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The provision of Healthcare in the United States before and after the introduction of the Affordable Care Act

A comparative institutional analysis of OECD countries

Supervisor
Ch. Prof. Vania Brino

Graduand
Giulia Brunello
Matricular number 878891

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A mamma e papà,
a cui devo tutto.

A Marco,
la mia roccia.

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INTRODUCTION

2020's global COVID- 19 pandemic has shaken to the core the already complex geopolitical, economic, and social context humanity has been living in for decades. It is indisputable the pandemic's role in changing the way the world is organized, putting under scrutiny many axioms of our reality and the complex systems created to protect people. Healthcare is for sure one of them. The strain the pandemic has put on our healthcare systems in all countries has caused profound re-evaluation about the way these systems cope with more and more fragile contexts, characterized by a high demand for healthcare services and lack of personnel and resources to actually satisfy this demand. To complicate the picture, the booming population and the increase of life quality have stressed the importance of finding new efficiency in welfare policies. People are becoming older and older, causing welfare states to sustain exponentially increasing costs that have important implications on the quality of services provided and structures' accessibility.

This thesis aims to shed light on these aspects that are of great concern for humanity's well-being, analyzing the impact of several factors on different healthcare systems, and understanding what the implication of these issues in the next future could be like.

In the first chapter, I will analyze the role public welfare will assume in aging economies, providing a definition of the concept, and clarifying which aspects are included in this broad notion. As a matter of fact, welfare programs not only include the healthcare aspect, but also many other protections offered to the individuals to increase the quality of their lives, including retirement policies, subsidies to families, unemployment safety nets, and social inclusivity programs. Many studies conducted on welfare

states have tried to outline a picture to categorize the different models used in all states: the most diffused one is that of Esping - Andersen, which will be discussed to provide the basis of further analysis. Moreover, I will give a synthetic but hopefully thorough overview about basic principles that are funding the rationale for the existence of welfare, providing a general framework that can be applied to all welfare states. Finally, I will conclude the chapter with some reflections on the future of welfare states, and what could be the possible natural development of welfare programs in the following years.

In the second chapter, I will shift the focus on healthcare systems, particularly on the US example, which I consider of great importance, not only for its peculiarity compared to others, but also because it has received lots of attention in the last ten years, following its recent reformation. I will first outline some basic principles in US healthcare, which I believe are helpful to provide a basic rationale to understand the foundations of the modern system's configuration. Secondly, I will focus on healthcare reform, by synthesizing the crucial steps undertaken by the different administrations that have conducted to the current healthcare system. This historical-evolutionary analysis will be helpful to develop further considerations on how the system has evolved throughout time and why it is constructed in this way also nowadays. Moreover, I will also touch on the topic of healthcare law, since the United States' health sector is one of the most heavily regulated industries in the world. I will try to emphasize the milestones that have brought to the modern US healthcare system, focusing on key legislation such as the Sherman Act (1890), the Clayton Act (1914), the Hart-Scott-Rodino Antitrust Improvement Act (1976) to culminate with the Patients' Bill of Rights (1990), which outlines the funding principles for the healthcare protection of patients. In paragraph 2.4, I will outline which are the actors involved in the system: it is an interesting topic to discuss, since understanding the key players of the US healthcare system outlines clearly

the complexity and peculiarity of this model. As a matter of fact, not only hospitals and policymakers are key to the success of the system, but also the role played by private insurance companies is crucial for its functioning. The final part of the chapter will analyze thoroughly the governmental programs that were set up by the US federal government to help needy citizens who cannot afford to buy assurance from private actors. These programs are *Medicare (*title XVIII of Social Security Act), mostly dedicated to people over the age of 65 or entitled to social security benefits, and *Medicaid* (Title XIX of the Social Security Act), destined to indigent people, who cannot afford to buy insurance themselves.

The third chapter will enter into the core topic of the paper: the Patient Protection and Affordable Care Act (PPACA), also called the Affordable Care Act (ACA) or simply *Obamacare*, after its promoter. This act of 2010 is considered one of the milestones of the modern US healthcare system because it tried to increase the coverage among US citizens by enlarging the parameters to get access to governmental programs. After having stated the goals of the ACA, I will turn to the structure and content of the act and its titles. Then, I will proceed with the clarification of controversial aspects that brought to the request of constitutionality after the cases *Florida v. Sebelius*, *King v. Burwell,* and the more recent *California v. Texas* and I will focus on the different evaluations of the act, according to scholars and public opinion. The chapter will also analyze the changes to the ACA brought by Trump's administration and the prospects that can be configured with the newly elected President Joe Biden. To conclude the chapter, I will provide an overall evaluation of the US healthcare system, using the so-called *Iron Triangle of Healthcare*, developed by Kissick (1994) to create a framework helpful to provide a common standard to rate healthcare systems based on three dimensions: cost containment, access, and quality.

The last chapter will be dedicated to a comparative analysis of healthcare systems around the world. I will utilize the comparative institutional

approach used by Professor Nadine Reibling to guide the reader through the complex and varied healthcare systems that characterize different states across the world, concentrating on key examples, such as, Germany, Italy, Hungary, and Japan. The paper will end up trying to answer the questions that all governments and policymakers are posing: *Are there rules that should be applied everywhere? Is there one best way that everybody should implement?* I will provide an opinion on the issue, giving evidence to the impossibility of setting up a common rulebook applicable in all countries, given the peculiarity of each environment and funding principles on which these systems are based.

CHAPTER 1 - PUBLIC WELFARE IN AGING ECONOMIES

This chapter will be dedicated to identifying the key important features of welfare states, to propose to the reader a comprehensive framework in which to construct the analysis of different health care systems across the world, with particular attention to the US case study. Welfare states emerged when policies of *laissez-faire* were overcome: before that, the market seemed to absolve the role of regulator, abolishing all forms of inequality, class, and privilege. Adam Smith - the ancestor of this idea – believed that:

"*Aside from a necessary minimum, state intervention would only stifle the equalizing process of competitive exchange and create monopolies, protectionism, and inefficiency: the state upholds class; the market can potentially undo class society.*"
{Smith, 1961, II, esp. pp. 232--6}.

