, and this perspective provides a reasonable and public justification to all for the policy decision not to fund, for example, HDC-ABMT.

Private for-profit insurance markets lack the sense of solidarity found in public universal health care systems. Profits transform the relationship, and cost-effective allocation decisions are perceived as serving the bottom line of corporate interest rather than overall patient interest. Rather than a public decision made in the name of a common and shared interest, we have a private market decision denying potentially life-saving care (or alternatively, a decision to cover a procedure that is less cost-effective and not in the long-term interest of all). In an NHS system, the decision is not distorted by profits but it is still probably made by distant government officials (government bureaucrats, as they say). Social insurance funds are managed by boards representing patients and their employers, and thus are most closely representative of the perspective of persons deciding what to cover as insurance against potential illness.

Both employees and employers want to maximize health outcomes and minimize the costs, which inevitably cut into paychecks. Clearly the more that goes into the health care fund the less is available for take-home pay. Indeed, the overall employment compensation package (wages and benefits) is generally balanced in different countries with different rates of employee and employer contributions. The less (or more) that employers contribute directly to health care funds, correspondingly more (or less) is the direct employee pay; i.e., if salaries are higher, then employer fund contributions are lower, and if fund contributions are higher, salaries are correspondingly lower. Overall compensation packages remain roughly equal across European Union countries with social insurance.

As a final point, social insurance systems can include complete *freedom of choice* in health care providers and funds. On the other hand, the United States private market often denies coverage or increases deductibles for "out of network" providers, and thus restricts patient choice. Furthermore, despite the for-profit market in the United States, patients actually have little market choice or ability to shape benefits and costs. Insurance packages are so complex that employees must defer to employers and insurers, and in most cases they just accept the coverage offered. Private for-profit insurance funds are not run by managers representing employees/patients and employers, and by design must focus on profits to stay financially viable.

On the other hand, choice and competition between social insurance funds can introduce *market forces* that drive efficiency and quality (Paton 2000; Busse 2000). The quasi-public status of social insurance funds provides an interesting mix of

public and market characteristics. The lifeblood of private insurance is profits. Social insurance can provide “market forces” focused exclusively on efficiency and health. The life and health of the patient, not the corporation, come first; is it thus surprising that the mortality and morbidity rates are better in countries with social insurance?

The Public–Private Distinction Reconsidered

It is actually a mistake to think in terms of pure models of either private or public health care delivery systems. The United States health care system, for example, is a mixed system with government expenditures of approximately 46% and private expenditures of 54%. The United Kingdom’s NHS, in contrast, accounts for 86% of health care costs with 14% private expenditures. The Canadian “single-payer” system accounts for 70% of health care costs. China’s communist system is supposed to guarantee a low level of health care for all through a publicly funded system of clinics and hospitals. The Chinese public system accounts for 38% of expenditures and is supplemented by a 62% private market. India’s national health care system primarily funds health care through subsidies to health care facilities that offer low-cost or free care to patients. In India, however, the universal health care system accounts for only 17% of expenditures and private expenditures account for 83% of health care costs.⁶

Government and Private Health Care Expenditures

UK	86% government	14% private
Canada	70% government	30% private
USA	46% government	54% private
China	38% government	62% private
India	17% government	83% private

If over 80% of health expenditures are private, it is reasonable to conclude that the *legal* entitlement right to health care in India simply does not provide reasonable and secure access to health care for all. Indeed, on the basis of these statistics, and the per capita government expenditures (India \$16 per capita and the USA \$2,725 per capita), the United States seems to do a better job than India in actually securing an expansive and effective right to basic health care. Indeed, the United States government also spends substantially *more* per capita on health care than Canada (\$2,215 per capita) or the United Kingdom’s National Health Service (\$2,209 per capita)—despite the fact that it does not provide universal coverage.

