Justice and Profit in Health Care Law

A Comparative Analysis of the United States and the United Kingdom

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Introduction

> The ideas of economists and political philosophers, both when they are right and when they are wrong, are more powerful than is commonly understood. Indeed, the world is ruled by little else … I am sure that the power of vested interests is vastly exaggerated compared with the gradual encroachment of ideas.[1]
>
> John Maynard Keynes

Vegetables have recently taken over discussions around issues affecting health care systems. A line of argument suggests that public powers should no longer be addressing health care, and like peas or broccoli, the allocation of these resources, to finance or provide health care services, should be left to the market. Proponents of this approach believe that health care is no more special than vegetables in the achievement of good health,[2] therefore why should it not be bought off the shelf? For instance, Jonathan Haidt, advocate of the 'vegetable rhetoric', explains that central to making peas available to the general public is the chain of manufacturers and suppliers involved in their production and marketing. Farmers, truckers, supermarket employees, and even miners and metalworkers contribute to making the peas available at an extremely low price. He attributes the affordability of the produce to the presence of competition among the suppliers at every stage of production and to the innovative techniques that helped reduce the aggregate price of the can. In a similar manner he claims that the allocation of health care resources would be most optimal and the price lowest if it were treated like a can of peas, i.e. left in the hands of the market and subject to competition.[3]

[1] John Maynard Keynes, *The General Theory of Employment, Interest and Money* (New Delhi, Atlantic Publishers and Distributors, 1936) 383–84.

[2] R Hanson, 'Why Health is not Special: Errors in Evolved Bioethics Intuitions' (2002) 19(2) *Social Philosophy and Policy* 153 doi.org/10.1017/S0265052502192077.

[3] J Haidt, *The Righteous Mind: Why Good People are Divided by Politics and Religion* (New York, Vintage Books, 2012) 303–04, Haidt imagines, to help consumers with the purchase of their groceries, a food insurance scheme with a substantial premium of $2000 and a co-payment fee of $10 payable at every shopping session. According to him, a certain point will be reached where food insurance prices will inevitably rise because supermarkets will only be willing to stock the produce that rewards them with the highest insurance payments and not the ones that provide the greatest value to the insured. An uncontrollable spiral of price increases will then be unleashed, and the price of a 'subsidized' can of peas will reach $30. A contribution to a tax-based subsidised scheme to cover all consumers' inflated grocery bills will then be imposed.

Similarly, vegetables have also made their way to the American Supreme Court during discussions pertaining to the validity of President Obama's Affordable Care Act (ACA).[4] The purchase of health care insurance was then compared with the consumption of broccoli. Justice Scalia argued that although imposing the purchase of vegetables on American citizens may produce good health outcomes, it would be unimaginable and ludicrous to do so. Nevertheless, as pointed out by Justice Ginsburg, health care presents attributes that have no parallel in modern life, since 'the inevitable yet unpredictable need for medical care and the guarantee that emergency care will be provided when required are conditions non-existent in other markets. That is so … of the market for broccoli as well'.[5]

Granted it may be argued that health care is no more special or unique than other determinants of health, such as nutrition, environment or safety, but it is greatly reductionist to equate it to a consumer good. For after all, health care is not just a vegetable. The importance it has in our lives and communities makes it a worthy subject of justice. Indeed, according to Norman Daniels, even in those societies, which tolerate or support significant inequalities in the distribution of social goods, most of their members feel that an equal distribution of health care resources is still justified.[6] The moral significance of health care derives directly from the importance of health in our lives. Its importance does not stem from the opportunity or advantages it creates but from its potential to alleviate suffering and absolute harm.

The indisputability and seriousness of health care needs therefore make the distribution of health care resources stand out from the distribution of any other good. It is the fundamental and critical nature of these resources that requires that their distribution follow principles of justice.[7] This is precisely why political philosophers have become interested in theorising the just allocation of health care resources. More specifically, the feeling that available resources are now seriously out of synch with our needs mandates that principles of justice be used for a better allocation.[8] Unfortunately, however, political philosophy seems to be at a distance from the reality of law and policy.[9] The waves of health care reforms experienced in Western welfare states partly reflect the law's inability to embody justice principles that could provide methods for tackling pressing issues.[10] Indeed, even though political philosophers have thought of multiple models to justly allocate resources, problems of availability and access to care remain major challenges.[11]

[4] *National Federation of Independent Business v Sebelius* 567 US 519 (2012).