However, in the 20th century, the passive *laissez-faire* was rejected by almost all states, signaling the start of a new era, characterized by a new role of the public, devoted to the active help of the population through policies and measures to sustain the needs of the most poverty-stricken. History is full of examples of this paradigm shift: Franklin D. Roosevelt and his "New Deal" to save the US after the Great Depression of 1929 is just the most noteworthy embodiment of a new conception of governmental help that was offered to defend the wellbeing of the community. This rapid, yet inexhaustive, historical overview of the evolution of the role of the State is crucial to provide a basic ground for the existence and the prominence that welfare policies have assumed nowadays. As a matter of fact, as noted by Esping-Andersen in his most

successful book "The three worlds of capitalism" (1990), "*To study the welfare state is, therefore, a means to understand a novel phenomenon in the history of capitalist societies*" and separating it from their evolution is impractical.

It is therefore the goal of this chapter not only to define what welfare state means and which are the models and principles that move its existence but also to encapsulate welfare in a broader context that encompasses different themes, such as religion and politics, that concurred to the development and evolution of welfare societies.

To conclude this first introductory part, I will try to give a possible prospect for welfare states, that are now living a moment of deadlock. COVID-19 pandemic has worsened the situation, by putting even more pressure on systems that were already buried in economic difficulties. Taking Italy as a reference case, we all remember the problems encountered by INPS[1] in releasing layoffs for a huge part of the population who was at home due to COVID restrictions and firms' shutdowns. In particular, INPS bureaucracy and structural heaviness prevented a fast granting of subsidies, unleashing citizens' anger[2]. Moreover, INPS has been questioned for its (in)capacity to be solvent throughout time, since the population is aging, and the resources required will increment more and more with time. *Will it be able to absolve its role in the future? Will the current forms of sustenance be granted also to future generations?* We will speculate on all those issues in paragraph 1.4, by emphasizing which are the key steps to undertake to realize a model of welfare that addresses these new issues.

[1] INPS is the acronym for "Istituto nazionale della previdenza sociale", in English "National Institute for social protection". It was born in 1898 and it is still active nowadays. The institution is left in charge of granting economic support to employee work and to supply retirement pensions and funds to the most indigent part of the population.

[2] Melis, V. (2020). *Coronavirus, nuova Cig dal 16 novembre ma ancora a rischio di ritardi 526mila lavoratori*. Il Sole e 24 Ore.

1.1 Definitions and models

The welfare state can be defined as the system of social measures ensured by the government to protect its most indigent citizens from poverty, disease, hunger, social and work exclusion by enacting state actions to monetary support them or by ensuring their independence through assistance and services. Maurizio Ferrara's definition of welfare[3] seems the most complete since it encompasses different basic principles of welfare. In his words, the welfare state is:

"(…) the system of public policies connected with the modernization process, through which the State supplies to its citizens protection against pre-established risks and needs, in the form of assistance, insurance or social protection, introducing specific social rights and financial contribution duties".

Another definition of a welfare state was provided by Briggs (1961), stating that:

"A 'Welfare State' is a state in which organized power is deliberately used (through policies and administration) to modify the play of market forces in at least three directions — first, by guaranteeing individuals and families a minimum income irrespective of the market value of their property; second by narrowing the extent of insecurity by enabling individuals and families to meet certain 'social contingencies' (for example, sickness, old age, and unemployment) which lead otherwise to individual and family crises; and third by ensuring that all citizens without distinction of status or class are offered the best standards available concerning a certain agreed range of social services."
(Briggs, 1961)

[3] From Ferrera M. (2006) *Le politiche sociali. L'Italia in prospettiva comparata*, Il Mulino. Cited in Vogliotti, Vattai (2014)

Many other definitions could be provided to the reader to frame the concept of the welfare state. Each of these definitions, though, mark some characteristic traits of welfare that can be summed up to claim that: a) the State is the central agent of welfare since it provides the minimum standards and the consequent benefits to the population that needs them; b) financial contributions are required, since the State cannot, on its own, provide care to all the individuals; c) the State uses different forms of support and involves different other actors in the challenge, which, as we will see below, absolve a role that is becoming more and more crucial in modern welfare societies; d) benefits highly depend on "contingencies", such as sickness, old age, and unemployment.

After having provided some key features of welfare, it is useful to know how welfare evolved throughout time and which are the models that States across the world used to provide it to the population. Vogliotti and Vattai (2012) identified four steps that conducted to the institutionalization of welfare states that we know nowadays. The first phase is called by the author "Experimentation": it includes the period right before the First World War (1870-1914 ca.) when the first national laws were formulated to support the neediest citizens. They were based on the famous English "Poor laws", created in the Victorian Age through the forms of workhouses, to help the population to get out of the streets and contribute to the welfare of the city by working in these facilities. It is well known, though, the failure of these policies in Victorian England, where workhouses, rather than being a safety net for the poor, were places of exploitation, scarce hygiene, and poor living. In Italy, like in other countries, however, "poor laws" were decisive, since they offered the first path to be followed to construct some models of welfare that could help people to socially thrive. This period is characterized by party unity since all parties were involved in creating welfare policies. The experimentation phase concluded with WWI, which stopped the advancement of certain programs and postponed their formulation.

The second phase identified by the authors is the "consolidation" of welfare programs. After WWI, welfare programs became more solid and structured, fostered by the new Keynesian doctrine, that supported the active role of the State in helping the population getting out of their unemployment status, even if that signifies compromising the State budget. Accepting Keynes' paradigm meant enlarging the part of the population who could benefit from the help of the government. As a matter of fact, before that period, welfare policies were addressed just to the working class, whereas now they are considered as useful instruments that could be helpful for a larger portion of the population – the so-called "deserving poor".

The following phase is "Expansion", which ended in the 1980s: this period is characterized by the increasing relevance of welfare programs in the public expense that followed the Second World War. The war was critical to contribute to the expansion of welfare since all Western states wanted to overcome the insecurity, devastation, and social discomfort triggered by the armed conflict of the 1940s. Even though welfare policies became dominant in the political and social context, the premises in which all these programs were based were far from the initial goals for which were thought by their creators: as a matter of fact, families were becoming more and more isolated from the community, and the continuous growth of the economies of the 1960s and 1970s produced a domino set of claims by all the classes that were the promoters of this economical change of pace. Welfare benefits, thus, became social compensations to all the individuals that needed them, in a situation that the authors call "fragmented endowment". This compromised the following policies since the budget of the State was put under pressure by the ever-increasing demands of the classes.

