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Health Care Reform: Ethical Foundations, Policy, and Law

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Abstract

Health care system reform has enormous implications for the future of American society and economic life. Since the early days of the republic, 2 world views have vied for determination of this country's political system: the view of the individual as sovereign vs government as sovereign. As they developed the foundations of our nation's governance, the founders were heavily influenced by the Enlightenment philosophy of the late 17th and 18th centuries—the US Constitution sharply limited the power of central government to specific narrowly defined functions, and the economic system was largely laissez faire, that is, economic exchange was mostly free of government regulation and securing individual liberty was a high priority. This situation has slowly reversed—the federal government originally was narrowly limited, but now it dominates states and individuals. The economic system has followed, lagging by several decades, so although it still retains some features of laissez faire capitalism, federal and state regulation have produced a decidedly mixed economy.

Among economic sectors, health care has led the shift toward government domination for decades. The shift is propelled by the idea that there is a right to health care, a concept that was first articulated by Franklin Delano Roosevelt in his address to Congress in 1944, in which he spoke of a new set of basic rights, including “the right to adequate medical care and the opportunity to achieve and enjoy good health.”¹ The debate over whether such a right exists has been ongoing for decades, some claiming it does exist,^{2,3} others that it does not.^{4,5} Although a right to health care has never been explicitly recognized in US law, the closest approach is in the new health care reform law with its amendments, the Patient Protection and Affordable Care Act (ACA).⁶ Various ethical arguments have been made for and against establishment of a legal right to health care in recent years—the current debate about the law rests on those ethical foundations.

To clarify competing ethical theories, I will describe 2 distinct ideologies, by which I mean systems of more or less coherent ideas, which bound the ends of a spectrum of approaches to health care reform. The ACA and most other reform proposals are admixtures of elements from the spectrum's boundary anchors that I refer to as “central planning,” which relies on

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regulatory controls, and “free market,” which favors minimal government involvement in the health care system. Opposing ideas drive these 2 positions: that health care is an entitlement that must be provided by society and that obtaining health care is the responsibility of individuals.

I will start by describing an approach to the ethical thought that underlies free market systems, then do the same for central planning. I will go on to argue that central planning is fatally flawed and that free markets will deliver substantial benefits for individuals and for society. Then I will describe the implications of these ethical considerations for the development of public policy, and will end by briefly describing health care system reforms that are well grounded ethically and are likely to actually achieve the goals of increased access and cost control, namely, systemic reforms using market mechanisms.

ETHICS OF FREE MARKETS

Moral justifications for limiting government intervention in markets have included the necessity for political systems to be based on voluntary cooperation because general agreement is lacking on any moral question,⁷ the presumption that the primary goal of society is to protect freedom,⁸ and the requirement for self-determination that is imposed by human nature.^{9,10} Based on the solidly grounded assumption that there is a human nature,¹¹ I will present a justification of free markets based on a particular understanding of human nature and corollary natural rights theory.

From human nature to natural rights

As human beings, we interpret the world through perceptions that are gained through our senses. We process perceptions into concepts and use our powers of reasoning to choose alternative actions in dealing with the real-world situations we encounter every day. The basic difference between human beings and other animals is that we make our way in the world by using our capacity to reason. The use of reason is volitional, however; that is, we have to choose to think rationally. If we fail make that choice, the alternatives are to act on unprocessed emotional responses or to respond blindly to the direction or command of others.¹⁰

In order to survive and thrive, we have to pursue certain goods or values that allow us to realize our potentials as human beings.¹² The list of such goods fluctuates over time and with differing viewpoints, but Aristotle’s list will serve our purposes here (Fig. 1). Every human being needs all of these goods, but not in the equal proportions depicted as Generic in Figure 1, because genetic endowment and environmental influences contribute about equally to define us as unique individuals.

For example, athletic pursuits attract more attention from a professional athlete, such as Tom Brady, so it weighs more heavily than other goods. To achieve a thriving life, a movie leading lady, such as Angelina Jolie, would want to focus on achieving beauty, Albert Einstein on intellectual matters, Warren Buffet on creating wealth, and John Roberts, Chief Justice of the US Supreme Court, on pursuing justice (Fig. 1). Each life contains all the goods needed to flourish, but every individual must spend time and resources differently in

pursuing those goods, and, in light of personal talents and experiences, only he or she can know what is needed. The process of realizing one's potential as a human being is highly individualized—there is no one-size-fits-all decision making. To make choices appropriate to one's own life, the decision-making process has to be protected from interference by others. The idea of “rights” provides such protection.