⁶The statistics are from the World Health Organization and these figures are from 2004 in international dollars. See <http://www.who.int>

These statistics do not tell the whole story on the ground, but they do suggest that we need to focus on the more complex mix of public and private financing of health care. Canada's "single-payer" system is supplemented by a 30% private market. The United States private market is supplemented by a 45% government NHS. Consequently, we can say that the United States health care system is 45% "nationalized" and the Canadian "single-payer" system is sustained by 30% private for-profit market. It is thus a mistake to simply contrast the supposed market-based system in the United States with national health care systems. The important question is whether the public-private mix actually provides secure access to health care services.

The health care systems of most countries include a complex combination of public and private insurance. The social insurance health care systems of France and Germany, according to 2004 WHO figures, divide expenditures at about 77% government and 23% private, and Japan divides expenditures at 81% government and 19% private; but *these numbers are misleading*.

As we have seen, these social insurance systems are largely employment-based systems funded by employer and employee contributions. What this means is that for France and Germany, 77% of expenditures flow through the nonprofit health care funds; but not in the more simple form of a single-payer nationalized health care system like that found in the United Kingdom or Canada. The health funds are instead quasi-public, independent, nongovernment organizations, and they are only partially funded by general tax revenues.

Similar to private market insurance systems, social insurance systems are largely funded by employer contributions and employee premiums. For example, in Japan in 1990–1991, the employee premiums and employer payroll taxes funded 56% of health care expenditures (as opposed to only 32% in the United States) and public *government* expenditures in Japan were only 31% (as opposed to 45% in the United States). Out-of-pocket payments accounted for the remainder of private expenditures (Japan 12% and United States 22%).⁷ In other words, in 1990–1991, *nongovernment* expenditures in Japan's social insurance system were 68% of total expenditures, as compared to 54% in the United States. Similarly, in Germany the employment-based social insurance system accounted for 57% of all expenditures (covering 88% of the population). Nonstatutory private financing accounted for 25% of expenditures. So, nongovernment expenditures in Germany's health care system account for over 80% of total expenditures.

The French system has a complex financing system of employer and employee contributions directly to particular funds based on wages, and an additional "general social contribution" (GSC) based on total income. The GSC is in some ways more like a general tax, but it is earmarked for social health insurance and thus maintains a clear connection between health care financing and benefits. The funds

⁷ Victor Rodwin, *Japan's Universal and Affordable Health Care: Lessons for the United States?* (with the assistance of Llyn Kawasaki and James Littlehales) New York: Japan Society, 1994. <http://www.nyu.edu/projects/rodwin/lessons.html>

themselves are quasi-public funds with independent managers. In France, 74% of funding is employer/employee-based, with only a 4% general government share.⁸ There are, however, large co-pays in the French system (with government subsidies for low-income families) and also limits on benefits. As a result, increasingly social insurance is supplemented by a complimentary private insurance plan. Indeed, in 2000, 86% of the French population purchased supplementary insurance coverage and this additional market accounted for 12% of total health care expenditures. Another 10% was financed by direct out-of-pocket expenses for a total of 22% additional private costs.

In 2003, 70% of the Swiss also purchased private insurance to supplement the mandatory social insurance plan. The total costs of private insurance (11%), out-of-pocket costs (28%), and other insurance amounted to almost 40% of health care expenditures. Although 60% of Swiss expenditures flow through the mandatory health funds, once again only 25% is funded by general tax revenues with the remaining 35% funded by employer/employee contributions.⁹

We have seen that in many important respects, social insurance schemes resemble the United States employer-based private insurance system. In addition, they also typically have a substantially smaller government-based national health care system than that found in the United States.

Health Care Funding Source for USA and Social Insurance Systems

USA	32% employee/employer	22% private	46% government
Japan	56% employee/employer	22% private	32% government
Germany	57% employee/employer	25% private	10% government, 8% other
France	74% employee/employer	22% private	4% government plus other
Switzerland	35% employee/employer	40% private	25% government plus other

(Private costs include out-of-pocket costs and supplemental private insurance. Other includes alcohol, cigarette, and taxes on pharmaceutical companies.)