The fourth and last phase was the period of the "Institutionalization", the Golden Age of welfare policies, that meant a wider coverage of the population and intensive use of public indebtedness. It was characterized by a new role of women, that began to cover a dual figure (mother-worker), enlarging the market, and fostering new reforms to support this double presence. For this reason, new

reforms and laws were promoted in the attempt to protect their condition (i.e., in Italy, L. 1204/1971 on the legal protection of the working mother). This last period, that ended in the 1990s, was the premise to the following decades, characterized by problems of economic sustainability of the system, that had now assumed vast proportions that were not only difficult to sustain from an economic side but that also compromised the future of following generations to receive basic support. This is why scholars and policymakers start to talk about "the crisis of welfare state", emphasizing the criticalities that emerged and that are still now a threat to the continuity of the system. I will further debate on this issue in the last paragraph of the chapter, emphasizing which are now the current problems that governments need to face, and which are the new frontiers to address. For now, we continue our analysis talking about the models of welfare that different states adopted throughout the years: this framework is useful to denote the situations that different governments are now living in, and why the current issues are pressing for certain states more than for others.

Literature has contributed to the debate on welfare states by providing the theoretical grounds to start a broader discussion on the models adopted by governments in the regards to social protection. Scholars have identified two archetypes that seem to be the basic foundations of the modern classification of welfare states: the occupational model, also called the Bismarckian welfare state, and the universalistic model, known as the Beveridgian model. Both of these systems were born by the ideas of two great personalities of the end of the 19th– beginning of the 20th century. Otto von Bismarck was the German Chancellor that enacted the first social security system of the world, who set the path for all the other states. His ideas are founded on the principle of ensuring a certain standard of living for the population, by considering vulnerabilities as risks. People, therefore, need to insure themselves against those risks in a collective form, using the State as a regulator. To ensure the continuity of the system, citizens are asked to contribute, according to their possessed income. This was the welfare model that paved the way in Continental Europe for the introduction of new

policies to protect the population. The second model of welfare was ideated by William Henry Beveridge, an English sociologistic and economist, who wrote a famous report on "Social insurance and allied Services", better known as "Beveridge Report". This document was fundamental for the creation of welfare states in Anglo-Saxon countries as well as in Sweden, Norway, Denmark, and Finland and was based on the principles of universal protection: Beveridge wanted to ensure coverage for the majority of the population, by allowing generous and egalitarian policies. Beveridge believed in a comprehensive and universal system, available to everybody in the same form and extent and able to cover all the problems of poverty and danger for individuals. He also supported a non-means-tested system, viable to all the population. However, he also talked for the first time about contributions: all the citizens, to receive the support of the State, must contribute with their resources to ensure the functioning of the system, and these contributions were based on the wage (social contributions). The main difference with the Bismarckian model was that the Beveridgian one was mostly financed with the state budget and only partially with social contributions.

Both these original models paved the way for other scholars to enact their classification of welfare states, according to different indicators: the most successful representation of welfare regimes was provided by Gøsta Esping-Andersen in 1990. He was able to identify three main categories according to the recipients, the level of services provided, the sources of financing, and the main agent of the system: the result was the constitution of the Liberal, Conservative and Social Democratic models. Esping-Andersen's categories were further integrated by the contribution of Maurizio Ferrara (1996) who added a fourth category: the Mediterranean welfare state. We start discussing them.

The Liberal model of welfare is based on the Beveridgian tradition: it is constructed on the ideas of providing some instruments to reduce poverty and to reduce the evils of society, such as social exclusion. The means through which states want to achieve those goals are social assistance programs, mostly

addressed to specific categories of needy individuals. Therefore, these are not universal plans destined to all the population, but rather efforts to reduce inequalities by allowing poor citizens to receive help to achieve a minimum standard of living. To understand which are the eligible candidates, the government enacts the so-called "means testing", that are ways to test which are the financial possibilities of the recipients, who need to provide proof of their state of need. These tests are required to access the system and to get governmental help: therefore, the population entitled to receive benefits is mostly low-income, usually coming from the working class. The strictness of the rules along with the modest benefits provided to the individuals encourages the population to adopt private welfare schemes and private insurance programs. The market is, thus, the main agent, since it provides coverage to whoever decides to subscribe to an insurance policy: the state's help can be therefore considered residual and destined to those who cannot afford to pay for private protection. The sources of financing are coming from both social contributions, which mostly support monetary inducements and taxation, who mostly pays for healthcare. This model is mainly diffused in Anglo-Saxon countries such as the United Kingdom, Ireland, New Zealand, Australia, and the United States.

The second model of welfare is the conservative/corporatist one, and it comes from the Bismarckian tradition. In this regime, the link with the labor market is strong, since it gives more privileges to workers. As Esping-Andersen (1990) notes, "*rights are attached to class and status*", rather than to a situation of need. Programs are therefore fragmented and strictly connected to the working position: the State intervenes mostly when the working stability is compromised (i.e., unemployment), by ensuring support. The most important actor of the system is the family along with the State, which grants subsidies only when the family is unable to ensure a decent standard of living. The system affordability is given by social contributions coming from workers, and partially by taxation. Conservatism happens mostly in Germany, France, Austria, and Holland.

The third model identified by Esping-Andersen is the Social Democratic, used in Nordic Countries like Sweden, Denmark, and Norway. It is based on Beveridgian principles of universalism, since it addresses indistinctively to all individuals, to provide the highest standards to all the population. The citizen is the central recipient of benefits, and the State grants him all the services required for his/her wellbeing. Means testing is not employed, given that everybody can get access to the system. However, benefits are provided according to the accustomed earnings. The system is mostly financed through taxes, and it is moved by the principles of equality and proactivity, by anticipating the possible situation of need rather than giving help when the family has lost economic independence.

The final category of welfare states was described, as mentioned above, by Maurizio Ferrara, who decided to discern the Mediterranean countries (i.e., Italy, Spain, Greece) from the rest of the Continent (that have a corporatist model), since, in his opinion, they have distinctive traits and characteristics that cannot be ignored. These countries have a model of welfare that is revolving around the concept of family which is the primary source of assistance to its components. The State has therefore a residual role and leaves to this institution the work of providing care to the individuals. Programs are fragmented and there is an accentuated form of political clientelism, that is considered by Ferrara (1996) one of the "original sins" of this model. Benefits are, in this view, forms of achieving political consensus, granted to the classes that can, in exchange, give their vote to the party.