I use the word *rights* in the sense of claim rights, which impose duties on others. Depending on the nature of the duty, claim rights may be positive or negative. A positive duty requires that certain goods or actions be provided; a negative duty imposes on others the requirement not to interfere. So, if Smith has a right to have a house, someone has the duty to provide him with a house—his entitlement is a positive right. If Jones has a right to live in a house he already owns, everyone else has the duty not to interfere with his use of the house—his right of ownership is a negative right.

The need for individuals to achieve the correct or best personal balance of the goods we all seek requires a great deal of thought, judgment, and appropriate action that are unique to each person. This need requires that others must not interfere with their actions. In other words, individuals have moral rights that are possessed in the same degree by everyone and are essentially negative rights of noninterference.¹⁰

Because such rights originate in human nature—who we are and what we are—they are “natural rights.” Natural rights are universal—they belong to every human being, and they exist before any common or statutory law. In a political-legal context, laws govern societies, so they must be constructed on a foundation of natural rights and must apply uniformly and equally to all human beings, irrespective of their individual circumstances.

From natural rights to the principle of noninterference

Because all human beings must pursue their unique forms of flourishing, no law can rightfully impose a preferred view of the requirements of a good life. At their roots, legal systems have to maintain conditions that permit many different approaches to the good life, so they must have the power to prevent the initial use of force by one person or group against another. This requirement limits government to providing 3 services: military forces for national defense, police for protecting people and property, and courts to adjudicate violations of law and other disputes. Government interference with voluntary exchanges among people and organizations is unjustified.

In the domain of economic action, the concrete expression of the principle of noninterference is the free market economy. This principle provides little guidance for determining what is right or wrong or good or bad, and makes no judgments about whether people make good choices or bad choices, or whether they achieve their own good; it is a metanormative principle, which states, “No person may initiate force against another, nor use another for one's own purposes without consent.”¹³

From ethical to political principles

The idea of metanormative ethics provides the basis for a legal system that respects the right to liberty—that is, does not allow initiation of force against others, nor allow anyone to use

others for their own purposes without consent. Most importantly, it is neutral toward differing views of the good life. Normative and metanormative social theories underlie the 2 basic forms of legal system (Fig. 2).

We clearly recognize the interference with human liberty by countries that are legally governed by the dictates of religious law, such as the Sharia of Islamic states, and by secular ideologies that determine how citizens' lives should be lived, such as the People's Republic of China, Myanmar, and other nations that impose secular norms of behavior through laws based on their communist, socialist, or nationalist views.

We do not so easily recognize that the governments of liberal democracies of North America and Western Europe also impose, to a significant extent, behavioral norms based on secular beliefs of how their citizens should live their lives. For example, welfare laws displace and ultimately replace voluntary charity in the name of social justice, a particular understanding of justice that makes dubious assumptions about human values and virtues that everyone should or must accept, thereby substantially interfering with individual self-determination.

Contemporary Western democracies are governed largely under normative standards—those in power impose by force of law limitations on what people can buy and sell and to whom their earnings will be redistributed through taxation. In contrast, societies can be and have been organized on the basis of metanorms, principles that say little about how lives should be lived, rather, that protect the power of sovereign individuals to live their own lives without forceful interference by others.

The best example of a country founded on metanormative political principles is the US. Our Declaration of Independence, says, “We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain *unalienable rights*, that among these are life, liberty and the pursuit of happiness. That to *secure these rights*, governments are instituted among men, deriving their just powers from the consent of the governed.”¹⁴ (Emphasis mine.)

Notice that the enumerated natural rights are unalienable—that is, they cannot be sold, given away, or taken away—and that governments do not give us or create these rights, they can only “secure” them because natural rights are universal and are ours to from the start.

Nothing in the original US Constitution imposes on us a particular vision of the good life or proper living; rather, its protections enable us to choose how we live our own lives and how we pursue our own happiness and that of our families and friends. This document is, in a word, metanormative.