[5] ibid, II D 1a.

[6] See generally, N Daniels, 'Health-Care Needs and Distributive Justice' (1981) 10 *Philosophy & Public Affairs* 146.

[7] N Daniels, *Just Health Care* (Cambridge, Cambridge University Press, 1985) 4.

[8] D Weinstock, 'Health Care in Political Philosophy: What Kind of a Good is it?' (Centre de recherche en éthique de l'Université de Montréal, 2010) 1.

[9] MJ Sandel, 'The Procedural Republic and the Unencumbered Self' (1984) 12 *Political Theory* 81, 81.

[10] See generally, RB Saltman and J Figueras, *European Health Care Reform* (Copenhagen, World Health Organization, 1997).

[11] DJ Hunter, *The Health Debate* (Bristol, Policy Press, 2016) 2.

The relationship between justice and health care, then, raises several questions that are central to this book. Considering the above debates in political philosophy, we may wonder whether it is the mismatch between the theory and the practice of law-making that is to blame for failing health care systems; or is it simply that theories of distributive justice do not inform the decisions of actors involved in the crafting of health care policies? The book suggests that the link between these two worlds needs to be examined more concretely to improve the organisation and the distribution of care. The very existence of a connection between moral philosophy and health care law has thus far been underestimated and unappreciated by law and policy scholars and as this book will show, understanding whether theories of political philosophy have made their way into law is an essential first step in solving health care issues. Rationing is, and will remain, at the top of governments' priority lists since only a finite amount of resources will ever be available to satisfy the infinite health care needs of populations.[12] Therefore, we should be able to explain how ideas of justice can be used to craft more adequate laws to ration, finance and provide health care services.

This book engages with literature in political philosophy and historical sources relating to the evolution of health care reforms in two Western welfare states, namely the United States and the United Kingdom, to understand the influence of theories of justice on health care policy over time. The legislative committees' debates that are presented in this book illustrate the deeper ethical and moral trends that were brought forward during the discussions leading to health care reforms. Attention is given to actors belonging to the for-profit sector: doctors, employers and insurers because of the different, but equally influential, roles they have played in the edification of both systems. Remarkably, these actors are also thought to be less sensitive to the social justice rhetoric.

Essentially, this book sheds light on the place given to theories of justice in the health care law-making process and on the place that we wish to give these theories in the crafting of future reforms. It is also a reflection on health care reforms as expressions of their broader social context. Health care law and policy are the products of path dependency evolving differently in the United States and the United Kingdom. These findings potentially have significant implications for health care law and policy in Western welfare states, especially regarding the need for change in these areas.

I. Justice, Profit and the Law

In theory, no health care system could ever be sustained without adjusting the distribution of resources according to certain rules,[13] and so, political philosophers continue to propose solving rationing issues with distributive justice principles.[14]

[12] D Wilsford, 'The Logic of Policy Change: Structure and Agency in Political Life' (2010) 35 *Journal of Health Politics, Policy and Law* 663, 664.

[13] E Elhauge, 'Allocating Health Care Morally' (1994) 82 *California Law Review* 1449, 1493–95.

[14] See works of Norman Daniels, Amaryta Sen and Carie Fourie on the subject.

At a clinical level, bioethics philosophers generally believe that the health care decision-making process should revolve around four principles: *autonomy*, encompassing the principles of self-governance, liberty, privacy, and freedom of choice; *non-maleficence*, encompassing the moral duties of doctors not to execute acts of torture or to behave harmfully towards their patients; *beneficence*, encompassing the moral duties of doctors to act for the benefit of others; and *justice*, the duty to treat like cases alike when allocating resources to patients.[15] In line with these principles, doctors select treatments based on an assessment of the disease and then run a cost–benefit analysis for each treatment option. At both stages, questions of justice and solidarity are weighed.

