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We Already Have Effective Socialized Medicine: Now Universalize It

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In the debates we hear about the significance of universal healthcare, there is something frequently left out of the discussion. A universal healthcare system is about providing a just and accessible healthcare system, the resources of which can and should be made universally available. It is also about ending a system which systematically reproduces health inequity, in a county which spent $4.5 trillion on health care in 2022—more than any other country in the world and twice as much as the average member of the Organisation for Economic Co-operation and Development (OECD). While we are spending far more, Americans generally have worse health outcomes than the citizens of rich European countries.

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Based on numerous benchmarks, we lag behind: for example, the US has the highest rate of infant and maternal deaths among the OECD countries; and one of the lowest rates of physician visits and practicing physicians. The Commonwealth Fund points out that life expectancy at birth in the U.S. was 77 years in 2020, three years lower than the OECD average. But what we tend to overlook is that we also have the foundational model of a truly universal system of healthcare right here in the United States, and while it can be improved upon it already functions quite well.

That basic model, which as explained below already exists in this country, should be expanded into a national healthcare system. To fully appreciate why this should be done, it is helpful to understand first that health disparity exists, and it has a racial, gender, ethnic, and socioeconomic structure: the empirical evidence is massive and overwhelming. Studies have shown that racial/ethnic minorities are "1.5 to 2.0 times more likely than whites to have most of the major chronic diseases." Black women are three times as likely to die from pregnancy-related causes as white women. Furthermore, Black Americans, American Indians and Alaska Natives have a lower life expectancy than do whites. In fact, the health gap between minorities and non-minorities in this country has in some respects widened over the decades.

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For example, black men had an average life expectancy of 61 years in 1960, compared with 67 years for whites. The life expectancy of blacks and whites grew over the next few decades, but so did the gap: by 1996, the gap increased to 8 years, with white males having an average life expectancy of 74 years, but only 66 years for black men. According to the Institute of Medicine, "American-Indian men in some regions of the country can expect to live only into their mid-fifties."

We should regard these disparities as what they really are; namely, forms of domination, ways of exerting power over bodies. This is not to suggest some form of nefarious

conspiracy; but simply to say that the adjustable dials on the economy (taxation policy, for example) are presently set to redistribute wealth to the topmost bracket of earners, and this affects the health and well-being of people of all races and ethnicities, although minority groups suffer disproportionately.

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Health disparity is a powerful weapon in the savage class warfare otherwise known as neoliberalism. (In 2020, the RAND Corporation did a study of the transfer of wealth over the last several decades from the working-class and the middle-class to the top one percent. Their estimate is a staggering $47 trillion – that is how much the "upward redistribution of income" cost American workers between 1975 and 2018.) Neoliberalism is a brutal form of labor suppression, which uses health as a means of maintaining and reproducing a condition in which wealth is constantly being redistributed upwards, and the middle-class is kept in a constant state of fear of sinking into the ranks of the poor. Medical expenses are the leading cause of bankruptcies in America – and that's according to the American Bankruptcy Institute. The ballooning costs of healthcare serve to maintain a system marked by morally unacceptable health inequity and injustice.

Like economic inequality, health inequity is not a necessary feature of the contemporary world, but a political choice. We know this because such levels of health (and economic) disparity do not exist in many other countries. Need we remind ourselves that the United States is the only large high-income nation that does not provide universal health care to its citizens. England, Spain, Sweden, and Denmark, among many others, have universal healthcare systems. In some cases, such as England's National Health Service (NHS), that system is socialized (although it has always maintained a private sector); while, in others it is not. While the British healthcare system is far from perfect, there is much we could learn from the NHS, the founding principle of which is that healthcare should be free at the point of service.

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The United States has, for the most part, opted instead to maintain a lucrative system of for-profit medicine, which treats healthcare as simply another commodity when it is clearly no such thing, but rather a basic human need. According to the World Health Organization, the United States spends on healthcare a higher portion of its gross domestic product than any other country but ranks 37 out of 191 countries according to its performance. The United Kingdom, by contrast, spends just six percent of GDP on health services, and ranks 18th.