ETHICS OF CENTRAL PLANNING

During the lengthy debates in Congress that preceded the passage of the ACA in March 2010, surprisingly little attention was paid to moral justification for collectivizing health care, but this was not always the case. The ethics subgroup of President Clinton's White House Task Force on National Health Reform in 1993 – 1994 developed a list of principles and values that they described as “fundamental national beliefs,” including, for example,

universal access to health insurance, comprehensive benefits, equal benefits, shared burdens, efficient management, and fair procedures.¹⁵

Members of the ethics subgroup wrote a detailed analysis of the main ethical principles of the proposed law. They said that equality is basic because health is a necessary condition for individuals to pursue their goals. Justice is foundational because it is a serious injustice when individuals suffer preventable loss of opportunity, pain and suffering, or loss of life for want of health care readily available to most inhabitants of a country as wealthy as the US. Liberty is undermined when an individual is threatened by illness or death. We are a single nation joined by community, they said, so there is a shared “concern and responsibility for one’s fellow members, especially those in need of help.”¹⁶

More recently, in 2007, the Ethical Force Program of the American Medical Association found 3 core American values underlying health care system reform: equality of opportunity, justice, and compassion, which they justified in a manner similar to that of the earlier commentators.¹⁷

The principles and values these groups describe are based on the assumption that broad agreement exists on what is meant by equality, justice, liberty, and compassion. This assumption is simply wrong—debate about what they mean is vigorous among philosophers and scholars in the social sciences and humanities. For current purposes, though, the important feature of these ethical principles and values is that they are normative, that is, they impose obligations or duties that require enforcement of rules, laws, and regulations to compel compliance.

Flaws of central planning ethics

An important hidden assumption underlying the ethics of central planning is that the promotion of human well being is a legitimate concern of politics. There is a difference between recognizing that certain actions are desirable and mandating those actions by law. Legally compelling people to act for their own good requires justification, but philosophers and politicians who have advocated a central role for government in the provision of health care have not provided a convincing case. As I have argued, however, there is reason to doubt that a connection of desirable actions to legal compulsion can be made rationally.

This weakly grounded assumption has led to an unjustified insistence on normative, that is, prescriptive solutions to policy issues. Central planning disrupts nearly every aspect of self-directedness, thereby undermining the very human flourishing the planners want to advance. The arguments central planners offer to morally justify regulating the lives of others are flawed. A few examples follow.

Liberty is lost to those who lack health care insurance

Central planners claim that freedom is limited if health insurance is not available, so to protect liberty, everyone is entitled to health insurance.¹⁶ This idea fails to distinguish between limitations imposed by facts of reality and those arising from forceful interference by others.¹⁸ For example, when I lived in Boston for the first half of my life, I could choose among several of the best health care facilities in the world if I had a serious illness. I have

lived in Charleston, SC, for the second half of my life. Charleston has excellent hospitals and physicians, but to obtain health care, my choices are limited to a much narrower range than they were in Boston. Despite these differences, I have been equally free to choose among the available options in both places—my liberty rights have not been infringed. Conversely, the liberty rights of black Americans were violated when they were prohibited by Jim Crow laws from using certain facilities, such as doctor's offices, available only to whites, even though the law was on the side of segregation. Liberty rights are beyond the reach of positive law—they are unalienable. Government has the power to constrain liberty, but not the right.⁴ The concept of liberty is not complicated. It means the unimpeded exercise of choice among available options, no matter how limited or expansive those options may be. Contrary to central planners, those who do not have health care insurance have not been deprived of their liberty.⁹

A compassionate society must provide health care

Many central planners have argued that benevolence grounded in compassion is an important reason to have a centrally planned health care system. The American Medical Association's Ethical Force Program says, "The traditional value of compassion for the least fortunate among us demands attention to the well-known effects of inadequate access to health care on individuals and families ... A compassionate society cannot tolerate such avoidable suffering."¹⁷ Society doesn't have a brain and cannot think or feel—it is a metaphorical construct. Put simply, a compassionate society cannot exist—only thinking, feeling people can have compassion. But even if compassionate society is taken as a reality, the term still makes no sense. Coercing people into doing good deeds is not benevolence, yet government claims its health care programs exhibit benevolence while using its monopoly on the use of force to generate the taxes that fund such programs.

Truly charitable giving comes from individuals, churches, synagogues, foundations, and other private charities. They manifest compassion and benevolence because they donate freely.⁹ Government programs, to the contrary, compel compliance of those who provide the funds. The legislators, executives, and judges who constitute government misuse their power when they force on their citizens a particular vision of the values and virtues that comprise the good life, when instead they should be protecting the right of its citizens to develop their own virtues and pursue their own values.