At a systemic level, it is less clear whether normative arguments, based on philosophical or moral standards, are the basis of policy goals or whether they are even used as normative tools to achieve certain outcomes. Evidently, because of the multi-layered and complex nature of health care policy-making, goals and outcomes rarely overlap. Although these normative theories have often been criticised for providing only broad guidelines with no concrete application, they may help situate health care in an ethical framework that can achieve fair distributive decisions.[16]

Ideas of justice are no more essential than institutional input, but they may have a different place in the decision-making process and it is important to determine what that place has been so far in order to determine what we want it to be in the future. Policies may reflect powerful economic interests, and ideas about the good society. Interests and ideas both shape policy choices and it is usually a matter of understanding how they come together to do so to be able to improve the access, delivery and financing of health care services.

A. Profit and Health Care

Arrangements for the delivery and financing of health care services vary across countries. However, most Western democracies have aligned themselves with an 'international standard' for health care.[17] One of the main features still distinguishing the organisation of health care systems in Western welfare states is the share of publicly financed services in the total health care expenditure.[18] At one end of

[15] TL Beauchamp and JF Childress, *Principles of Biomedical Ethics* (Oxford, Oxford University Press, 2001) 12.

[16] C Fourie, 'What Do Theories of Social Justice Have to Say About Health Care Rationing? Well-being, Sufficiency and Explicit Age-rationing' in A den Exter and M Buijsen (eds), *Rationing Health Care: Hard Choices and Unavoidable Trade-Offs* (Antwerp, Maklu, 2012) 73–74.

[17] J White, 'The 2010 US Health Care Reform: Approaching and Avoiding How Other Countries Finance Health Care' (2013) 8 *Health Economics, Policy and Law* 1, 14–15.

[18] D Brady et al, 'Path Dependency and the Politics of Socialized Health Care' (2016) 41 *Journal of Health Politics, Policy and Law* 355, 356.

the spectrum lies the United States with less than half of its total spending coming from public funds, and at the other, is the United Kingdom[19] that finances over 80 per cent of health care services through taxes.[20] The amount of private sector activities related to health care is inversely proportional to the state's involvement in both of these countries. All of this inevitably impacts the organisation of these systems.[21] Indeed, the share of publicly financed services translates the degree of 'socialisation' of medicine. Some political scientists have attributed this variation to the different role played by the for-profit sector in each of these countries, while others believe that culturalist explanations can justify the difference in health care and social policy.[22]

Political elites and the public, as cultural agents, may perceive the importance of health care and relay their perspectives to law-making institutions differently, but looking at culturally similarly situated welfare states the culturalist argument becomes difficult to defend. The United States and the United Kingdom are countries that share a common cultural background and are both common law jurisdictions. They have achieved a similar level of development and political freedom. However, the American health care system has always been singled out as the exception in comparison to its European counterparts given the extremely prominent role played by the private sector in health care.[23] The medical profession, employers and insurers have had a critical impact on the edification of the system and neither culture nor political allegiance can properly explain their dominance.[24] This book explores how the for-profit actors are in great part responsible for the lack of universal care in the United States.[25] Having long resisted and contested the idea of compulsory insurance they have shaped health care policy and have had a significant impact on the law-making process.[26]

Comparing and contrasting the American health care system with the National Health Service (NHS), it is obvious that the share of activity of general practitioners acting as independent contractors, of medical consultants engaging in the private practice of medicine, and of other medical professionals providing health care services privately in the United Kingdom, does not compare with the American for-profit sector's stake in its health care system. The role of the private

[19] In this book, references to the United Kingdom after the devolution of power in 2002 relate only to NHS England.

[20] Brady et al, above (n 18) 356.

[21] H Maarse, 'The Privatization of Health Care in Europe: An Eight-Country Analysis' (2006) 31 *Journal of Health Politics, Policy and Law* 981.

[22] See generally, C Geertz, *The Interpretation of Cultures: Selected Essays* (New York, Basic Books, 1977).

[23] White, above (n 17) 1.

[24] EM Immergut, *Health Politics: Interests and Institutions in Western Europe*, 6th edn (Cambridge, Cambridge University Press Archive, 1992) 1–67.

