What’s Not to Like About Universal Healthcare?

# Abstract

According to the World Health Organization (WHO), “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being…”. The WHO is not alone: most rich countries already have universal healthcare and, even in the U.S., public support for it is a perennially centrist position. Rights, however, are easier to claim than to justify, and are often reduced to lazy, rhetorical cover for lack of ethical clarity. I will explain how a clear understanding of universal healthcare reveals the implausibility of claiming it as a basic, human right. But I will also argue that, even if the ongoing failure to deliver universal healthcare in the U.S. is not a human rights violation, it is a serious policy failing that should be corrected. Finally, I will float some thoughts about the implications of what universal healthcare is for how it should work.[[1]](#footnote-2)

# Introduction: Rights Left and Center

According to the World Health Organization (WHO), “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being…”[[2]](#footnote-3) and “Understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable healthcare”.[[3]](#footnote-4) The WHO is not alone: most rich countries already have universal healthcare and, even in the U.S., where appeal to healthcare as a human right has long been a fixture on the political left, public support for universal healthcare is a perennially centrist position.[[4]](#footnote-5) Asserting fundamental rights to health or healthcare delivers a sharp rhetorical bite, casting the ongoing failure to deliver universal healthcare in the U.S. as a human rights violation. Rights, however, are easier to claim than to justify, a combination that frequently sees them reduced to lazy, rhetorical cover for lack of ethical clarity. Look again at the WHO: it’s easy to adopt a noble elevation of the bureaucratic chin while asserting a right to the ‘highest attainable standard of health’; much harder to get your head down and figure out what that could plausibly mean. Even charitably interpreted, as an aspirational right, the *highest attainable* standard of health is overreaching. ‘Highest attainable’? That requires too deep a sacrifice in beer and pizza to be a reasonable aspiration.

My aims in this paper are threefold: In Part 1, I show how a clear understanding of what universal healthcare is requires lays bare the implausibility of diagnosing the lack of it in the U.S. as a violation of citizens’ fundamental rights; In Part 2, I make the case that the U.S. should have universal healthcare anyway; In Part 3, I begin a discussion about the implications of what universal healthcare is for how it should work.

# Part 1: The Implausible Right to Universal Healthcare

My argument for the implausibility of a fundamental right to universal healthcare is an almost maximally straightforward piece of analytic philosophy. The first steps are to do the basic analysis and get clear on what we mean by ‘fundamental rights’ and by ‘universal healthcare’. The next steps are to follow a chain of implications starting with the analytical point that universal healthcare implies universally affordable healthcare. From there it is easy to see that universal affordability implies universal healthcare insurance which, as a practical matter, turns out to require mandatory healthcare insurance. With the analysis and its implications clear, the final step is simply to note the implausibility of asserting that my fundamental rights as a citizen are violated by a failure to force me to carry healthcare insurance. This is not an argument against any appeal to rights in healthcare contexts: for example, plausible cases can be made for the recognition of autonomy and welfare rights that may be violated by some intrusions into women's healthcare decisions, prohibitions on assisted dying, and bans on kidney sales by living donors. Nor am I arguing against universal healthcare itself: to the contrary, I will make the case for universal healthcare in Part 2, I just won’t do it on rights grounds.

## What Kind of Right?

Because rights-talk takes on a bewildering range of roles in different debates, I need to specify the kind of claim that is relevant here. I opened with the WHO’s notoriously wild claim of a fundamental right to enjoyment of the highest attainable standard of health, and their assertion that this creates a legal obligation to ensure accessible and affordable healthcare. It’s possible that the WHO’s appeal to rights is just confused, but there are ways to try to make sense of it, three of which provide helpful illustrations of different ways for rights claims to be beside the current point. This will help clarify our focus on the kind of rights claim that is at issue.

One possibility, suggested by the WHO’s mention of a ‘legal obligation’, is that they are gesturing towards a legal right. Although it is obscure what statute or legal principle the WHO might have in mind, the general notion of legal rights is (a) respectable and (b) to be distinguished from moral rights. My concern is the ethical question of whether governments *should* recognize human rights requiring universal healthcare, not the legal question of whether they do.

A second possibility is that the WHO’s appeal to fundamental rights is merely rhetorical. Understanding ‘rhetoric’ as the art of persuasive communication, it’s not inherently problematic. As philosophers, we aspire to persuade and to be persuaded by best reasons, but we are leery of darker rhetorical arts that can be distressingly effective independent of, or even against reason. I use ‘mere’ to flag rhetoric that is not clearly tied to reasons. But even mere rhetoric has its place: the fact that the WHO have called health a ‘fundamental right’ doesn’t give any reason to agree, but it serves as a verbal thump on the table to help convey the importance they place on health. If that’s what’s going on, I have no great objection to such rights talk, other than a preference for less misleading ways of adding emphasis. However, such merely rhetorical rights-talk is not relevant to the question of whether governments have ethical reasons to deliver universal healthcare.

I have already mentioned a third possibility, that the WHO’s rights claim is aspirational; a motto; a *per ardua ad astra* for healthcare; an idealized goal to inspire rather than a duty to meet. But inspiring expressions of the idea that it would be nice to be healthy don’t address the question of what governments have a duty to do about it.

Drawing this together, the kind of right to healthcare we’re after is not just legal but ethical, not merely rhetorical but reason giving, and not vaguely aspirational but tightly tied to specific duties on governments to deliver. It is on this understanding that I will argue against the claim that governmental failure to deliver universal healthcare is a violation of citizens’ fundamental rights?