Compassion and benevolence are important virtues, but they cannot be duties that entitle some to take the fruits of the productive time and effort of others, without their consent, to use for their own purposes.

Justice demands a fair share of goods and services for all

The claim that justice requires everyone to receive a fair share of goods and services is poorly grounded because widespread disagreement surrounds the meaning of the ideas of justice and fairness.¹⁹ Two of the many understandings of justice are justice as equality—all people equally deserve basic goods and services, regardless of their effort or accomplishments—and justice as reciprocity—hard-working, productive people deserve

what they've earned and it is unjust for those who are unproductive to benefit from the labor of others. Which of these approaches is more consistent with our nation's culture?

A Pew Foundation international poll asked which was more important—that everyone be free to pursue their life's goals without interference from government, or that government should play an active role in society to guarantee that no one is in need²⁰ (Fig. 3). A significant majority in the US—58%—favored freedom, the opposite of the result in other developed countries and regions of the world,²¹ in which the majority favored government support. Since Colonial times, emphasis on individual freedom had been a persistent characteristic of our culture.

Health care exceptionalism

Perhaps the most common argument in support of the collectivization of health care is that the need for health care is categorically different from all other areas of human activity, even basic needs, such as food, clothing, and shelter.²² The idea of health care exceptionalism is based mostly on moral intuitions—it just feels as though health care is more important than almost anything else—but moral intuitions are, at best, an unreliable source of moral guidance.²³

Two misunderstandings underlie the idea of health care exceptionalism: first, an unreasonably restrictive view of what it means to be healthy and second, conflation of health and health care.²⁴ Many different activities contribute to health, including the choice of a proper diet, routine exercise, and avoiding dangerous activities such as drinking too much alcohol or driving too fast. Less obvious contributors to health are stress-reducing activities such as performing or listening to music and achieving an appropriate balance between work and play.

For most people, health care is a minor component of health. Achieving a proper balance of all the activities that lead to good health is highly individualized in light of individual talents and abilities, so each person needs the freedom to determine how best to use personal time and limited resources to gain and maintain good health.

If “health” were a positive right, that is, an entitlement, as claimed by many central planners, then legislators have a duty to enforce that right by ensuring access not only to the minor factor of health care, but to everything else that contributes to good health, such as properly chosen diet and exercise facilities for maintenance of physical fitness. It should be clear that such a role for government is inconsistent with the notion of a free society, so if we believe that we have a free society, we cannot accept the idea of a positive right to health or to health care.

THE POWER OF ECONOMIC FREEDOM

The idea that freedom to live their own lives is beneficial for individuals and for society is supported by good empirical evidence. The ethical principle of noninterference is realized economically in the form of free markets, which, in turn, are the clearest expression of economic freedom. Some of the best evidence for the power of liberty to advance human

welfare is found in the relations between economic freedom, economic growth, and human happiness.

Economic freedom in 141 countries has been analyzed using 42 variables in 5 broad areas. National economies grow faster with increasing amounts of economic freedom²⁵ (Fig. 4). Life expectancy increases; it is about 20 years longer in countries with the most economic freedom than in those with the least (Fig. 5). Literacy increases with increasing economic freedom, especially among women (Fig. 6). More economic freedom is associated with substantially greater per-capita incomes (Fig. 7). Extreme poverty is inversely related to economic freedom—its lowest incidence is seen when economic freedom is greatest (Fig. 8).

Human happiness can be measured and is associated with about 50% genetic variance.²⁶ It is interesting, therefore, that a separate analysis using world economic freedom data along with several previously published instruments for measuring happiness, a nearly linear relationship was found between economic freedom and human happiness²⁷ (Fig. 9). If happiness can be taken as a measure of human flourishing, then these data support the proposition that freedom is a key constituent of human flourishing.

IMPLICATIONS FOR HEALTH CARE REFORM

Legislators do not have expertise in the wide range of problems they are called on to repair, so they rely on groups of experts to develop policies addressing the problems. The critical difference between experts in the private sector and experts in government is that governments have monopoly power that is ultimately backed by force, so government experts do not face the competitive pressures that constrain those in the private sector. In order to prosper, private organizations must satisfy the needs of their customers, because if they do not, customers can simply walk away and find services elsewhere—not so for experts whose policies are ultimately backed by law enforcement agencies.