[25] P Starr, *The Social Transformation of American Medicine* (New York, Basic Books, 1982) 6.

[26] ibid, 256. Further details on the history of the American health care system and the role of the for-profit system will be given in ch 3.

sector is different in the United Kingdom as the for-profit stakeholders have not been equally hostile to a government-led health care system.[27] From the inception of the NHS and throughout its modern history the for-profit sector in the United Kingdom has helped preserve universality of care. In some respect, the medical profession has presented itself as the shield protecting the NHS's core values as further demonstrated in this book.

Actors from the for-profit sector in America and the United Kingdom are at the heart of the organisation of their systems and greatly impact governmental decisions regarding the allocation of health care resources, be it directly or indirectly. That is not to say that political institutions do not play a major role in the drafting of health care laws, but it is important to understand how these institutions are permeable to the for-profit sector's input to fully grasp the nature of health care policy in both countries. Therefore, the influence of political philosophy on the crafting of health care laws should also highlight the role of the state in the allocation process.[28]

B. Discourses of Justice

Political philosophy mandates the analysis of public discourses to understand the law's deep-lying objectives, even if those are not necessarily being reflected in the legislative outcome. Jürgen Habermas in his book *Between Facts and Norms* points to the argument made by some philosophers about the absence of absolutes and grounds for morality in modern, liberal and pluralistic societies, such as Western welfare states, but explains that a moral foundation nonetheless exists within discourses.[29]

For Habermas morality is not metaphysical but pragmatic and present in the use of language. A statement about the morality of a matter made to establish what is right for society participates in the edification of the moral foundation. Habermas' conception of morality sees discourse as a mechanism for conflict resolution and language as instituting social order. Of course, laws and political institutions also participate in the coordination of the social order. Thus, law is a medium for social integration and politics is a support to morality. The realm of politics is itself divided into two spheres: the informal sphere constituted by civil society where actors exchange informal and spontaneous discourses; and the formal sphere of political institutions such as Parliament or Congress, Cabinets

[27] JS Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (Cambridge, Cambridge University Press, 2002) 221–69.

[28] Brady et al, above (n 18) 361.

[29] See generally, J Habermas, *Between Facts and Norms: Contributions to a Discourse Theory of Law and Democracy* (Chichester, John Wiley & Sons, 2015).

or elected assemblies where members of the political community engage in the decision-making process and formulate laws and policies.[30]

Habermas argues that for politics to elaborate a valid legal rule, a normative and a factual aspect must come together.[31] Thus, a legitimate rule cannot be 'self-validated' since it requires that members engage in a dialectic process and reach an agreement as to the rightness of the law.[32] Norms must go through a democratic process to be enacted and this requires the use of a specific form of communication. Policies and laws are the reflection of civil society's discourses transferred and formalised in the discourse of the political community.[33] In this respect, positive law is the mechanism that complements and stabilises key stakeholders' communicative actions. Discourses and their moral foundation also infuse ethical values in a legitimate law.[34] Thus, this theoretical underpinning establishes that discourses conveying ideas or theories of justice, formulated during the elaboration of health care laws, are proof of a connection between moral philosophy and the reality of law and policy. The formal sphere of legislative institutions also provides tangible evidence of moral discourses recorded in various reports and legislative drafts. More particularly, as this book will show, the discourse of for-profit actors during the negotiations and drafting stages explains how and why ideas of justice have made their way into health care policy.

The impact of the for-profit sector on the enactment of health care reforms in the United States and the United Kingdom results from its ability to participate in the legislative framework. The presence of language employed by doctors, employers or insurers in these contexts may reflect a justice theory and demonstrates its social recognition. Indeed, language and communication styles also reflect visions of the world, identities and the roles individuals play in social relations. Discourses are socially embedded and, to a larger extent, reflect social movements and our perception of a society at a particular time and place. Analysed in different contexts, social domains, or different institutions they reveal factors that contribute to social change.[35] Thus, in order to unpack the social context of health care reforms, this book pays close attention to the language of legal and policy discourse.