## What is Universal Healthcare?

### Universal Healthcare Implies Universally Affordable Healthcare

If you are turning blue, a grape wedged snugly atop your trachea, things are grim if the only accomplished and reasonably priced devotee of the Heimlich maneuver is ten minutes away, things are equally bad if the only nearby and affordable option thinks it has something to do with magnets, and you’re no better off if the only competent and proximate practitioner refuses your credit card. For these reasons, the WHO is right to recognize the importance of “access to timely, acceptable, and affordable healthcare.”[[5]](#footnote-6) With all three elements essential to any meaningful understanding of universal access to healthcare, each must be recognized in any meaningful right to healthcare.

My focus, in this paper, is on the affordability element. Affordability is the issue whenever a human right is invoked to support anything along the lines of a single payer system, or default insurance for anyone who doesn’t make other arrangements. In this context, the corresponding standard for universal healthcare, is universally affordable healthcare; meaning that everyone should be able access reasonable and necessary healthcare regardless of ability to pay.

### Universally Affordable Healthcare Implies Universal Healthcare Insurance

Clearly healthcare is not affordable in the sense that everyone is able to pay the actual cost of needed care. The costs of being sick can quickly soar out of the reach of all but the richest. Even routine care is prohibitively expensive for many people. Problems of affordability are compounded by the impact of illness on earnings.

In practice, all approaches to delivering healthcare access regardless of ability to pay, distill down to providing universal healthcare insurance, with subsidies for those who can’t afford the premiums. Not all universal health systems make it obvious that they are insurance schemes. In the United Kingdom, for example, the primary provider of healthcare is the government run and taxpayer financed National Health Service (NHS). But paying taxes may not feel much like buying insurance, not even if one of the taxes is helpfully called ‘national insurance’. The fact that the UK government provides healthcare goods and services, makes it harder to see that they are also providing insurance. There is a helpful comparison with roadside assistance. If I break down, I call a towing company and my car insurance pays for it. It's obvious that this is insurance. But maybe you joined an automobile association. When you break down you call the association who both tow you and bear the associated costs. It doesn’t matter who owns the tow truck and it doesn’t matter whether payments are called ‘premiums’ or ‘membership fees’; either way, it’s insurance against the costs of needing a tow.[[6]](#footnote-7)

The necessity of subsidizing premiums further obscures the fact that we are dealing with insurance. When my insurance company sends me a bill, it's clear that I'm paying for insurance. But for the taxpayers funding the NHS, there’s no easy way to tell how much of their bill covers the implicit cost of their own insurance and how much subsidizes the cost of other people’s. Conversely, for those who are subsidized, the NHS doesn’t hand out any documentation explaining that, in effect, they have received a welfare transfer in the form of subsidized healthcare insurance premiums.

### Universal Healthcare Insurance Implies Compulsory Healthcare Insurance

Universal healthcare systems aim to safeguard the ability to access healthcare, not to impose a requirement to do so. Having coverage for fertility treatments secures the financial option for those who want children, but imposes no obligation on those who don’t. Although universal healthcare is compatible with the option not to use healthcare insurance, it is not compatible with the option not to have that insurance. The idea of guaranteeing everyone the option, though not the requirement, to enroll in healthcare insurance at a price they can afford is a pretty piece of nonsense, despite finding occasional favor on the U.S. presidential campaign trail.[[7]](#footnote-8) If guaranteed the option to pick up affordable coverage when I feel like it, like any sensible person, I will wait until my back goes out, or I’m diagnosed with lupus, or I get pregnant on Monday; I will sign up for my guaranteed insurance on Tuesday; and I’ll start running up the serious bills on Wednesday. No insurer can long afford to run that line of business.

Such sensible decision making scaled up to the whole population, is the essence of the problem of adverse selection. The people with most reason to sign up for optional healthcare insurance are old, sick, planning to start a family, or have some other reason to suspect that they will soon be facing stiff medical bills. Hearty youths with no history of illness or plans to have kids will be most inclined to find other uses for their insurance payments. The result is that optional insurance will disproportionately enroll the riskier people. This can even lead to what is colloquially known as ‘the death spiral’: loss of healthier clients forces premium hikes, driving even more of the less risky clients out of the insurance pool, forcing more premium hikes, until insurance no longer makes sense for any but the very richest and sickest, and the whole scheme breaks down.[[8]](#footnote-9)

Because of adverse selection, healthcare insurance can be optional, or it can be universal, but it can’t be both. Obviously, holding premiums down by forcing healthier people to stay insured is incompatible with optional insurance, and allowing premiums to rise is incompatible with universal insurance. One could hold premiums down with price controls, but that means forcing premiums below the actual cost of insurance and is incompatible with the survival of any kind of insurance scheme, universal or otherwise.

The only other way to try to deliver universally optional healthcare insurance is to use subsidies to blunt the effect of adverse selection on premiums. How might that work? Suppose that the break-even cost of insuring the whole population is $10,000 per person per year. Since we’re making insurance optional, some people will exercise the option to put that money to other uses, and they will tend to be the lower risk people for whom insurance is less valuable. Let’s say, just for example, that the average per-person cost of insuring those higher risk people who stay in the insurance pool is $12,000. Completely offsetting the impact of adverse selection on premiums requires a $2,000 annual subsidy for everyone who chooses to remain insured – that seems doable, and seems to square the circle of keeping insurance both optional and affordable despite adverse selection – but it’s only pretend. There’s still the sensible person problem; the holdouts who contract lupus, or plan a pregnancy, or just get older and then decide that they’d rather like to enroll in that affordable insurance after all. Do we let them? If not, then healthcare insurance is not universal. But if we do, then healthcare insurance was never really optional. Like it or not, those holdouts were insured all along, it’s just that someone else was paying their premiums in the form of those $2,000 annual subsidies.