Federal regulations have the force of law—they are referred to as administrative law. As of 2009, the Code of Federal Regulations contained 163,333 pages. In 2009 alone, 3,503 new rules were added.²⁸ Compliance with these regulations costs the nation's productive sectors more than \$1 thousand billion (\$1 trillion) per year.²⁹ The justification for this crushing mountain of regulation is that external controls are required to correct market failures, yet those who argue for that need almost always fail to consider the problem of government failures, of which our health care system is a good example.

Origins of our health care system

In the late 19th century, most sick people were treated at home and only the sickest went to hospitals. The increasing use of hospitals in the early 20th century led to prepayment plans, originally at Baylor University Hospital in 1929, then Blue Cross and Blue Shield in the early 1930s.³⁰

In the mid-1930s, Blue Cross gained exemption from insurance regulations in exchange for charging lower rates than commercial insurance and insuring all comers. Soon, hospital

services were reimbursed for their operating costs plus a percentage of the hospital's capital, known as cost-plus reimbursement.³¹

Perversely, hospitals could prosper best not by the usually effective method of decreasing their costs but by increasing their costs and expanding services and facilities unrelated to demand for them. Perverse incentives were also firmly implanted in patients, who cared little about the prices that were paid on their behalf, because they paid only a very small percentage out-of-pocket. The fundamental problem of our health care financing system today has never been properly addressed by previous attempts at reform. The basic problem is this: because patients pay only 10 cents out-of-pocket on every dollar spent for their health care choices, they buy health care at a 90% discount, so, unlike their behavior in nearly all other areas of economic life, people are not prudent buyers of health care because they do not have the perception that they are spending their own money. Why buy a Kia when for only a few dollars more—a mere 10% of the actual price difference—you can be driving a Lexus? The perception of health care at 90% discount is responsible for much of the uncontrolled inflation of health care costs of the last 50 years. We were led into this situation a step at a time by failures of government policy.

After the Blues solidly established prepayment for health care in the 1930s, wage and price controls during the World War II forced employers to attract workers they needed by offering noncash benefits, specifically, health insurance; the Internal Revenue Service ruled that health insurance was deductible when purchased by employers, but not deductible when purchased by individuals.³² Employer-based health insurance became an enormous tax dodge for both employers and employees. By 1947, these inequities were solidly in place and positioned to lead our health care system incrementally into its current state.

Those unsound policies led to a series of laws to attempt repair of the damage they produced. Medicare and Medicaid, in 1965, built on the deeply flawed, inflationary system already in place. The politically unpalatable but inevitable massive increases in health care costs spawned by Medicare and Medicaid led to the Health Maintenance Organization Act of 1973; the National Health Planning and Resources Development Act of 1974; the Tax Equity and Fiscal Responsibility Act of 1982; the Health Insurance Portability and Accountability Act in 1994; the Medicare Reform Act of 2004; and, most recently, the ACA (Fig. 10). All these expertly designed programs at the federal and state level have failed to achieve their main objective—cost control—while creating hundreds of thousands of pages of federal regulations and enormous amounts of mandatory paperwork that increase the cost of health care, making health insurance too expensive for millions of Americans. Worse, these programs have created a dangerously intrusive bureaucracy.

Friedrich von Hayek, a Nobel Laureate in economics, showed that prices in a free market are critically important and arise from perceptions and preferences of a very large number of individuals. No expert or group of experts can possibly acquire the price information needed to allocate resources correctly, so central planning by experts will eventually fail.³³

One of the leading economists of the 20th century, Ludwig von Mises, argued that a centrally planned system could never succeed in the long run because the planners have no

way to allocate resources efficiently.³⁴ Without the price fluctuations driven by supply and demand in a free market, central planners cannot know where resources are needed most, resulting inevitably in either shortages or overproduction of some goods and services. The resulting problems motivate laws and regulations attempting correction, which lead to new unanticipated adverse consequences, attempted correction of the new problems, and so forth, in a downward spiral, which is precisely what we've seen in our health care system (Fig. 10). Mises predicted that a centrally planned economy ultimately will collapse, a prediction that proved prescient when the socialist economies of Eastern Europe did in fact collapse in the late 1980s and 1990s.

The latest in the concatenation of policies attempting to control costs of health care by fixing the failed policies of the past is the ACA. The ACA was passed and signed into law in great haste as the Democrats were about to lose their supermajority in the Senate, so, it suffers from prodigious length (2,700 pages), Gordian complexity, and numerous internal contradictions that ensure it will be extensively revised well into the future. We can still hope for substantial improvement.