Private Markets and Social Insurance

Social insurance funds are quasi-public, nonprofit organizations, and these characteristics, of course, make the social insurance model fundamentally different from a private for-profit insurance market. But from the point of view of the employee's pocketbook, there is no significant difference in how these two systems are funded. The difference is in the results—social insurance funds are simply more likely to

⁸France and Germany statistics are from the European Observatory, *Social Health Insurance Systems in Western Europe*; p. 106.

⁹Banafsheh Siadat and Michael Stolpe, *Reforming Health Care Finance: What Can Germany Learn from Other Countries?* December 2005; p. 7, 13–14: <http://www.uni-kiel.de/ifw/pub/kepp/2005/kepp05.pdf>.

be responsive to patient and employer interests in quality, costs, and efficiency, rather than to profits and stock prices.

Indeed, the French social insurance system also incorporates fee-for-service payment of doctors and unrestricted freedom of provider choice for patients.¹⁰ It is thus hard to make sense of the common, too simple-minded contrast between United States market-based and French “*socialist*” medicine. The French, German, Swiss, and Japanese “socialist systems” have significant free market dimensions (perhaps more so than the United States), and the United States market is supplemented with one of the largest per capita National Health Systems (i.e., Medicaid and Medicare) in the world.

As we have seen, the statistics on public and private funding are confusing because, in social insurance systems, the “public share” is funded primarily by employer premiums and direct payroll employee contributions, rather than general tax revenues; in addition, the “public” health funds are not run by the government. In the United States, employers and employees also pay for health insurance directly, but the funding goes through a private for-profit, insurance market instead of a quasi-public, nonprofit, social insurance fund. Social insurance schemes do typically mandate universal coverage, but the health care delivery system is not run from the top down by the government, and it is not funded from the top down with general tax receipts. Instead the health care system is organized into many health care funds that are run by boards selected by employees and employers. Although there is significant government oversight and regulation of funds, as WHO surveys of satisfaction with the health care system indicate, the fund boards tend to be responsive to the concerns of the members and sensitive to the demands for affordability, efficiency, and efficacy.

All advanced health care systems are expensive. It is clearly simply false to describe health care as “free” in either NHS or social insurance countries. NHS systems are financed by general taxation and thus citizens pay for health care when they pay taxes. The quality of care and access is strongly influenced by government spending on health care, which is limited by tax revenues. If an NHS system increased national spending from 8.1% of gross domestic product (GDP) to the United States spending level of 15.4% of GDP, this would surely have an overwhelming effect on access and services. Since social insurance systems are funded more directly by employers and employees, they are no more “free” than is private for-profit market insurance. However health care is funded, it costs real money, and the particular amount of money is a percentage of the GDP that is not spent on other things. It is an advantage of social insurance that the link between cost and benefit is direct and transparent, but health care is not free. Health care spending in France is 10.5% of GDP, and in Germany it is 10.6%. Social insurance systems may spend a greater percentage of GDP on health care than NHS systems, but this is the result of a public system that sets costs and determines benefits. The higher spending may be directly related to the tighter connection between financing and benefits, and thus the perceived value of better health care. On the other hand, the nationalized system in Canada spends 9.8% of GDP, and the Italian NHS is the second-ranked health

¹⁰The European Observatory on Health Systems and Policies Report, *Health Care Systems in Transition: France 2004*; p. 14.

care system in the world while spending only 8.7%. Japan's social insurance system has the best health outcomes with spending at only 7.8%. It is thus hard to draw any tight correlations between spending levels and overall quality. What is clear is that high-quality health care services are never free.

Some argue that employment-based social insurance systems burden employers and weaken *business competitiveness*. This view is probably a mistake. First, if employment-based insurance is mandated for all businesses, as it is in a social insurance system, then there is no competitive disadvantage to any one business. Second, if social insurance leads to better health outcomes, this directly benefits employers with less lost time and lost productivity due to illness. This is one of the reasons that employers in Germany first supported, and why employers in all social insurance countries continue to support, employment-based social insurance plans. It is in the common interest of all employers to have a standard health care benefits package at a set cost. Third, if benefit packages are set nationally or across broad regional funds, employers do not have to negotiate with particular insurers over annual premiums and benefits. Managers of social insurance funds represent employees as a class and employers as a class and set a common benefits package for all. Contribution rates are often set nationally and progressively as a percentage of income. Additional private insurance coverage can be purchased by individuals, if they so desire. Fourth, if there is a national system of risk-pooling, the premiums and costs to particular employers are not affected by the annual risk assessment of private insurers. More consistent health care costs allow for more reliable long-term planning and capital investment. Finally, if health insurance is not tied to a particular employer, the market in labor will be more fluid and this should benefit employers and employees alike with a more productive and competitive work force. In all of these ways, a social insurance system is significantly better for business than a private insurance market.