For-profit actors' speeches are interlocutory acts that have raised a set of criticisable claims and, when they have made their way in the final version of a legislative act, have received universal validity.[36] Positive law therefore represents

[30] J Gordon Finlayson, *Habermas: A Very Short Introduction*, Vol 125 (Oxford, Oxford University Press, 2005) 108.
[31] ibid, 93–115.
[32] ibid, 108.
[33] Habermas, above (n 29) 110.
[34] ibid, 99.
[35] MW Jørgensen and LJ Phillips, *Discourse Analysis as Theory and Method* (London, Sage Publications, 2002) 61.
[36] Habermas, above (n 29) 4.

a mechanism that structures different stakeholders' communicative actions.[37] Essentially, flowing from Habermas' theory, this book suggests that discourses of justice formulated by for-profit actors have led to the enactment of legitimate health care reforms as the product of a larger social consensus in the United States and the United Kingdom.

C. Legislative Intent

The United States and the United Kingdom are unique case studies in the realm of health care policy. The United States remains the only Western democracy without a universal health care system, and the United Kingdom is the first country to offer free comprehensive health care services to its entire population.[38] The differences in the organisation and objectives of these systems make the comparison even more interesting and relevant. Looking at these contexts together also provides evidence that normative thinking in health care policy is not just the reflection of national preferences. Despite fundamental differences, both Western welfare states have developed mature health care systems and, as demonstrated in chapters four, five and six, have seen the drafting of health care reforms impacted by for-profit actors and ideas of justice. For the sake of clarity, it should be specified that the analysis presented in this book focuses only on American federal health care laws and the laws pertaining to the NHS of England (even though health care laws enacted prior to 1999, some of which discussed hereafter, were also applicable to NHS Wales, NHS Scotland and NHS Northern Ireland).

The American Congress through formal and specialised committees collects testimonies from its members, officials of the executive branch, policy experts and interest groups (including the for-profit sector) to evaluate the necessity to create new law in certain domains. The reports of these hearings constitute influential information used to draft legislative proposals. These documents also provide key elements to make sense of the controversies arising at the early stages of the policy-making process.[39] Committee hearing reports have the most probative value in determining Congress' legislative intent, more so than the reports of the discussions taking place in the House of Representatives or on the floor of the Senate, which only offer technical information on the negotiations of the wording of the law. As further discussed in the book, abstracts from these reports relate language of justice used by for-profit actors to comment on potential laws pertaining to the financing and provision of health care services. These documents are a primary source of information for the analysis of key policy moments in the United States.

[37] ibid, 37.

[38] N Vetter, *The Public Health and the NHS: Your Questions Answered* (Oxon, Radcliffe Medical Press, 1998) 33.

[39] 'Congressional Hearings' (US Government Publishing Office), available at: www.gpo.gov/fdsys/browse/collection.action?collectionCode=CHRG.

In the United Kingdom, the government's request for an inquiry can ignite the legislative process. The review leads to the drafting of a White Paper: an authoritative report presenting the issues, potential solutions and tentative timeline to implement new legislation. The document presents the reasons for a reform, usually voicing the reactions of different groups and mentioning potential controversies surrounding the project. The White Paper contains many elements that are later incorporated in the Bill.[40] Following the publication of the White Paper and before the law receives royal assent, the draft Bill is read three times before Parliament. The Second Reading of the Bill provides the most information about the intent behind the future law. Depending on the activity of each House the draft law is presented either before the House of Commons or the House of Lords. During this process House Members discuss the principles that motivate the enactment of the new law. Second Reading reports also shed light on the role of certain Members in the legislative process and on the role (although indirect) played by pressure groups in the elaboration of health care reforms.[41] Interest groups such as the for-profit sector do not enter the walls of Parliament to discuss future legislation, but often relay their opinions to their representatives, who may carry the group's support or grievance inside the institution. Similarly, to Congressional Hearing reports, abstracts from transcripts of the Second Reading of a draft Bill may reveal discourses of justice. They are therefore analysed in chapter six to shed light on key health care reforms.