The role of politics is seen as crucial for the development of certain welfare policies in the respect of others and the parties can shape directly the form that welfare states can assume throughout history. This view is also shared by Lynch (2006), who underlines how politics has assumed a significant role in welfare regimes by creating a circle of path dependency in which political parties of the past have paved the way, positively or negatively, to the development of modern welfare states. In Italy, for instance, what Lynch calls "particularistic

politics", compromised the ability to create universalistic policies, and instead constructed fragmented programs, highly elderly-oriented. Instead, in other countries, especially in the North of Europe (i.e., Sweden), a more programmatic approach to welfare allowed to achieve a broader and higher-level coverage, more youth-oriented and universal.

In addition to politics, also religion played a significant role in the development of welfare states across the world. Bassi (2012) claims that religion influenced the development of welfare from both a cultural and institutional point of view. In the former, religion and the role of the Church created a set of values that paved the way to the development of welfare programs, according to those values. These principles were included in the norms and precepts of the religious doctrine, in the services managed by the religious community, and in the political parties inspired by the religious values. In the latter case, the fact that the population was fragmented under different religious denominations or unified under the same religion defined the division of work between the public administration and other actors of the society, like the so-called Third Sector (i.e., non-profit organizations, cooperatives). In the example proposed by the author, in Germany and Holland, the population worshipped different religions, and this created a large set of non-profit actors to support them in addition to the State, while in other countries, like Italy and Sweden, the fact of having one strongly diffused religion caused the creation of one strong welfare actor. This depended mostly on the relationships between the State and the religious institutions, that set the path for certain policies to be adopted by the highest institutions of the country.

It is therefore clear that in addition to variables such as the force of the labor movements, the division in classes, the level of industrialization, and the composition of the legal system[4], also religion and politics have contributed to models of welfare that we know nowadays.

[4] Manow Philip (2002), *The Good, the Bad, and the Ugly.* Cited in Bassi (2012).

1.2. Principles of welfare states

As we have seen so far, different models of welfare are moved by different principles: some of them are keener on assuring citizens when their economic independence is put at risk (i.e., Bismarckian models), while other models are more concentrated on providing universal and high standard universal protection (i.e., Beveridgian models). However, even different regimes have characteristic traits in common, especially when addressing the basic foundation of their existence.

We can retrace three pillars that are at the basis of each welfare state of the world: solidarity, equality of opportunity along with the equal distribution of wealth, and public responsibility. The first one, solidarity, is important for welfare states because it emphasizes the crucial role of individuals in mutually support each other creating a web of assistance for all those in a state of need. It helps to build unity and wellbeing on the assumption that everyone is contributing to the creation of such support. Solidarity is a value that is also promoted in the Italian Constitution in article 2: in particular, it is clearly emphasized the role of the Republic in recognizing and granting to everybody duties of social, economic, and political solidarity that are considered "inalienable". This means that such duties cannot be derogated to others, and everybody is required from birth to accomplish them. Moreover, no citizen is excluded from them, and no one can refuse them since they are mandatory and required by law. The European Union also encourages solidarity: the Lisbon treaty emphasizes it in article 1bis, when it states the founding values for the Union, along with non-discrimination, tolerance, justice, and equality. Moreover, solidarity is also cited in article 2 (c.3) where it emerges clearly the importance of intergenerational and interstate solidarity, making this value central in the European debate.

The second pillar of welfare states is equality. Equality means not only providing equal opportunity among citizens in receiving care and support, but it means also providing the tools to allow an equal distribution of wealth among the society. Equality is therefore not necessarily considered only in absolute terms (i.e., giving everybody the same number of resources) but rather it is willing to pursue a redistribution of wealth that provides more support to those who require it more. Again, the Italian Constitution provides a guideline in this sense in article 3, when it claims at c.1 that every citizen has "equal social dignity" (s.c. *formal equality*). Moreover, at c.2 it clears that it is the goal of the Republic to remove the obstacles that impede the fulfillment of the actual equality (s.c. *substantial equality*). Also, in this case, the European legislation reinforces this principle, especially in Chapter 3 of the European Charter of Fundamental Rights, when equality is stated as a central goal to be accomplished by all member states.

Finally, the very last principle over which welfare states found their existence is public responsibility. The latter encounters the active role of States and governments to produce and provide the tools for the community to thrive. The Italian Constitution cites this value in many articles: art 31 emphasizes the role of the Republic in providing economic sustenance for the family (c.1), protecting motherhood, childhood, and youth (c.2.). In article 34, it supports education, by allowing everybody to get access to it (c.1.) and by providing families the necessary economic help to accomplish a complete formation path (c.3.). Finally, art 38 is the milestone for all measures related to labor assistance: at c.1. it states the right of work unable individuals to receive maintenance and support; at c.2, it gives citizens the rights to be ensured against disease, work injury, invalidity, old-age, and involuntary unemployment. Among the others, therefore, article 38 is the central rationale for all protective measures ensured by the State to its needy citizens, and thus being the bedrock of the Italian welfare state. To conclude, the Italian Constitution provides the grounds also for public responsibility in healthcare, by safeguarding health in the social interest of the

individual and the community, especially by providing free cures to the most indigent part of the population (Art. 32, c.1).

These were the basic funding grounds of welfare states and the principles on which many systems of social protections are based. In addition to these broad rationales, welfare states find other important common precepts in the guidelines provided by the European Economic and Social Committee (2015) that summed up some of them to create a common framework for the adoption of policies according to certain goals. These principles were revolving around the concepts of social protection and need, to assure support to whoever is currently living in a state of economic or social deprivation. To guarantee sufficient help, it is important that all systems priorly decide and determine the objectives of their action, to provide services and benefits proportionally and according to the state of need of each individual. These basic concepts are integrated by principles of solidarity and personal responsibility, guaranteeing fair treatment of each individual but advocating for their active participation in the system. Therefore, individuals are not passive actors at the mercy of states, but they are engaged in actively pursuing their wellbeing, being at the same time legally certain of the support of the institutions that surround them. It is, for this reason, of public interest to be transparent and to allow coordination among the different agents of the society, and this goal is left to states, that supply the tools to achieve these results. Finally, the aim of welfare should be to construct what is called a "level playing field", by defining rights and duties that are clear to citizens and make welfare as equal as possible in the way it selects, and attributes benefits.