In the United States, one of the many problems with the health care system is the economic burden on employers and businesses. There is also always the risk in a free market system of a "race to the bottom" where employers have incentives to drop or weaken health care benefits to stay competitive with others businesses that do not provide insurance. The result is a Hobson's choice between an inability to compete with competitors, if reasonable health benefits are provided, or providing no health benefits, with worse health outcomes for employees, less employee satisfaction, and negative public relations. Neither choice is attractive. As a result, to create an equal business playing field and prevent the race to the bottom, many employers, including large low-cost business like Wal-Mart, have joined with workers to support comprehensive health care reform that includes universal coverage.¹¹

At the core of national health care or social insurance is a sense of *social solidarity* manifest in a commitment to cover the health care of all. Some argue that by adding deductibles and co-pays, the sense of social solidarity that is expressed by universal health care coverage is undermined. There is room for debate and disagreement

¹¹ *New York Times*, Business, November 13, 2007. A Health Plan for Wal-Mart: Less Stinginess by Michael Barbaro and Reed Abelson <http://www.nytimes.com/2007/11/13/business/13walmart.html?ex=1196139600&en=af3ed9092bbffcc4&ei=5070&emc=eta1>.

about the wisdom of deductibles and co-pays as mechanisms to help control costs. Assuming, however, that they are justified on overall cost–benefit grounds, they need not offend justice and equity. As argued at the outset, the right to health care requires that access to health care be socially secured. As long as the deductibles and co-pays are reasonable and affordable to all, they do not threaten secure access to health care services. It is important to have deductibles and co-pays for the poor either waived or government paid, but for those who can afford to pay, how can it offend justice to have most payments through payroll and some payments at the point of service? Indeed, the total cost to the individual should be *less* if the initial assumption of cost-efficiency is accurate. If no one is made worse off, and indeed all are probably better off, then there is no violation of justice here.

Private supplemental insurance also raises concerns about the justice of a *two-tiered health care system*. There are two kinds of supplemental private insurance: (i) one provides insurance coverage for procedures or costs that are not covered by national or social insurance, and (ii) the other provides coverage for procedures and services that *are* covered by the national or social insurance. The reasons for this complementary coverage include avoiding waiting lines for public services or upgrading service through more luxurious private hospitals.

The first kind of private insurance, providing additional coverage, is not controversial. The second form of supplemental coverage is more controversial. A health care system that incorporates the first kind of supplemental insurance but prohibits the second kind of complementary private care essentially enforces equity by prohibiting private coverage of basic health care services, but it permits purchasing private insurance for additional services or to cover co-pays and deductibles. An analogy in public education would be a system that prohibits private schools from replacing public schools, but allows private tutors or other educational options that supplement public education. Since such a system restricts freedom of choice, it needs to be justified by some demand of justice or utility. If the private market does not make anyone worse off (i.e., if the benefit to some hurts no one), then it is not a violation of justice. Does the addition of a private system, offering services that are otherwise covered by the public universal system, make anyone worse off?

With private school education a case can be made that the initial educational inequity can result in a long-term competitive advantage, undermining equality of opportunity. Nonetheless, private schools are permitted. We will not here explore why this is so and whether it is justified, all things considered. The case of health care is different. A better private hospital room, for example, is purchased perhaps with greater wealth, but it is not the *source* of a competitive advantage. In general, if society allows significant inequalities in wealth, these inequalities buy better housing and cars and toys. Similarly, private health care allows some to spend their money on private hospitals or providers that they think are worth the extra costs. If inequalities in wealth are justified, why can't it be spent on better health services (i.e., services that go beyond the basic health care services due to all), rather than yachts or penthouses?