D. History and Health Care Reforms

The book focuses on a 70-year period starting with the birth of modern medicine and the discovery of antibiotics and penicillin[42] going all the way to President Obama's health care reform in 2010 and the UK Coalition government's health care reform in 2012.[43] This period marks years of great economic, social and political change in both countries with watershed policy moments and major turning points. The presence of discourses of justice in the policy and law-making process during this era testifies to the fact that these occurrences are not isolated events but enduring trends in both welfare states.

Indeed, health care policy must be understood as part of a political, economic and social context. National health care programmes are the product of a constellation of factors taking place at particular points in time. The history surrounding

[40] Select Committee on the Constitution, *The Legislative Process: Preparing Legislation for Parliament*, 4th Report (2017–19, HL 27) 14.

[41] ibid.

[42] 'Antibiotics changed the focus of medical care from prevention of disease through inoculation and hygiene to cure of illnesses'. See K Patel and ME Rushefsky, *Healthcare Politics and Policy in America*, 4th edn (Armonk, NY, ME Sharpe, 2014) 54; see generally, MC Bernstein and JB Bernstein, *Social Security: The System That Works* (New York, Basic Books, 1988).

[43] Health and Social Care Act 2012 c 7.

the enactment of major health care reforms in the United States and the United Kingdom recounted in subsequent chapters brings about a different perspective on the connection between political philosophy and institutional outcomes.

Obviously, historical events and their sequencing matter as they provide a specific conjecture favouring certain interest groups and their ideas.[44] A bird's-eye view of American and British health care policies helps us determine whether ideas and theories of justice have been ingrained and preserved in the systems as part of a set policy, or whether they have made their way into the legislative process as an accident of history.[45] Ideas of justice are certainly part of a larger social narrative, but they have also been instrumental in helping actors set trends for the distribution of health care resources. The book thereby explores path dependency theory as a tool to unpack the complex nature of political philosophy's relationship with the practice of law and policy making.

Path dependency theory suggests that similar outcomes in public policy are the result of a political trajectory born out of historical events.[46] More than a mere description of historical phenomena, the theory emphasises the significance of social variables to explain how policy 'got to where it is'. Essentially, it demonstrates how and why past events lead to repetitive policy outcomes and offers a systemic understanding of history.[47] Policy moments often consolidate the path, but sometimes their importance is such that they deviate the trajectory.[48]

Institutional arrangements attempt to prevent divergence because of the high cost associated with reversal of a policy.[49] Public policy tends to create large constituencies that have a great interest in maintaining social programmes and benefits, and some actors and organisations participating in these programmes become stakeholders with vested interests and therefore are reluctant to encourage any change in policy. The state must continue to meet set standards and normative expectations.[50]

Findings later presented in the book confirm that the medical profession and other for-profit actors in the United States and the United Kingdom have helped

[44] JS Hacker, 'The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and US Medical Policy' (1998) 12 *Studies in American Political Development* 57, 59.

[45] Throughout the book the adjective 'British' is used to talk about reforms in England, Northern Ireland and Wales, except for acts and events post-devolution (2002) for which 'British' is used to qualify acts pertaining to NHS England only.

[46] See generally, AL Stinchcombe, *Constructing Social Theories* (Chicago, IL, University of Chicago Press, 1987).

[47] Brady et al, above (n 18) 355.

[48] D Wilsford and LD Brown, 'Path Dependency: A Dialogue' (2010) 35 *Journal of Health Politics, Policy and Law* 681, 687–88.

[49] M Levi, 'A Model, a Method, and a Map: Rational Choice in Comparative and Historical Analysis' in M Irving Lichback and AS Zuckerman (eds), *Comparative Politics: Rationality, Culture, and Structure* (Cambridge, Cambridge University Press, 1997).

[50] Brady et al, above (n 18) 360–61.

set policy paths that were, at times, diverted with the enactment of a health care reform. The for-profit sector in both countries seems to be responsible for setting trends for the allocation of health care resources and for upholding certain elements of justice to reinforce their respective positions. Thus, path dependency theory provides an important perspective in the assessment we make of the legislative systems' sensitivity to conceptions of justice.