1.3. What is included in welfare States?

Welfare states include a vast range of provisions supplied by the State to support its citizens. The sectors in which welfare regimes operate are multiple: the most

important are healthcare, social services, housing, education, and social security measures. In healthcare, we can encounter both personal health services (i.e., medical research), and public health provision (i.e., protection from viruses, mass inoculation, medical assistance, hospitalization…etc.). For what concerns social services, welfare states ensure protection to the weakest classes – children, elderly, disabled – in the forms of special benefits and help. For instance, care allowances are guaranteed to elderly individuals, along with reductions in the prescription charges; subsidies are granted to disabled citizens along with the support of rehabilitation services and families can receive monetary subsidies for newborn children, disabled children, and kindergarten contributions. In addition, social security measures are created to protect workers in case of maternity, sickness, unemployment, a decrease of family income, and retirement. In these cases, the state grants leave of absence to new mothers to take care of their children, leave of absence to sick employees along with medical support in case of work injuries, and finally retirement pensions to old workers who have paid their social contributions through their income and have matured certain seniority of service.

All these measures are for sure expensive for states: OECD statistics[5] on social spending indicate that in OECD countries 20% of the GDP is destined to social support. Percentages vary substantially across different countries: for instance, the United States spends around 18.8% of its GDP on social measures, while Italy spends more than 28% of its public revenues. However, examining the per-capita spending, the United States spends 10,785 dollars per capita, while Italy invests less – 10,542 dollars per capita. These controversial results indicate that these data say little about the efficacy of social measures in countries. More interesting is therefore to examine how different states invest these funds and which are the most expensive items of expenditure. Taking Italy as a reference case, OECD statistics indicate that it has the highest spending on

[5] Data are referred to the period that preceded COVID-19, since it is preferred to examine results without pandemic's distortions

pensions of all OECD countries: compared to the average of 7.7, Italy spends more than double (15.6). This data is said to be favored by demographics since Italy's population is composed of one of the highest percentages of over 65 in the world (Vogliotti & Vattai, 2012). For what concerns the healthcare expenditure, Italy is in line with the OECD average since it uses 8.7% of its GDP. This percentage refers to 2019: OECD data are not available for 2020 but healthcare expenditure is presumably higher due to the COVID-19 crisis. Interesting is to outline healthcare expenditure in the United States: it is the state that spends more for health services in OECD countries, but, as we will see in the next chapters, this huge mole of expense is destined only to restricted parts of the population, leaving the others uncovered. In terms of family expenses, Italy's percentage of GDP employed is once again in line with the OECD expenditure: however, if we consider the average per-capita spending, Italy spends only 329 euros, while the average European spending is 552 euros. (Vogliotti & Vattai, 2012). Finally, unemployment contributions are in Italy above OECD average, but far from countries, like Finland, Belgium, and Spain. Once again, surprising results are to be seen in the US, where unemployment spending is one of the lowest in OECD countries, being practically absent.

From what we have seen so far, it is evident that there are huge differences in the quantity and quality of the services provided by OECD countries, signaling the unequal treatment that citizens of different countries receive. In the first paragraph we have mentioned the importance of culture and the historical context in the development of welfare programs; now, instead, we have witnessed the different distribution of expenditure across the nations, clearly indicating that the role of the Public varies substantially depending on which area of welfare we want to examine.

Our analysis of what is included in welfare cannot exclude some remarks on how social spending is financed. There are different ways through which states get access to the necessary resources to finance these programs. The most important sources are social contributions, paid by the employer for the safety

of its employees (i.e., in case of unemployment, sickness, or old age retirement) and typical of the liberal, conservative and Mediterranean models. In addition, the State itself pays for social services through its state budget (i.e., taxation), and finally, a part of the expense is paid by the recipient himself through direct contributions or by paying for private insurance. Social contributions and State budget are, however, the most important sources of financing, since they cover the majority of the expenses. (Vogliotti & Vattai, 2012).

1.4. Open problems of the modern welfare state: the future of welfare programs

We have seen so far the evolution of different welfare models, who have now assumed maturity and huge proportions in terms of recipients and public resources spent by all governments to fund their activities. However, especially from the 1990s, some signs of failure have been witnessed in all welfare regimes: this decline has begun to put under scrutiny their efficacy and sustainability, starting a period called "the crisis of welfare states". In the effort to restore trust in welfare and to address the new needs of the population, welfare scholars have tried to elaborate new paradigms, that we now examine. To understand which are the new demands that welfare needs to cover, however, it is useful to start outlining which are the causes of this deterioration.

We can divide the factors that contributed to the downfall of welfare in different macro-areas: demographics, new social configurations, and new economical phenomena.

Starting with the demographical influences, the aging of the population is a key determinant of the crisis of welfare states. We are now living in a world that is becoming older and older: in 2020, the percentage of elderly people is reaching 9.3% of the total, and will presumably continue to grow, until reaching

16% in 2050[6]. To give the proportion, in 2020 more than 700 million people are now over 65, but this number is expected to double in less than thirty years[7]. From one side, the fact that the population is aging in this amount is a sign of wealth: it means that quality of life is improving, thanks also to social protection policies implemented in the past years. However, on the other side, it is undoubtable that this phenomenon puts heavy pressure on healthcare, strained by the number of people that need assistance. Moreover, we cannot forget the increasing expense states have to bear to provide retirement pensions, jeopardizing the state budget and presumably compromising the ability of future generations to receive the same treatment reserved to their ancestors. This problem is pressing for some countries more than others: the Western world is experiencing more troubles than the Eastern one, mainly because Western societies are generally witnessing a slowdown in birth rates, while in other Eastern states, such as India and China, the booming of the economy encouraged families to procreate. Among the countries that are mostly affected by the demographical issue, we can retrace Italy, as denoted by the recent ISTAT and Eurostat statistics released respectively in February and August 2020. Italy has the highest mean age of all Europe (45.7 years) and registered only more than four hundred thousand new births in 2019, the lowest rate in more than 150 years.[8] To explain to you why it is a problem for welfare's sustainability we can use the age dependency ratios, that are, as defined by the OECD, " *measures of the age structure of the population (that) relate the number of individuals that are likely to be "dependent" on the support of others for their daily living – youths and the elderly – to the number of those individuals who are capable of providing such support.".* For this analysis, it is important to consider the old-age dependency ratio, which relates the number of people aged 65 or more to the working population (from 15 to 64 years old) multiplied by 100. Put in other words, it is