## The Implausible Right

If an appeal to rights is doing more than merely rhetorical work in support of universal healthcare, the claimed rights must entail duties such that failure to deliver constitutes a violation of citizens’ substantive, ethical rights. However, a straightforward corollary of the claim that a right to R entails a duty to D, is that lack of a duty to D entails the absence of the alleged right to R. As we’ve seen, delivering universal healthcare entails compulsory healthcare insurance and, therefore, the alleged right must entail, among other things, a duty to force everyone to carry healthcare insurance. The problem, then, is the implausibility of saying that neglecting to force me to carry healthcare insurance violates of my substantive, ethical rights.

Still, implausibility doesn’t guarantee indefensibility, and it is the nature of positive rights that they generate duties to do things *for* people. Perhaps they can also generate paternalistic duties to do things *to* un-consenting people. It’s plausible to say that I have a right to have that grape forced from my trachea, even if I can’t muster the breath to consent to a bout of vigorous abdominal thrusts. It’s plausible to say that children have a right to be forced to go to school, even on days they’d rather be playing Minecraft. When consent can’t be had due to lack of opportunity or lack of capacity, the benefits must be very clear to justify paternalistic intervention. The bar is even higher when consent can be had but is not sought or is overridden, as with mandatory insurance. In Part 2, I will take a closer look at the benefits of healthcare insurance and find that they are more robust even than most defenders of universal healthcare recognize. Not robust enough to restore the plausibility of a fundamental right to be forced to carry healthcare insurance, but plenty robust enough to make a strong, pragmatic case that we should do it anyway.

# Part 2: Why We Should Have Universal Healthcare Insurance

## The Benefits of Healthcare Insurance

The only direct benefit of healthcare insurance, qua insurance, is financial: it does not provide healthcare benefits, it pays for them. Financial benefits don’t matter in themselves, but they are of great instrumental importance because of their impact on welfare. I will review three mechanisms by which the financial benefits of healthcare insurance translate to welfare benefits for the insured: benefits for health; benefits for risk management; and benefits for expected welfare.

### Health Benefits

The most obvious route from healthcare insurance to welfare starts with securing financial access to otherwise unaffordable services. From there, it runs via the impact of those services on health. And it ends with the contribution of health to welfare. A 2002 report of the National Academy of Medicine (then the Institute of Medicine) found that “uninsured adults receive health care services that are less adequate and appropriate than those received by patients who have either public or private health insurance, and they have poorer clinical outcomes and poorer overall health than do adults with private health insurance.”[[9]](#footnote-10) While stressing the difficulty of distinguishing the causal impact of healthcare insurance from associated impacts on outcomes, a 2008 literature review concluded that the evidence “conclusively demonstrates that health insurance improves the health of vulnerable subpopulations such as infants, children, and individuals with AIDS and that it can improve specific measures of health such as control of high blood pressure for a broader population of adults, especially those with low income.”[[10]](#footnote-11)

This presentation of evidence for the impact of healthcare insurance puts the focus on those who already have high blood pressure or some other clinical condition, and a focus on that subset of people who already need healthcare services makes it easy to overdramatize the benefits. Most of us, most years, would get through just about as healthily with or without the tender but costly mercies of the healthcare industry. Not having healthcare insurance doesn’t doom you to ending the year dead or diseased, and having access is no guarantee of making it to January free of any of the thousand natural shocks that flesh is heir to.

How should a healthy, young adult evaluate the prospective health benefits of enrolling in insurance for the coming year? Signing up is just another way to tweak the odds. How big a tweak are we talking about? The National Academy report adopted “an estimate of a higher overall mortality risk for uninsured adults of 25 percent.”[[11]](#footnote-12) Let’s not worry about how speculative that estimate is, it’ll do for example. Continuing to draw illustrative inspiration from the report, assume a ballpark, base mortality rate of one in a thousand for young adults with healthcare insurance.[[12]](#footnote-13) On these assumptions, the decision to save a year’s insurance premiums would push up overall odds of ending the year dead by 0.00025 (one in four thousand) to 0.00125. For comparison, a ten-year Australian study suggests annual death rates of 0.00028 for participation in power boating and 0.00038 for cycling.[[13]](#footnote-14) In other words, the risk of death from non-participation in healthcare insurance looks comfortably in the ballpark of risks we normally leave to the autonomous discretion of individuals.

### Financial Risk-Management Benefits

Flood insurance doesn’t hold back the storm, renter’s insurance doesn’t deter burglary, and liability insurance doesn’t mean you will never make a mistake. Qua insurance, the only direct benefits are financial: if you are flooded, robbed, or sued, the insured financial losses are covered. Healthcare insurance is no different: qua insurance, it doesn’t prevent ill-health, it only addresses some of the financial risk that goes with it. Like any other insurance, it converts a small risk of a big financial loss into the certainty of a small one in the form of premiums. Making his case for mandatory, universal healthcare insurance, L. Chad Horne argues that people should have it “to provide them with greater stability in their future expectations and thus to protect their ability to form, revise and pursue a rational plan of life.” There are two potential benefits here: the direct benefit of insurance for financial stability, and the further benefit of financial stability for life-planning.