One objection to private health insurance is that it enables the better off to jump the queue (or line) and avoid waiting times for access to health care procedures, a consequence

that seems unfair to many. Two points here. First, if the queue is unacceptably long so that it is a threat to health, then this is a threat to basic health services and needs to be addressed directly with increased funding and access. In fact, long wait times are more characteristic of NHS systems than social insurance systems. I suspect this is due to the greater responsiveness to patients of social insurance funds and a greater willingness to directly fund adequate health care. On the other hand, if adequate health care is secured by the public system, and the wait-lines are the result of public funding decisions, then the objection to "jumping the queue" is merely an objection to jumping to the front of the line. But people using the private system do not jump to the front of the line; they jump out of the line and switch to the private market, giving up their spots to others. They also freely add more money to the overall health care system through private contributions over and above the tax or employment-based contribution already made. By using private health care, they pay for and support the public health care system that they do not use. This shortens the lines for public services for others and so how is this unfair? In addition, in many countries physicians must work primarily in the public sector with private practice as a supplement. If this is so, the private sector also directly increases the income of medical personnel without raising overall taxes. So, even in systems with significant wait-lines, it is not clear that the addition of a private system hurts anyone and it may also be beneficial overall.

One additional important issue here is whether the private system drains personnel from the public system thus causing a greater shortage of providers. This is most likely an issue in systems that are underfunded generally, but the problem can also be addressed through regulation requiring public service of all private physicians. The question of justice, however, should be focused on the overall impact of the private system on the universal public system and not on the individuals opting for more expensive private care. If the public system is adequate, and secures the right to health care for all, then an additional private system does not offend justice.

One last complication in judging these matters is the difficulty of specifying the basic health care package that is due to all. Clearly, countries with greater overall wealth and more developed health care systems also have an expanded sense of what is due to all. As an objective matter, one can look to see which interventions have the most cost-effective impact on morbidity and mortality outcomes as one indicator of relative importance. This is just a start, however, and many other considerations complicate these judgments. When benefit packages are set through a deliberative democratic process, as they often are in social insurance systems, we have at least a procedurally just system for setting priorities.

Poverty and Public Health

In developing economies, where vast wealth cannot be spent on hi-tech hospitals, public health measures are clearly the most important investment in the health of the people. Clean water, adequate sewage treatment facilities, adequate nutrition,

and immunizations have the largest impact on mortality and morbidity. To take one example, in Tibet over the last 50 years infant mortality rates have dropped from the extremely high level of 430 per 1,000 in 1951 to 35.3 per 1,000 by 2000. Life expectancy for Tibetans increased from 36 years to 62 years since the 1950s.¹² These results are due primarily to general public health efforts. In countries with serious poverty, nothing can fight chronic poverty and affect public health as much as free public schools with free lunches, clinics, and immunizations. Education helps break the cycle of poverty; free lunches help fight malnutrition and keep kids coming back to school; and clinics and immunizations directly fight illness and disease. In developing countries, broad public health measures and universal education should be the focus. In the context of serious poverty, more expensive biomedical interventions simply cannot be the first priority of the national government.

As countries develop and markets and employment expand, however, private insurance markets also take off and are available for the emerging middle classes. I suspect in the context of free markets, the emergence of a two-tiered health care system is somewhat unavoidable. Given the clear advantages of social insurance systems, we can expect that laws and regulations that promote social health insurance funds through mandatory employment-based health insurance are likely to mitigate, and, over time, undermine the degree of inequality in access to health care services. It is an advantage of a social insurance system that it can in this way build a broader health care infrastructure on the backs of a growing employment base. Indeed, this is the history of social insurance in Europe; perhaps we can learn from Europe's success.