[6] United Nations (2020). *World Population Ageing 2020 Highlights.* Department of Economic and Social Affairs
[7] Ibidem
[8] Giuffrida A. (2020) *COVID and climate of fear puts Italian birth rate at lowest since unification*. The Guardian

the number that indicates how many working individuals are needed to pay for the retirement pension of another (retired) person. The results of this analysis outline that there are just three people of working age for each over 65, entailing that the retirement plans are in serious jeopardy due to the lack of working force necessary to sustain the increasing number of elders. *Why did it happen?* If you are looking to find a simple reason to answer this question, the past decade of economic depression for sure aggravated an already serious situation. However, it was not the crisis *per sé* that triggered the demographical and consequent welfare emergency, but more importantly, a structural problem in which families and children were left in the background, with low support to motherhood and low assistance related to childhood. In the end, the favoring of the present in previous policies[9], instead of the long-term eye on the future, compromised dramatically the sustainable development of welfare states.

The second sphere of factors that compromised the well-functioning of welfare states pertains to the new social phenomena that were witnessed in all countries. The massive increase of percentages of employed women in the labor market with full-time jobs[10] makes it more difficult for families to conciliate household responsibilities with working commitment: this new state of the art highlights new problems that societies need to face. Firstly, childcare, which was previously managed mostly by the woman, needs now to be redistributed in the family, with new roles and new responsibilities, or it requires new external structures, such as kindergarten facilities and babysitters, to help in their management. The same can be said in the assistance of the most elderly ones, that as we have seen, are becoming an increasing percentage of the population. Women have less time to dedicate to them and therefore nursing homes are more and more employed by families. All these conditions had a strong effect

[9] In the 70s, huge concessions were given to employees pertaining to specific categories, that were allowed to retire, in some cases, with just 15 years of service - the so-called "Baby Pensioni".

[10] OECD statistics (2017) report an increase in the percentages of working women that spans from +10% to +20% in the period that goes from 1970 to 2016 with an OECD average of 11.43 percentage points. Just to provide the reader some examples, in 1970s' France the percentage of employed women was 39.42% while in 2016 it was 51.72%; in the US, it goes from 43.34% in the 70s to 56.80%; in Italy from 24.68% to 40.45% in 2016.

especially in the welfare systems of those countries revolving around Mediterranean models of welfare (and, with less strength, on conservative welfare models), since the main institution deputed to the assistance of the individuals – the family – was now redefining its role in the society. The State, by being the other main actor of the game, had to replace the position of families, taking the burden of the assistance of these categories of the population through new measures. This had a huge impact on the governmental budget and on the facilities destined to these aims because they were forced to augment their capacity rapidly, and with little resources.

This set of conditions is strictly connected with the overall economic situation that states are living in. The crisis of 2008 and the more recent COVID-19 pandemic underlined the inability of welfare states to support families and workers in the right way, being incapable of responding quickly and efficiently. Before COVID-19, globalization put under pressure low-skilled workers, since their jobs were relocated in countries in which work was less expensive. This produced unemployment and the so-called "social dumping", a condition in which many emerging countries lowered the protections for workers to attract investments. This "race-to-the-bottom" favored relocation of jobs in developing economies, triggering the unemployment crisis in Western countries, and putting welfare systems under stress. Coronavirus pandemic has slowed down globalization, but it has not erased the problems for welfare. Firstly, it has questioned the ability of the healthcare sector to support a sanitary crisis, putting strain on already overcharged systems. Furthermore, it has aggravated the issues of unemployment, showing that the threat to modern welfare states is not the new globalized world, but rather the welfare state's incapacity to respond quickly to the contemporary issues of the population. For instance – as we mentioned in the introduction of this chapter – INPS was unable to respond with timely actions to the needs of the population, being incapable of providing layoffs and contributions in time for families to benefit from them. Moreover, families living in poor conditions are becoming more and more and precariousness is a

serious threat to the ability of young adults to construct a solid life. The instability of the family is also reflecting on its incapacity to guarantee the wellbeing of its components since the risk of poverty and social exclusion is always at the door. Therefore, welfare states are required to start a new chapter, that takes into account these new challenges that the modern world is now presenting.

In light of these considerations, a new strategy is needed to improve the efficacy of welfare states and this needs to start from politics, which has to commit to a new approach. Welfare has traditionally been seen as an instrument to gain public consensus by allowing individuals to receive benefits for their private good. The focus was, therefore, to achieve individual wellbeing, even if that entailed compromising the ability of others to receive the same benefits. What we are desperately looking for, nowadays, is to construct more cohesiveness in welfare, by creating a system in which not just single classes receive benefits, but rather every individual can have the right opportunities to thrive, allowing the older ones to live a peaceful life. Now governments are required to overcome their traditional *modus operandi* and adopt instead a more collective approach, that considers the overall consequences of each policy, not only for the present but also for the future. In particular, we can refer to the concept of "intergenerational justice", which encapsulates the ability of a certain policy to be "just" in the respect of future incoming generations by not compromising their capacity to survive. All reform proposals should therefore be widely interconnected since the advancement in one part of the society can produce benefits to all the others. Believing in youth - like especially Nordic countries are doing - could be an excellent choice also for the elderly: as a matter of fact, fostering a more youth-oriented society could encourage motherhood, and the enlargement of families, allowing the welfare system to survive in the long term, thanks to the new individuals who can enter the labor market and contribute with their work for the payment of social services, pensions, and healthcare. Doing so is, however, a quite complicated matter, since the welfare of