I’m guessing that colleagues turning out the kind of paper you are now reading, tend to be professionally academic types: not rich beyond the dreams of avarice, but still, comfortably off. Perhaps some of this paper’s readers are similarly appointed. Doesn’t stability look good? But I’d love it if some of my readers are grad students or interns, hoping to find a path in academia or policy. Hi there! Some of you might be awash in family money but most of you are not, and you are well positioned to remind the smugly tenured that stability only means carrying on much as you are: whether that’s a good thing depends on where you are. Even if where you are is good it can usually be better, and running some risk in the attempt to make it so can be a rational plan of life. Risk aversion is not rationally required. To mandate insurance, is to compel people to forgo other goods in pursuit of financial stability. Such paternalism is hard to justify, which is why we ordinarily allow wide discretion for individuals to exercise their autonomy in striking their preferred balance between risk and reward. The same goes for the rational life-planning benefit that Horne claims? I grant that stable expectations can simplify planning by limiting contingencies. But stabilizing expectations though mandatory insurance doesn’t protect planning ability; it forces people into a risk-averse subset of potential life plans, cutting off a broader range of defensible options.

### Expected Welfare Benefits

We have considered the potential health and risk management benefits from healthcare insurance, and found that they appear to sit comfortably within the range we normally leave to autonomous decision making. These benefits clearly show why many reasonable people would find healthcare insurance appealing. But ‘reasonably appealing’ is a weak justification for using the coercive power of the state to force everyone to carry healthcare insurance. Justifying a mandate would be much easier if we could start from a stronger claim, something more like: Healthcare insurance is significantly beneficial for (near enough) everyone. We can get there, without any contentious assumptions about risk aversion, by appealing to the expected welfare benefits of healthcare insurance.

A clear way to see the expected welfare benefits, and to tie together other aspects of this discussion, is through an example:

**Gammy Shank Disease** (GSD): In Egalitaria, everyone has annual assets of $110,000, plenty for a good life. The only disease that afflicts Egalitarians is gammy shank disease, which strikes a random 10% of the population every year. There is a treatment that clears GSD right up for $100,000. Even though people eventually recover from GSD without treatment, it is so unpleasant that everyone who gets it will want to pay for the treatment, even though it will leave them with only $10,000, barely enough to scrape by for the year. How should Albert Krankenbein, a typical Egalitarian, evaluate an offer of insurance that covers the full cost of GSD treatment at an annual premium of $10,000?

In this example, the premium matches the risk, so insurance is neutral in terms of its expected financial impact. From Albert Krankenbein’s point of view, a 100% chance of a $10,000 premium is financially equivalent to a 10% chance of a $100,000 loss. This financial neutrality makes it look as though Albert should decide according to his own level of risk aversion: if Albert is risk neutral, he might as well flip a coin; but if he is risk averse, he should take the insurance.

Once again, although we can easily see why insurance might be appealing, it’s not obvious that we’re any closer to justifying the stronger claim that, it is significantly beneficial to (near enough) everyone. However, if Albert Krankenbein evaluates insurance as just outlined, he is making a serious error. Perhaps he’s read too many papers in which dollars go proxy for the goodness of outcomes. In the process he may have forgotten that money is just a tool; though dollars can be used to advance welfare, they are not themselves welfare. More dollars can be used to generate more welfare, but with diminishing marginal returns. An impecunious student subsisting on supermarket ramen and pizza left over from departmental events will get a big welfare boost from another $10,000, while the Dean of the Business School won’t even notice ten grand more or less. Figure 1 shows the general form of the relationship one would expect between a person’s wealth and their welfare, taking diminishing marginal returns into account. Despite individual variations, this general form is probably applicable, near enough to all of us.

`

Figure 1: Wealth boosts welfare, but the richer you get, the less difference another $10k makes.

$10k

$20k

$100k

$110k

welfare

wealth

(c)

(b)

(a)

Albert can use his welfare / wealth graph to read off the welfare impact of different wealth-affecting scenarios. To evaluate the welfare impact of paying that $10,000 premium, he can project the difference between $110k and $100k up to the curve from the wealth axis, and then horizontally across to the welfare access. Difference, (a), on the vertical axis is then the welfare impact of paying the premium. It’s tiny. Now, what if Albert goes uninsured and ends up paying the full $100,000 for GSD treatment? The financial cost of the treatment is ten times more than financial cost of the premium, but the welfare cost is much more than ten times (a). The first $10k is just like paying the premium, so the welfare cost is still (a). But each subsequent $10k of the total GSD bill costs more in welfare than the one before. And look at how much more welfare Albert loses with the final payment, the one that drops him from $20k to $10k; reading across we see that the welfare cost of that $10k is (b). Very much not tiny. The overall welfare cost of paying for treatment is (c), the welfare difference between $110k and $10k. The expected welfare cost of being uninsured, then, is a tenth of (c). As long as (a) is less than a tenth of (c), which it is certain to be given the shape of the graph, then the difference between (a) and 0.1 times (c) is Albert’s expected welfare gain from having GSD insurance.