Studies by the Congressional Budget Office and actuaries for the Centers for Medicare and Medicaid Services show that the ACA's goals of universal insurance coverage and reduced cost will not be achieved.³⁵ The number of uninsured will drop about in half by 2020, but will leave about 23 million Americans still not covered (Fig. 11). The proportion of the gross domestic product (GDP) consumed by health care will actually be higher under the ACA (Fig. 12), and its cost from full implementation in 2014 through 2024 will be \$2.7 trillion.

The centerpiece of the ACA, its insurance purchase mandate, has been found unconstitutional by 2 of the 3 Circuit Courts of Appeals that have considered the issue, and the US Supreme Court has agreed to hear the case.³⁶ A decision is expected by the end of this term, in June 2012. There appears to be a reasonable chance the ACA will be found to be unconstitutional in part or in whole.

Whether or not the law is found to be unconstitutional, Congress has the opportunity now to undo some of the worst aspects of the ACA by replacing them with free market policies.

EFFECTIVE SYSTEMIC REFORMS

Through disregard of the principle of noninterference as it was embodied in the original US Constitution, faulty policies have reduced the financing of health care to a deplorable state. It has taken more than 70 years to reach our current condition, so a relatively free market in health care cannot be achieved quickly. Markets are not perfect, nor will they repair all the problems the health care system faces. The point is, however, that government failures have worse consequences than the market failures they aim to correct, and although markets are continuously self-correcting through what economist Joseph Schumpeter called "creative destruction,"³⁷ poorly conceived laws are rarely repealed—instead, they enter the spiral of legislative fixes that beget more failures and more losses of liberty, as we have already seen.

In the modern world, the surest way to solve problems is to encourage innovation, which is stimulated by competitive forces that work most effectively in a free market. Government can have an important role in health care by supporting market institutions and facilitating innovation, which is the engine for improvement of any system, as we in surgery know very well. Some specific policy ideas may indicate some of the ways government can help repair decades of damage.

Free market reforms: a few suggestions

To encourage innovation in health insurance, Congress should reform the inequitable tax system so that individuals get the same tax deduction as employers.³¹ Legislators should increase innovation through competition by allowing purchase of health insurance across state lines, as is possible for nearly everything else in this country.³⁸ They should repeal forced purchase of unwanted benefits, so-called mandated benefits, under many state laws.³⁹ When the innovation that comes from competition drives costs down, health insurance will become affordable for a large number of those currently uninsured.⁴⁰

To encourage innovation in the provision of care, legislators should deregulate the health care sector to further increase healthy competition, such as doing away with certificate of need laws.³⁸ They can support development of high-quality, accurate outcomes data to help patients and their advisors in making health care decisions, for example, through tax breaks for developers of sophisticated risk-adjusted databases.

Congress should reform Medicare by instituting a means test for Part A, so that ordinary workers do not have to pay for Warren Buffet's health care.⁴¹ It should give participating seniors vouchers that will work like food stamps in a grocery store—participants will have the same range of choices in the health insurance market as every other American, thereby strengthening the market. The size of the voucher should be adjusted according to the health status and financial resources of the enrollee.⁴²

Many other reforms can also help to move us away from ineffective, ultimately harmful central planning for health care, toward a more effective, beneficial, and morally appropriate market system. A national health care policy guided by the ethical principle of noninterference will free the health care market from burdensome and expensive regulation, allowing physicians and surgeons to keep our professional activities fully focused on our proper objective, care of and caring for our patients.

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Figure 1.

Human goods: constituents of a flourishing life. Everyone needs certain goods to realize the potentials for their own lives; several are depicted in the generic pie graph. Each person has unique talents and abilities arising from genetic composition and environmental experiences, and must use his or her personal judgment in allocating time and resources to achieve a flourishing life.

Figure 2.

Legal systems: control of an individual's life activities. The locus of control of life activities can be internal (individual liberty) or external (coercive control by others). In highly regimented social orders, such as the People's Republic of China, one's personal choices are markedly restricted; in liberal social orders, such as the US, the areas for unimpeded choice are much more numerous. In a metanormative social order, the only constraints on liberty lie on the border, where one's actions affect others.

Figure 3.