Conclusion

We have seen that universal health care coverage through social insurance has many of the advantages of private market insurance without the disadvantages. The debate on health care justice needs to focus on social insurance and avoid the false dilemma of having to choose either national single-payer health care or the private for-profit insurance market.¹³

¹²The United Nations Economic and Social Commission for Asia and the Pacific: <http://www.unescap.org/esid/psis/population/database/chinadata/tibet.htm>. For a general health analysis, see Zang T. "Physical Quality of Tibetan Population," *China Population Today* vol. 3-4, August 1997, pp. 11-12: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12321518&dopt=Abstract.

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Health Care Statistics Cited**Household Incomes of the (47 million) Uninsured in the USA**

Under \$25,000	14.6 million
\$25,000–50,000	15 million
\$50,000–75,000	8.3 million
\$75,000 or more	8.7 million

Employment Status of the Uninsured in the USA

26% unemployed, 28% part-time jobs, 46% full-time jobs
 Businesses with 10 or less employees: 26% uninsured
 Businesses with 100 or less employees: 21% uninsured

Government and Private Health Care Expenditures

UK	86% government	14% private
Canada	70% government	30% private
USA	46% government	54% private
China	38% government	62% private
India	17% government	83% private

Health Care Funding Source

USA	32% employee/employer	22% private	46% government
Japan	56% employee/employer	22% private	32% government
Germany	57% employee/employer	25% private	10% government, 8% other
France	74% employee/employer	22% private	4% government plus other
Switzerland	35% employee/employer	40% private	25% government plus other

(Private costs include out-of-pocket costs and supplemental private insurance. Other includes alcohol, cigarette, and taxes on pharmaceutical companies.)

Health Care Spending as a percentage of GDP; Per Capita and Government Per Capita (Figures from World Health Organization)

USA	15.4%	\$6,096	\$2,725
Switzerland	11.5%	\$4,011	\$2,347
Germany	10.6%	\$3,171	\$2,440
France	10.5%	\$3,040	\$2,382
Canada	9.8%	\$3,173	\$2,215
Italy	8.7%	\$2,414	\$1,812
UK	8.1%	\$2,560	\$2,209
Japan	7.8%	\$2,293	\$1,864
India	5.0%	\$91	\$16
China	4.7%	\$277	\$105

References

- Busse, Reinhard. (2000) Impact of Market Forces: Six Hypotheses and Limited Evidence, *Eurohealth* vol. 6.4: 29–34.
- Cummiskey, David. (2006) Confucian Ethics: Responsibilities, Rights, and Relationships, *Eubios Journal of Asian and International Bioethics* vol. 16 no. 1.
- Daniels, Norman. (1986) Why Saying No to Patients in the United States Is so Hard, *New England Journal of Medicine* vol. 314.21:1380–1383.
- Eddy, David M. (1991) The Individual and Society: Is There a conflict. In *JAMA*, vol. 265.11; reprinted in *Clinical Decision Making: From Theory to Practice: A Collection of Essays From the Journal of the American Medical Association*. Sudbury MA: Jones & Bartlett Publishers, 1996.
- Ihara, Craig. (2004) Are Individual Rights Necessary? In *Confucian Ethics*, ed. Shun K.L. and Wong D.B. Cambridge: Cambridge University Press.
- Mill, John Stuart. (1979 [1861]). *Utilitarianism*. Indianapolis, IN: Hackett.
- Paton, Calum R. (2000) Analysis of Market Reforms in Europe, *Eurohealth* vol. 6.4:29–34.
- Pogge, Thomas. (2002) *World Poverty and Human Rights: Cosmopolitan Responsibilities and Reforms*. Oxford: Blackwell.
- Rodwin, Victor. (1994) *Japan's Universal and Affordable Health Care: Lessons for the United States?* (with the assistance of Llyn Kawasaki and James Littlehales) New York: Japan Society.
- Siadat, Banafsheh and Michael Stolpe. (2005) *Reforming Health Care Finance: What Can Germany Learn from Other Countries?* Kiel: Institute for World Economics, pp.7, 13–14.
- Zang, T. (1997) Physical Quality of Tibetan Population, *China Population Today* vol. 3–4: 11–12.