Although GSD is fictional, the wrecking ball that exorbitant healthcare costs can take to personal wellbeing is painfully real. Because of this, near enough every one of us is like Albert Krankenbein in standing to enjoy significant expected welfare gains by having access to good healthcare insurance. These benefits require no assumptions about rationally required risk aversion or preferences for a particular kind of stability in life-planning. Expected welfare benefits, then, do justify the claim that healthcare insurance is significantly beneficial for (near enough) everyone. As Kenneth Arrow observed in his seminal 1963 paper, “The welfare case for insurance… is overwhelming.”[[14]](#footnote-15)

## Universal Healthcare Insurance Mitigates a Serious Coordination Problem, and Government Should Mitigate Serious Coordination Problems

In Egalitaria, Gammy Shank Disease is the only disease. Because it strikes randomly, potential purchasers of insurance have no special knowledge they can use to get an edge over insurers. Insurers, therefore, can set premiums using the general population’s 10% risk without fear of being driven out of business by adverse selection. Reality, as we have seen, is much less benign for insurers. Though reasonably priced healthcare insurance delivers significant expected welfare benefits to near enough all of us, it will be unavailable to near enough all of us unless adverse selection is addressed. This is a classic coordination problem and, given the “overwhelming” case for the expected welfare benefits of healthcare insurance, it is a serious one.

I will not defend it here, but I believe that one of the core duties of government is to mitigate serious coordination problems, if it is possible to do so at reasonable cost. It is a matter of childish simplicity to show that it is possible to mitigate the healthcare insurance coordination problem. Just look! Every nation remotely comparable to the U.S., bar the U.S., has, in fact, mitigated it. Though the details differ, one way or another, they have done so by effectively mandating healthcare insurance.

Of course, it may be theoretically possible to mitigate a coordination problem without it being cost effective to do so in practice, and there are serious costs to mandatory healthcare insurance beyond the obvious hit to autonomy. One of the trickier problems baked into expanding insurance coverage, is moral hazard: the tendency for insurance to incentivize risky behavior. It is usual to distinguish two kinds of moral hazard: *ex ante* and *ex post*. Suppose I hold off on a skiing holiday until my healthcare insurance kicks in. In that case I exemplify moral hazard *ex ante*, indulging in risky behavior when I know that insurance will pass the financial component of that risk on to other people. When I return from Tahoe with my knee a bit sore from all those moguls, I check in with my doctor. She’s confident I just need to rest it, but muses about a $500 x-ray “just to be on the safe side.” I balk, until I remember that the x-ray will only cost me a $10 copay. Then I shrug and decide it’s not worth $10 to argue the point. As I limp over to radiology, I exemplify moral hazard *ex post*: the x-ray costs hundreds of dollars more than it’s worth to me, but what do I care when, though insurance, other people pay most of the tab?

Copays and coinsurance mitigate moral hazard by returning some portion of the cost of claims from insurer to insured. If that $10 copay doesn’t get my attention, perhaps $100 will induce me to press my physician on whether there’s a real downside to holding off. If my physician persuades me that it’s well worth it, perhaps 50% coinsurance will make it worth shopping around for a more reasonably priced radiologist. But copays and coinsurance work by reducing coverage; not a great concern for those who can easily afford their cost share, but a big problem for those who struggle to make both rent and copays, and for those whose coinsurance makes needed care unaffordable.

Moral hazard is a serious problem, in theory and in practice.[[15]](#footnote-16) Unless a rollout of universal healthcare insurance is accompanied by serious cost containment measures, moral hazard pretty much ensures that such a big expansion of coverage will drive healthcare spending upward. But is the problem so serious and so intractable that we should throw up our hands and abandon the welfare benefits? Again, just look! The U.S. has by far the highest spending on healthcare of the Organization for Economic Cooperation and Development (OECD) nations, higher than any of the nations that have universal healthcare. In 2021, for example, U.S. total spending was $12,197 per person as compared to $5,467 per person in the U.K. The U.S. also has higher taxes for healthcare than most: 2021 per person spending on government and social health insurance schemes was $6,551 is the U.S. (with tens of millions uninsured) but $4,539 in the U.K. (with everyone covered).[[16]](#footnote-17) Such stark differences might be justifiable if the U.S. were getting better results, and yet 2018 (pre-covid) life expectancy at birth was 78.7 in the U.S. versus 81.1 in the U.K. , infant mortality is 5.7 per 1,000 live births in the U.S. but 3.9 in the U.K., and avoidable mortality estimates are 277 and 204 deaths per 100,000 in the U.S. and U.K. respectively.[[17]](#footnote-18) Overall, there’s little to no reason to think the U.S. is getting more for all that extra spending, it’s just paying more.[[18]](#footnote-19) Anyone still hoping that all that money is somehow buying great healthcare in the U.S., might take a moment to reflect that, on standard estimates, U.S. hospitals killed more people than Al Qaeda – in September of 2001.[[19]](#footnote-20) If the proof is in the pudding, there is good reason to think that it is not only possible for mandatory, universal healthcare insurance to mitigate the coordination problem that undermines access to the expected welfare and other benefits of healthcare insurance, it can be cost effective, or at least not catastrophically cost ineffective, to do so. It’s unsurprising that screaming liberals should prefer the ‘socialist’ universal coverage of the U.K. system; but it is striking that frothing libertarians should also prefer it, at least for imposing less of a tax burden.

# Part 3: What Universal Healthcare Should Look Like

If your lungs fail, for about $1,000,000,[[20]](#footnote-21) a transplant might boost your chances of surviving another five years from near enough zero to about 50%.[[21]](#footnote-22) Transplant surgeons with boat payments will wax sentimental about the incalculable value of buying time to see your grand-nephew’s middle-school graduation, but individual preferences are diverse. Some may think it well worth a million dollars to have the chance of hearing five ill-tuned recorders and a tambourine do irreparable damage to the Ode to Joy. Others may prefer no more than palliative care, even if transplant heroics were free. Is this the kind of thing a universal healthcare scheme should cover? I’m not going to be able to detail resolutions of specific coverage decisions in the closing paragraphs of a short to middling paper, but I will sketch some considerations that come into focus when we keep in mind that including a service in a universal healthcare scheme requires it to be, not just beneficial, but beneficial enough to justify forcing people to carry insurance for it.