Pew Global Attitudes Project. This global survey asked the following question: “What’s more important in (survey country) society – that everyone be free to pursue their life’s goals without interference from the (state or government) OR that the (state or government) play an active role in society so as to guarantee that nobody is in need?” Responses in the US were different from those in other developed countries and regions:²¹ a substantial majority in the US favored freedom, unlike in Japan, Canada, East Europe, and West Europe (Australia and New Zealand were not included in the survey).²⁰ (Data derived from The Pew Research Center for the People & the Press. Pew Global Attitudes Project 44-Nation Major Survey (2002). Question 34. 2002:T44.) Blue bar, freedom; red bar, government support; green bar, no answer.

Figure 4.

Economic freedom and economic growth. Economic growth is linearly related to economic freedom.²⁵ (Reprinted from: Gwartney J, Lawson R, Hall J. Economic Freedom of the World: 2011 Annual Report. Vancouver, BC: Fraser Institute; 2011, with permission.)

Figure 5.

Economic freedom and life expectancy. Life expectancy is linearly related to economic freedom.²⁵ (Reprinted from: Gwartney J, Lawson R, Hall J. Economic Freedom of the World: 2011 Annual Report. Vancouver, BC: Fraser Institute; 2011, with permission.)

Figure 6. Economic freedom and literacy. Literacy is linearly related to economic freedom, and the greatest increase is among women.²⁵ (Reprinted from: Gwartney J, Lawson R, Hall J. Economic Freedom of the World: 2011 Annual Report. Vancouver, BC: Fraser Institute; 2011, with permission.) Purple bar, women; blue bar, men.

Figure 7.

Economic freedom and income per capita. Income per capita is linearly related to economic freedom.²⁵ (Reprinted from: Gwartney J, Lawson R, Hall J. Economic Freedom of the World: 2011 Annual Report. Vancouver, BC: Fraser Institute; 2011, with permission.)

Figure 8.

Economic freedom and poverty. Poverty is inversely related to economic freedom.²⁵

(Reprinted from: Gwartney J, Lawson R, Hall J. Economic Freedom of the World: 2011 Annual Report. Vancouver, BC: Fraser Institute; 2011, with permission.)

Figure 9.

Economic freedom and happiness. Happiness is linearly related to economic freedom.²⁷

(Reprinted from: Gropper DM, Lawson RA, Thorne JT. Economic freedom and happiness. *Cato J* 2011; 31:237–255, with permission.)

Prepaid Health Insurance 1930s
NWLB: HI exempt from wage controls 1940s
IRS: HI deductible for employers 1940s

Figure 10.

Successive laws for cost control. The foundation for our employer-based health insurance system was laid in the 1930s and 1940s by the development of prepayment for health insurance and key decisions by the NWLB and the IRS. Attempts were made by a series of laws to control the resulting hyperinflation of health care costs; none provided more than temporary relief from health care cost inflation.^{30,32} ACA, Patient Protection and Affordable Care Act; HI, health insurance; HIPAA, Health Insurance Portability and Accountability Act; HMO, Health Maintenance Organization Act; IRS, Internal Revenue Service; M/M,

Medicare and Medicaid; MRA, Medicare Reform Act; NHPRD, National Health Planning and Resources Development Act; NWLB, National War Labor Board; TEFRA, Tax Equity and Fiscal Responsibility Act.

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Figure 11.

Number of uninsured under the Patient Protection and Affordable Care Act (ACA).

Although the number of uninsured Americans will drop by more than half, 23 million will remain uninsured after the ACA has been fully implemented.³⁵ (Reprinted from: Tanner MG. Bad Medicine: A Guide to the Real Costs and Consequences of the New Health Care Law. Washington, DC: Cato Institute; 2011, with permission. Source: Letter from Douglas Elmendorf, director, Congressional Budget Office, to House Speaker Nancy Pelosi, March 20, 2010.)

Figure 12.

Estimated increases in national health expenditures under the ACA. A major goal of the ACA is cost control. According to the chief actuary of the Centers for Medicare and Medicaid Services, the proportion of GDP consumed by the health sector will be higher than it would have been without the new law.³⁵ (Reprinted from: Tanner MG. *Bad Medicine: A Guide to the Real Costs and Consequences of the New Health Care Law*. Washington, DC: Cato Institute; 2011, with permission. Source: Richard S Foster, chief actuary, Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Health Care Act,'" as amended, April 22, 2010.) ACA, Affordable Care Act; GDP, Gross Domestic Product. Dotted line, current law; solid line, under ACA.