today is strongly bounded to past decisions that were taken. The new welfare, as Vogliotti and Vattai (2012) imagined it, has to overcome the passive dependency culture in which it is perceived, from the individual side, a contrasting choice to work and, from the collective one, just as an expense for states: consequently, it has to assume a position in which it actively pursues the wellbeing of the individuals, by investing in their future and by encouraging them to enter the labor market. Instead of providing just economic assistance to the needy population, new welfare regimes should be involved in the education of workers, to provide them the tools to seek work opportunities instead of relying on governmental subsidies. In this case, the help of institutions other than the State could be encouraged. For instance, some countries are relying more and more on the Third Sector, to ensure individuals additional support to the one given by the State; however, the Third Sector is not diffused in all countries[11] and sometimes it is hindered by bureaucracy and scarce governmental support. However, the Third Sector, by being constructed by voluntary associations committed to special causes, could be crucial in the development of a web of assistance able to supplement and integrate the governmental aid. In this new paradigm, we could achieve a model in which the State, the market, and the Third Sector are actively cooperating to cover each other's gaps. Many scholars (Vogliotti & Vattai, 2012; Arena, 2020) are advocating for what they call "circular subsidiarity" and "horizontal subsidiarity". Both concepts entail the active participation of the Third Sector to support public administrations in their role of directors and managers of welfare programs. This proposal cannot be accomplished without the blessing of the public authorities that should – as the Italian Constitution denotes at the article 3 subsection 2 – "*remove all the economic and social obstacles that (…) prevent the full development of the human being and the effective participation of all workers in the political, economic and social organization of the country*". The State, in this view, leaves the role of *factotum*

[11] For example, as we have seen when discussing the role of religion in the development of different welfare models, in Germany and in Holland the Third Sector is more diffused than in Italy.

and instead becomes a facilitator, that helps independent associations to construct additional support by being closer to the population.

To conclude, the analysis of welfare states leaves for sure open questions that governments need to face: *how can we make more effective and more just policies that help the population without deteriorating the economic situation of the State?* Some countries are more prepared to take upon this challenge, while others will have to fight to reinstall a more fair society, coping at the same time with a troubling economic situation. As we have seen, the process of change is difficult, especially because it is strongly linked to past actions and the culture that was constructed throughout the years. However, a more programmatic strategy is needed to reinstall trust in the future, by allowing new generations to achieve economic independence and prosperity, being able at the same time to contribute to the sustenance of the elderly part of the population.

CHAPTER 2 - THE EVOLUTION OF THE US HEALTHCARE SYSTEM: FROM ROOSEVELT TO OBAMA

We approach now the core argument of this thesis, which will be focused on examining one specific part of the welfare state: healthcare. The health sector has always been included in the debates of scholars across the world because of its strategic role in the lives of individuals. However, especially after the outbreak of the COVID-19 pandemic, the dilemmas of healthcare have gained prominence also in our daily news, re-instating healthcare as a major concern for our modern societies. Criticalities were founded in almost all systems in the world: the pandemic made us realize that no system is immune to flaws and therefore, understanding them could be a great starting point to overcome problems and create more efficient systems.

After all, we are all consumers of healthcare at some stage of our lives and analyzing different healthcare systems can help us develop more awareness in a crucial part of our wellbeing.

It is therefore the goal of the following chapters to create a comprehensive picture of different healthcare systems of the world. In particular, the center of attention will be, at first, the American case study, which was chosen for its prominence in the world, complexity, and intrinsic controversies, that render it a fascinating example to examine. In the two following chapters, we will see how healthcare in the US has evolved from the beginning of the 20th century till today, by outlining the main characteristics that emerge from this model, and the principles over which it founds its existence. It will not be an easy task, due to the different actors involved in the system – both private and public – and due to the complexity of the programs enacted by the government and destined to different parts of the population with specific access requirements and rules. Yet, it will be – hopefully – an interesting journey that will try to present the readers

(especially the non-American ones) an approach that for decades has produced large debates and big question marks related to its incapacity to provide basic care for all.

To provide the reader a general overview to understand the following pages, it is the goal of the author to clarify here certain aspects that are essential for the in-depth knowledge of US healthcare. To begin with, it is important to note that the US healthcare system is one of the very few - if not the only- system in the developed world that is not universal, since not all its citizens can get access to its services. This means that, for treatments that are not essential for his survival, the individual has to purchase insurance that covers the expenses of the medical procedures he needs, or he has to pay the full cost of them. The Government helps the most indigent people through some programs that are financed to allow them to receive basic care: these programs, which will be analyzed in the next two chapters, are Medicare and Medicaid. To receive the benefits, recipients must provide proof of their state of need: the system is, therefore, based on the "means testing" approach[12], that requires each subscriber to demonstrate to possess the requirements necessary to be enrolled in the programs. The qualifications to be included are based on different criteria: age and income are the most employed ones since the benefits are mostly devoted to children and over 65 and low-income individuals. Despite the (limited) help provided by the government, most American citizens purchase insurance from the healthcare market, which is composed of both private and public insurance companies. Private insurance companies are independent entities that elaborate plans for healthcare that increase the coverage proportionally to the increase of the premiums paid by the individual, while public insurance companies are typically created at a federal or state level to allow citizens to purchase coverage from the government or federal states. These

[12] In chapter 1 paragraph 1 we discussed different models of welfare, relating US to the liberal one. As a reminder for the reader, the liberal model is based on the market as the main agent, since it governs relationships efficiently. Moreover, this model of welfare is based on "means testing": this means that each citizen has to provide actual proof of his state of need.

two types of companies compete against one another since individuals are free to choose the best alternative for themselves and their families according to the costs-benefits they are willing to pay-receive. It is thus clear how the American system is a mix of private and public that act together to make the sector work.

The complexity of the sector is also shown in the jungle of rules, laws, and principles that revolve around it: from the beginning of the 20th century till today, many Presidents and Governments have had their perspective on healthcare, making the sector one of the most regulated in the world. Many of the theoretical grounds over which US healthcare bases its existence, however, confront themselves with some structural problems, both of economic and ethical/social nature. American healthcare is one of the most expensive systems in the world, with $ 11,072 per capita spent in health services, which means 17% of its annual GDP[13]. These expenses are huge if compared to the average in OECD countries, which indicate an amount of $4,224 per capita.[14] All these economic resources employed allow US healthcare to be one of the most innovative and progressive examples in the world. Yet, this innovation is denied to some parts of the population – almost 30 million people - who cannot afford to pay for insurance and are not included in governmental programs. This limbo, in which this slice of the population lives, raises questions about the intrinsic unfairness of the system, who creates huge disparities between those who can afford it and those who cannot.