Most people inform their view of what universal healthcare should look like by appeal to their rationale for endorsing it in the first place. On Norm Daniels’ influential Rawlsian approach, for example, the case for universal healthcare is grounded in protecting normal human functioning which, in turn, is essential for fair equality of opportunity, a core demand of justice.[[22]](#footnote-23) With this rationale, coverage decisions emphasize care that protects or restores opportunity over care that promotes welfare.[[23]](#footnote-24) By contrast, on Jennifer Prah Ruger’s interpretation of a health capabilities paradigm, health is viewed as an intrinsically valuable element of human flourishing. With the aim shifted from protecting function to promoting flourishing, Ruger sees “a moral duty to give the highest quality health care that resources permit, to everyone.”[[24]](#footnote-25) Few are as generously inclined as Ruger, and some are positively parsimonious. Liran Einav and Amy Finkelstein, for example, defend universal coverage as the best way to make good on a “revealed social contract” that government will step in to help with emergencies.[[25]](#footnote-26) This leads them to advocate for a very basic level of universal coverage, with long waits and rudimentary facilities, but with the option for those who want more to buy more.[[26]](#footnote-27)

### Is There a Presumption Against Coverage?

Since healthcare insurance pays for services, it is natural to focus on the benefits of a service being considered for inclusion. Those lung transplants, for example, do offer a benefit – that 50%, five-year survival isn’t nothing – and no one is being forced to have a transplant if they don’t want one. By putting the focus on vital benefits to people in immediate need, and by downplaying the costs to everyone else, this *ex post* – after the fact – framing pushes presumptions in favor of coverage: beneficial treatments should be covered absent compelling reasons for exclusion.

But we’re not dealing with the *ex post* question of whether people will be glad they had insurance once things have already gone wrong. We need to justify an *ex ante* – before the fact – decision to force people to carry insurance for something that might never go wrong, and to which they might prefer a less aggressive response if it does. This forced-insurance framing shifts presumptions against coverage: coverage should not be included unless we can justify forcing people to carry it. Granted, framing issues are more rhetorical than substantive, and a broad range of basic coverage will easily meet reasonable interpretations of being significantly beneficial to near enough everyone; but the rhetoric is of great importance in the politics of universal healthcare, where actuarial logos needs all the help it can get against the pathos of death by emphysema.

I do not wish to downplay the burden of justifying decisions not to include coverage in a universal, mandatory scheme. We’ve just noted how Einav and Finkelstein propose pairing bare-bones mandatory coverage with the option for those who want more to buy more. I support allowing a private healthcare insurance market alongside a universal scheme, but that that word ‘option’ should sound alarms. Because of adverse selection, hoping for a functioning market for optional coverage feels like magical thinking. Even if top-up insurance isn’t illegal, if there’s no functioning market for it, it’s not an option. My best empirical guess is that quite extensive and high-quality coverage can be justified as significantly beneficial to near enough everyone.

### Coverage Should Not be the Same for Everyone

A second point is that universal healthcare should probably not be the same for everyone. I would not be surprised to learn that the benefits of transplant coverage change across the lifespan. Suppose that near enough everyone would favor a lung transplant if they needed one in their thirties but near enough no one would in their nineties, then it might be justifiable to mandate transplant coverage for youngsters but perverse to force it on codgers. Elite sports provide another example of where differential coverage might be desirable. An elite philosopher who busts an ACL on an especially vigorous trip to the coffee maker will probably be happy enough with coverage for a bit of physio and, if absolutely necessary, basic surgery. An elite skier, though, might derive elite benefits from coverage for a range of far more exotic and expensive surgical options to get them back on the slopes.

There will likely be many cases in which differential coverage is desirable in principle but administratively impractical. It’s not the greatest administrative challenge to tell nonagenarians from thirty-somethings, but elite skiers are harder to spot in social security and census databases, and relying on self-identification runs into those adverse selection problems. But, if we are aware of the issue, we might be able to spot policy options for differential coverage here and there. For example, those with dreams of Olympic glory need to be members of U.S. Ski and Snowboard to compete in sanctioned events. If membership included mandatory, additional insurance coverage, then at least some of those who’d get outsize benefits from super-premium sports medicine might be able to pool their particular risks without too much trouble from adverse selection.

In addition to potential administrative difficulties with identifying groups for specially tailored coverage, there might be ethical qualms about some group identifications. For example, suppose it turns out that poor people are like old people in tending not to find transplantation coverage all that beneficial. In that case, the current line of thinking would suggest a universal scheme with transplant coverage only for wealthier people: a result likely to raise ethical eyebrows. This is another case in which remembering that we are talking about mandatory coverage sheds a fresh light on the situation. If we require universal healthcare to have the same coverage for everyone, then either everyone gets transplantation coverage, or no one does. Suppose everyone does. Then the poor are forced into a benefit that costs more than it is worth to them, and that’s just a way of saying that they could have put the money to better use. We are not doing poor people any favors by forcing them to carry the same transplant insurance as everyone else, when they could better use the money, say, for more extensive coverage for lost wages and other expenses of accessing basic healthcare, or simply for higher welfare payments.