Although a system of universal healthcare does not require socialized medicine, we already have a working and effective model of socialized medicine in this country: the Veterans Healthcare Administration (VHA) – comprising the national network of VHA Hospitals, clinics and nursing facilities, and part of the US Department of Veterans Affairs (VA). In 2021, the VA maintained and operated 1,600 health care facilities, 144 medical centers, and 1,232 outpatient sites. According to the Rand Corporation: "By almost every measure, the VA is recognized as delivering consistently high-quality care to its patients." To be sure, the VHA has had its problems, but following the Veterans Health Care Eligibility Reform Act of 1996, the VA began a systemwide reengineering which sought, first and foremost, to improve its quality of care – "the VA sought to reinvent itself by undergoing major structural and management reorganization, which resulted in its emergence as a national leader in health care within a decade." A 2007 study observes that

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> "VA care outperforms non-VA care on various dimensions, particularly process measures of quality that have been targeted for improvement. Patient satisfaction also

> appears to be higher within the VA than among those who receive care in the private sector. Numerous press accounts have extolled the VA system as a model of high-quality, efficient health care."

Like every healthcare system, there are still challenges facing the VHA – and to be sure, the population it services is relatively small compared to the U.S. population. But it is disingenuous at best to claim that these challenges are insurmountable. One of the biggest challenges facing the VHA today is that veteran healthcare is becoming increasingly privatized: It is clear, as the Washington Post observes, "that the dismantling of VA is desirable to Republicans because of what it represents: a successful, publicly funded, integrated health-care system." As Paul Krugman put it in his NY Times column: The VHA is "free from the perverse incentives created when doctors and hospitals profit from expensive tests and procedures, whether or not those procedures actually make medical sense," – and naturally, "Republicans are especially eager to dismantle government programs that act as living demonstrations that their ideology is wrong."

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Doctors employed by the VHA are salaried and therefore without any financial motive to subject patients to avoidable healthcare procedures. Phillip Longman, renown economic journalist, and Schwartz Senior Fellow at the New America Foundation, makes a powerful case in The Best Care Anywhere: Why VA Care is Better than Yours (2007), for the VHA as providing the basic blueprint for rescuing America's healthcare system, with its soaring costs, failure to meet significant health benchmarks, and deep structural health disparities. As many experts have observed, the VA can and should be used as a national model on which to build a system of universal healthcare, one that is just and benefits all Americans regardless of race, ethnicity, or socio-economic status. As the Rand Corporation stated, "'socialized' or not, we can learn from the VA."

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We do not have a healthcare system in the United States, but a for-profit health insurance system which functions as a form of bio-domination, of exerting power over vulnerable bodies, of keeping the poor destitute and the middle-class in check for fear of falling into the ranks of the dispossessed. Yet a universal healthcare (or better, socialized medical) system would be to the advantage of every American, because this higher burden of disease and mortality among ethnic and racial minorities has significant consequences for all Americans, as it results in a less healthy nation and higher costs for health and rehabilitative care.

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While the utilitarian case for universal healthcare is clear enough, we can and should also make the case on deontological grounds: that universal healthcare is consistent with respect for human dignity, whereas the commodification of healthcare is not. As Joseph Crisp argues: "Since health has dignity, rather than value, it cannot be treated as a market good…. One might choose to buy an I-Phone, rather than a television set, or one might choose to buy neither. But one has no choice but to fix a broken arm, or to undergo treatment for a life-threatening disease." Health is irreducible to mere exchange value. The patient is not merely a healthcare consumer, and to treat the patient as a mere consumer of health services is reductive and dehumanizing.

I have been teaching healthcare ethics to undergraduates since 2000. I always begin the course by taking Socrates, the father of moral philosophy, as our guide in terms of what moral philosophy should do. Socrates characterized himself as a 'gadfly' – and as we know was charged with corrupting the youth, and ultimately sentenced to death in 399 BC. But that is precisely our job as moral philosophers: to corrupt the youth if you will. 'Corrupt' has

of course a negative connotation: from the conservative standpoint we are corrupting ourselves simply by questioning the claims that we are expected to take for granted.

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One basic claim is that any limitation on privatization is a limitation on capitalism, and any alternative to capitalism leads invariably to totalitarianism. This is for many Americans commonplace dogma. The prevailing ideology is that we don't have to like capitalism, we just need to accept the fact that 'there is no alternative' (TINA)—a claim associated with Margaret Thatcher, but which is truly ubiquitous now. Consequently, we allow capitalism to infiltrate and colonize nearly every aspect of our lives, including healthcare, where, I believe, it does not belong.

Fast forward 2200 years to another gadfly, this time in France: the man generally recognized as the first communist revolutionary, Gracchus Babeuf demanded a universal healthcare service, which is free of charge at the point of need. He stated, "[t]hat doctors, apothecaries and surgeons should be paid wages out of public funds so that they can administer assistance free of charge." This is now the NHS system that England enjoys, one of the world's best. So much for Babeuf being a fanatical dreamer. Like Socrates, Babeuf was executed, guillotined in 1797.

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