Not all political scientists support the path dependency theory or the findings derived from it. Famously, Lawrence Brown has been particularly critical of the theory as he considers that there are no good reasons to justify using it as a prism for the analysis of public policy.[51] He argues that the theory has no major added value since policies are merely the outcome of an institutional push and pull, and therefore the theory becomes an invitation to describe the political phenomenon rather than to make sense of it.[52] Brown makes a valid point about the extensive negotiations involved in the law-making process; however, the theory still offers a valid account for the design and organisation of health care systems. As this book will argue, path dependency theory is key in explaining successive waves of reforms and the recurrent issues relating to access, cost and sustainability of health care services in the United States and the United Kingdom. This is further explored in chapters three to six.

II. Essential Elements of the Book

Medical professionals, employers and insurers, in the United States, and the general practitioners, medical consultants and independent sector in the United Kingdom, have all had a great impact on policy making and health care reforms. Their ability to participate in the legislative framework highlighted throughout the book demonstrates how their actions in and outside the legislative sphere have shaped decisions relating to the financing and provision of health care services. Their 'institutional' influence also sheds light on path dependency constraining health care policy in both countries. From the beginning of the twentieth century to the present day, for-profit actors have certainly been instrumental in maintaining some of the attributes of both health care systems. In this respect, the United States and the United Kingdom provide exemplary case studies. Their cultural similarities and their unique approach to health care financing and delivery allows us to put into perspective the level of engagement the for-profit sector has had with ideas of justice. This systematic comparison puts forward the different roles these actors have had in the only mostly privately run system and the first

[51] See generally, LD Brown, 'Pedestrian Paths: Why Path-Dependence Theory Leaves Health Policy Analysis Lost in Space' (2010) 35 *Journal of Health Politics, Policy and Law* 643.
[52] ibid, 643.

universal health care system in the world. The analysis is concentrated on watershed moments in the history of the American and British health care systems to better highlight specific aspects of health care policy in both countries. This also allows a parallel examination of what were the factors in both systems that led to these hinging points.

Universality of care is a major underlying theme of this book as it has helped develop the necessary theoretical framework to lead a coherent and consistent historical and comparative analysis of legislative work. Essentially, *Justice and Profit in Health Care Law* is the first book to examine whether the lack of an overlap between theories for the just allocation of resources and the process leading to the enactment of a law, has led to reforms unsuccessfully tackling problems affecting mature health care systems in Western welfare states. An analysis of the role played by American and British for-profit actors, deemed least sensitive to ideas of justice, provides pertinent insights into health care law and policy making, and the comparative dimension of this study offers an unprecedented outlook on both the legal and policy aspects of health care provision.

A. Methodological Considerations

Discussions, arguments and negotiations between powerful stakeholders have led to legislative proposals that are sometimes turned into laws. The strategic and rhetorical use of language is most crucial to this process. Stakeholders often directly relay their interests to the sphere of law and policy making through discourses uttered in political and legislative institutions. Setting and framing issues with language establishes precise conceptual boundaries, which have a significant impact on legislative outcomes.[53] The book therefore adopts a discourse analysis methodology to determine whether for-profit actors have used ideas of justice to relay their interest in health care law, and whether their discourses have influenced the health care allocation process in the United States and the United Kingdom. The enquiry examines the concrete linguistic occurrences made by these for-profit stakeholders during the negotiation of important health care reforms.

The appendix to the book encloses key words associated with the five allocation models used to theorise the just allocation of health care resources. These words constitute a reading grid used to analyse reports of legislative preparatory work. Contextualised, these occurrences provide evidence that discourses relating to these distributive models were used to convey ideas of justice in health care law.[54] This methodological approach also mandates that historical elements be taken into consideration, as on many levels they have made an impression

[53] See generally, J Russell et al, 'Recognizing Rhetoric in Health Care Policy Analysis' (2008) 13 *Journal of Health Services Research & Policy* 40 doi.org/10.1258/jhsrp.2007.006029.

[54] See appendix for the detail of textual occurrences analysed in the primary sources.

on the production of the actors' discourses. Thus, the textual analysis of pattern in and across occurrences is supported by the historical analysis presented in chapter three and in chapter five. Throughout the enquiry, historical and sociological sources also clarify the influence elements of a broader context have had on interlocutors.