### Insurance Should, Where Practical, Offer Cash Settlement

Opportunities to fine-tune compulsory healthcare insurance for different groups are likely to be quite limited and will do nothing to address the diversity of coverage preferences among individuals within groups. Even if transplant coverage is enough of a benefit for enough people to justify inclusion in a mandatory scheme, there will still be people for whom it is not enough of a benefit to justify the cost, and some for whom it is not a benefit at all. This isn’t an objection to a universal scheme; we must accept the inevitability of some people missing out due to the tradeoffs inherent in practical policy making. However, it is a reminder to be alert to opportunities to structure mandatory healthcare insurance in ways that enhance its value, or extend its value to a broader range of people. One such opportunity is, where practical, to offer cash settlement of claims.

Here's how cash settlement works with my car insurance: Someone smacks into the back of me on Monday; an insurance assessor has a look on Tuesday and says that fixing the cosmetic damage to the rear bumper should cost about $1,000; the money’s in my account by end of week. If the fix ends up costing more than expected, I send them the invoice and they pay the difference. But if I shop around and find a better price, or settle for a less perfect patch, or decide that I really don’t care about a cracked bumper; then I keep the difference.

Relative to insurance that will only pay the bill once the repair is done, a well-designed cash settlement option has the potential to both enhance the value of coverage for policyholders, and to save the insurer money. The benefits to policyholders are obvious: those for whom a good-as-new repair is worth over $1000 still get it, while the rest of us can spend the money on things we value more than pristine plastic. The opportunity for insurers to save money lies in the spread between what a good-as-new repair costs, and what it is worth to those who aren’t out waxing their ride every Sunday. If the average repair that adjusters say ‘should’ cost $1,000, ends up coming in at $1,200, that will be the average cost per claim for repair-or-nothing insurance. But plenty of people won’t even notice a ding and a scrape under a good layer of honest road grime. Given the option, they’d rather have the $1,000 cash than the $1,200 repair, saving insurance an average of $200 on each client who accepts cash settlement.

Another merit of cash settlement is the potential to mitigate moral hazard. Like copays and coinsurance, cash settlement mitigates moral hazard by effectively increasing the cost of covered services for the insured. However, because the cost is a cash settlement forgone rather than a bill payable, it mitigates moral hazard without reducing coverage to the detriment of those who struggle to meet out of pocket expenses. If insurance will only pay for repairs, I don’t care whether they offer good value for money. With a cash settlement option, I very much do care about value for the money I can otherwise keep. If I can keep the cash, any body shop that wants my business will have to persuade me of the value proposition. Where moral hazard dulls the imperative for providers of insured services to compete on value, a cash settlement alternative reintroduces a bit of healthy, market discipline.

In principle, cash settlement could be an option in healthcare insurance. Standard lung transplant coverage is of great value to someone who desperately wants a transplant, of marginal value to someone who could take it or leave it, and of no value to someone who prefers palliative care. Insurance with a cash settlement option is just as valuable for transplant candidates who want the procedure but, unlike standard coverage, it is also of value to those who’d rather use the resources to check a couple of expensive items off their bucket list and improve the financial security of dependents. In the context of mandating coverage, it’s helpful if we can structure that coverage in ways that make it valuable to more people.

The in-principle benefits of cash settlement may be difficult to realize in practice. If I can show up with non-descript knee pain and claim 500 bucks for refusing an x-ray, there’s an obvious opportunity for insurance fraud. Another problem is that, while I have a pretty good idea of the benefit I can wring out of a bit of auto-bodywork, it often takes medical expertise to evaluate the benefits of human-bodywork. Most likely, cash settlement should not be offered in lieu of cost-effective preventive care, where forgoing care would be a bad idea for most people, where fraud would be too easy, or where we would not be ok with holding people to their decision if they spend the money and later change their mind. Although I expect that these and other obstacles will markedly constrain the range of coverage for which cash settlement is a practical option, the potential benefits suggest looking for opportunities where it can be made to work.

# Conclusion: What’s Not to Like?

Rejecting a fundamental human right to be forced to buy insurance as implausible, I have built my case for universal, mandatory healthcare insurance on the grounds that healthcare insurance offers significant expected welfare benefits to near enough everyone, and making it mandatory solves a coordination problem that otherwise seriously undermines that benefit.

So, what’s not to like? Well, quite a lot. This paper has focused attention on the insult to autonomy inherent in universal, mandatory coverage. But autonomy concerns cut both ways: with a mandate, those who don’t want insurance can’t forego it; without one, many of those who want it can’t get it. Another thing not to like is that to expand insurance is to expand moral hazard. Even if we can mitigate that effect with cash settlement options or other interventions, we cannot eliminate moral hazard. Therefore, absent historically unprecedented cost containment measures, extending coverage will lead to increased spending.[[27]](#footnote-28) Though all countries that already have universal healthcare spend less than the U.S., it’s unlikely that we can get there from here. There are many different approaches to delivering universal healthcare insurance, but all of them raise fiendish policy problems and involve painful tradeoffs. But that’s the way it is with the rumpled rug of policy – pushing one problem down makes another to pop up, and the best we can do is try to chase the bulges to where they are least problematic. The right policy does not have to be perfect, it does not even have to be all that good, it just has to be better than the alternative. By that standard, if the alternative is the U.S. status quo, universal healthcare is the right policy.