The purpose of this project however is not to enter into socio-psychological study that attributes meaning to the leading actors' discourses and behaviours. The book makes no claim of inside information on the motivations and private views of for-profit actors. The enquiry only presents how and when theories of political philosophy and organising principles have made their way into the legislative process as exemplified by the discourses of these key policy actors. Essentially, the book proposes a theory of legal development and advances methodological elements for the study of legal change.[55]

B. Outline of the Book

The chapter following these introductory remarks ('Understanding Health Care as a Question of Justice') presents theories of political philosophy that outline methods for the just allocation of health care resources while addressing the fundamental philosophical, political and legal debate on universality of care as a requirement for the attainment of justice. Some of these conceptions of justice (egalitarian, utilitarian and communitarian) confer a special status to health care and argue in favour of a universal system. Others (libertarian and neo-liberal) value individual freedom or a certain laissez-faire, which should not be infringed to promote free access to health care. All five theories are fleshed out in order to understand their potential influence on health care policy-making. This chapter intends to set the table for subsequent discussions on whether these normative schemes have been instrumental in setting goals or organising the financing and provision of health care services in the United States and the United Kingdom over the past 70 years. The purpose of this chapter is not, however, to critically assess each theory but to offer a global view of distributive justice theories to later proceed to a meta-normative analysis of discourses of justice in the legislative framework.

Subsequent chapters deal with health care law and policy making in the United States and the United Kingdom. Chapter three ('For-Profit Stakeholders in American Health Care Policy') is dedicated to the presentation of the history and developments of main policy trends in American health care. Attention is given to the role of leading actors in the construction of this unique system. The part played

[55] D Ibbetson, 'Comparative Legal History: A Methodology' in A Musson and C Stebbings (eds), *Making Legal History: Approaches and Methodologies* (Cambridge, Cambridge University Press, 2012) 134.

by employers in the creation of risk-pooling systems, by insurers in the creation of third-party payer schemes and by the medical profession in the consolidation of the privately run health services are explained with a historical narrative. This brief panorama is most useful in understanding issues of cost and access affecting health care in the United States and the solutions that have been so far provided in an effort to manage and contain these problems.

Chapter four ('Locating Ideas of Justice in American Health Care Reforms') brings to light major reforms for the financing and provisions of health care services in the United States. It begins with the enactment of a law for the indigent aged, the Kerr–Mills Act (1960) and finishes with the most recent change brought to the system with the ACA (2010), without omitting the amendments to the Social Security Act (1965) that created the federal programmes of Medicare and Medicaid, and the Republican Health Maintenance Organization (HMO) initiative established through the enactment of the Health Maintenance Organization and Resources Development (HMO) Act 1973. The analysis of the language and discourses used by actors belonging to the medical profession, insurance industry and corporate employers brings forward the existing overlap between concrete policy-making choices and theoretical normative patterns.

Similarly, for the United Kingdom, chapter five ('For-Profit Stakeholders in British Health Care Policy') introduces the historical foundation of the NHS. From its inception in 1948 to the present, the role played by the for-profit sector, more particularly the medical profession, in the creation of the first publicly run health care system in the world is highlighted. The focus of this presentation is on the NHS and the evolving role of the private sector in the delivery of health care services and its impact on the organisation of the national system of care. The private partnership initiatives to finance and provide health care in England are also highlighted.

This historical tour d'horizon leads to the presentation in chapter six ('Locating Ideas of Justice in British Health Care Reforms') of key health care reforms in the United Kingdom. Attention is given to the indirect participation of the medical profession, through its dialogue and confrontation of various governments' health care policy, in the elaboration of the following legislation: the NHS Foundational Act (1946), the reform brought by Margaret Thatcher with the NHS and Community Care Act (1990) and the most recent overhaul of the system brought by the Health and Social Care Act (2012). The chapter also presents the importance of foundational ideas of justice at the core of the NHS that instilled path dependency in British health care law and policy.

Finally, the analysis led in previous chapters invites a conclusion on the role of distributive justice theory in the law-making process. The conclusion, chapter seven, therefore reiterates the crucial need for prioritising resources in health care and on the influence of path dependency leading the American and British health care systems to more recently adopt converging health care policies.