1. Acknowledgements: [↑](#footnote-ref-2)
2. “Basic Documents,” World Health Organization (2020), p. 1. [↑](#footnote-ref-3)
3. “Human Rights,” World Health Organization (2022), https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health, accessed on: August 17, 2023. [↑](#footnote-ref-4)
4. “In Depth: Healthcare System,” Gallup (2021), https://news.gallup.com/poll/4708/Healthcare-System.aspx, accessed on: November 5, 2021. [↑](#footnote-ref-5)
5. “Human Rights,” [↑](#footnote-ref-6)
6. Maybe twice, if you joined an automobile association without checking what your regular insurance already covers. I’ll wait while you go and check. [↑](#footnote-ref-7)
7. Andrew Cline, “How Obama Broke His Promise on Individual Mandates,” The Atlantic (2012), https://www.theatlantic.com/politics/archive/2012/06/how-obama-broke-his-promise-on-individual-mandates/259183/, accessed on: Nov 17, 2023 [↑](#footnote-ref-8)
8. See David M Cutler and Richard J Zeckhauser, “Adverse Selection in Health Insurance,” in *Frontiers in Health Policy Research*, ed. Alan M. Garber (Cambridge, MA: MIT Press, National Bureau of Economic Research, 1998): 1-32; Michael A. Morrisey and Administration Association of University Programs in Health, *Health Insurance* (Health Administration Press ;

   Association of University Programs in Health Administration, 2020), http://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=2459482

   http://www.vlebooks.com/vleweb/product/openreader?id=none&isbn=9781640551640

   http://public.eblib.com/choice/PublicFullRecord.aspx?p=6186441

   http://www.vlebooks.com/vleweb/product/openreader?id=none&isbn=9781640551619, accessed . [↑](#footnote-ref-9)
9. “Care without Coverage: Too Little, Too Late,” Institute of Medicine (2002), p. 87. [↑](#footnote-ref-10)
10. Helen Levy and David Meltzer, “The Impact of Health Insurance on Health,” *Annual Review of Public Health* 29 (2008): 399-409, p. 406. [↑](#footnote-ref-11)
11. “Care without Coverage: Too Little, Too Late,” p. 161. [↑](#footnote-ref-12)
12. “Care without Coverage: Too Little, Too Late,” p. 163. [↑](#footnote-ref-13)
13. Christina L. Ekegren, Ben Beck, Pamela M. Simpson and Belinda J. Gabbe, “Ten-Year Incidence of Sport and Recreation Injuries Resulting in Major Trauma or Death in Victoria, Australia, 2005-2015,” *Orthopaedic Journal of Sports Medicine* 6 (2018): 1-8, p. 3. [↑](#footnote-ref-14)
14. Kenneth J. Arrow, “Uncertainty and the Welfare Economics of Medical Care,” *The American Economic Review* 53 (1963): 941-73, p. 961. [↑](#footnote-ref-15)
15. Amy Finkelstein, *Moral Hazard in Health Insurance* (Columbia, NY: Columbia University Press, 2015). [↑](#footnote-ref-16)
16. “OECD Data Explorer”, Organization for Economic Cooperation and Development, Paris, France. <https://data-explorer.oecd.org>, accessed February 12, 2024. All spending is given in U.S. dollars at purchasing power parity. [↑](#footnote-ref-17)
17. Ibid. [↑](#footnote-ref-18)
18. G. F. Anderson, P. Hussey and V. Petrosyan, “It's Still the Prices, Stupid: Why the Us Spends So Much on Health Care, and a Tribute to Uwe Reinhardt,” *Health affairs (Project Hope)* 38 (2019): 87-95. [↑](#footnote-ref-19)
19. The Institute of Medicine’s much quoted estimate is that there are between 44 and 98,000 deaths due to medical error in U.S. hospitals each year. 44,000 / 12 is over 3,667 deaths a month, comfortably beating the 9-11 death toll of nearly 3,000 for that month. [↑](#footnote-ref-20)
20. T. Scott Bentley and Nick J Ortner, “2020 U.S. Organ and Tissue Transplants: Cost Estimates, Discussion, and Emerging Issues,” Milliman (2020), p. 5. [↑](#footnote-ref-21)
21. “Lung Transplant,” Mayo Clinic (2022), https://www.mayoclinic.org/tests-procedures/lung-transplant/about/pac-20384754, accessed on: Aug 18, 2023. [↑](#footnote-ref-22)
22. Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985). Because of the importance of social determinants of health, Daniels stresses that healthcare *per se* is not the only, or always the best means of protecting normal function; Norman Daniels, “Justice, Health, and Health Care,” in *Medicine and Social Justice: Essays on the Distribution of Health Care*, ed. Rosamond Rhodes, Margaret P Battin and Anita Silvers (New York: Oxford University Press, 2012): 17-33. [↑](#footnote-ref-23)
23. Daniels, *Justice, Health, and Health Care*, pp. 18-19. [↑](#footnote-ref-24)
24. Jennifer Prah Ruger, “The Health Capability Paradigm and the Right to Health Care in the United States,” *Theoretical Medicine and Bioethics* 37 (2016): 275-92, p. 283. [↑](#footnote-ref-25)
25. Liran Einav and Amy Finkelstein, *We've Got You Covered: Rebooting American Health Care* (New York: Portfolio / Penguin, 2023), p. 134. [↑](#footnote-ref-26)
26. Einav and Finkelstein, *We've Got You Covered*, p. 95 et seq. [↑](#footnote-ref-27)
27. Einav and Finkelstein, *We've Got You Covered*, p. 109. [↑](#footnote-ref-28)