I will describe all of these aspects in detail in the following chapter, trying to create a framework capable of analyzing in an evolutional perspective the historical phases that brought to the modern US healthcare system. This evolutionary path we will undertake will allow us to understand the rationale that made necessary the normative intervention brought up by the Obama administration through the Patient Protection and Affordable Care Act (PPACA)

[13] OECD (2021), Health spending (indicator). doi: 10.1787/8643de7e-en (Accessed on 28 January 2021). Data are referred to 2017 (latest available).
[14] ibidem

or better known as “Obamacare”, that is the only major reform of the healthcare enacted since 1965.

Obamacare will also be the focus of the third chapter, in which I will technically analyze in detail the changes brought up by the Obama presidency and the criticalities which are still unsolved. All these considerations will end up with an overall evaluation of the system as we know it nowadays, underlining which will be the possible future scenarios for this part of the American welfare state after the official assignment of President Biden. The role of Biden, already crucial in the Obama presidency as vice-president, is now even more emblematic since it has to deal with a global pandemic and with mounting turmoil from that part of the population who felt left behind by the previous administrations.

2.1 Some basic principles in the US healthcare

To begin our analysis of the American healthcare system, I believe it is useful to outline which are the ethical foundations that built the system we know nowadays. This picture will help us not only to fully understand how the system works but also to shed light on some aspects of the reality that seem to go against that ethics.

When we think about American healthcare, what first comes to mind is the multitude of different actors that interact in the system. Every agent has its interests and requirements to be satisfied, but, among all these stakeholders, one of them is for sure the most important one: the patient. The patient/individual seems to be the center of all the attention since he is the one to which all the actions and interests are directed. That is why the healthcare system in America is often addressing the approach of “patient-centered care”, which outlines the treatment of the patient as the first concern for the system. To be more specific,

the International Alliance of Patients' Organizations (IAPO) has released a comprehensive definition of this approach:

*"The essence (*of patient-centered healthcare*) is that the healthcare system is designed and delivered to address the healthcare needs and preferences of patients so that healthcare is appropriate and cost-effective. By promoting greater patient responsibility and optimal usage, patient-centered healthcare leads to improved health outcomes, quality of life, and optimal value for healthcare investment. "* [15]

The definition clearly outlines that the patient is not only the center around which almost all actions are based but he is also the parameter over which the healthcare can evaluate its results. The main relationship we can encounter in healthcare is that of patient-physician since the actions of the physician are destined to the satisfaction of the need of the individual to which the cures are addressed. That is why, throughout the years, there was the need to write down certain principles that were able to guide the work of professionals toward the interest of the patient without crossing the lines of the individual's autonomy of decision. Code of ethics was born with this purpose and is still employed in the field of medicine as basic guidelines to be respected. The codes of ethics we know nowadays are just the results of a long-lasting tradition that dates back to the 4th century, when Hippocrates created the Hippocratic Oath to guide the work of physicians in the practice of medicine. Its oath - which was re-adapted to address the requirements of the modern world[16] - is still adopted by physicians when

[15] International Alliance of Patients' Organizations. *Declaration on Patient-Centered Healthcare. 2006.*

[16] The classic version of the Oath was readapted by Dr. Lasagna to the meet the need of the modern medicine without, however, overturning its original principles of non-maleficence and confidentiality.
The oath recites:

"I swear to fulfill, to the best of my ability and judgment, this covenant:
I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.
I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

they start practicing medicine and serves as empowerment of their actions along with the code of conduct. We will now concentrate on the physician code of ethics since it is the one that refers specifically to the relationship between physician-patient, knowing, however, that there are many other important stakeholders involved in the system (i.e., nurses, insurance companies, families, the government), that need to be remembered since they all play a crucial role, have different aspirations and exert their influence in the system.

The American Medicine Association (AMA) was the first association that released a physician code of ethics in 1847 (Niles, 2018: 309): this code is still the guideline for all other codes of ethics in healthcare since it emphasizes the basic rights and duties of physicians in the practice of medicine. The code, revised in June 2001, is based on nine principles, that indicate what a doctor can or cannot do. The "duty to treat" is traditionally considered the milestone of the conduct of each physician who approaches the job. Despite article VI of the AMA Code of Medical ethics emphasizes the possibility of the doctor to decide whom to treat, in emergencies this principle is not valid. Moreover, in opinion 9.12 of the act, the Code specifies that each physician has the duty to offer his services "(…) *regardless of race, color, religion, national origin, sexual orientation, or any other basis that would constitute invidious discrimination*". From a legal point of

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I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.
I will not be ashamed to say, "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.
I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.
I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.
I will prevent disease whenever I can, for prevention is preferable to cure.
I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.
If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling, and may I long experience the joy of healing those who seek my help."

Lasagna, L. (1964). Hippocratic Oath—Modern Version.

view, it is not a general duty to treat all individuals, like it happens in other countries[17], but rather a duty not to discriminate based on prejudices of any kind. The AMA medical principles state also other important duties of physicians. As a matter of fact, doctors are asked to provide "*competent medical care with compassion and respect for human dignity and rights*" (principle I), be professional and honest in their work, respecting the law (principle II-III), respect the patient privacy and confidences (principle IV), continue his/her education in the medical field to produce the best healthcare as possible (principle V), contributing to the wellbeing of the community (principle VII) and finally, care for the overall health of the individual "as a paramount" and encourage access to all (principle VIII-IX).

In literature, scholars have also tried to identify some precepts able to guide the behavior of physicians. The most employed list of principles is ascribable to Beauchamp and Childress (2001), which were able to synthesize the conduct of doctors in four essential guidelines. These principles are respect for autonomy, beneficence, non-maleficence, and justice. Let us analyze their meaning in detail. Respect for autonomy is described by Beauchamp and Childress as the duty of the doctor to respect the autonomy of the patient to decide what is best for his life, even though this decision differs from the doctor's beliefs and recommendations. This gives the patient the right to self-determinate himself and decide whether and which cures to receive[18]. For example, the Jehovah's Witnesses refuse blood transfusions and all blood derivatives for religious beliefs. Controversies have been raised since a blood transfusion in many clinical cases can help save the life of the individual. However, the principle of autonomy forces physicians to cope with the decision of the individual not to

[17] For example, in Italy the right to health is explicit in the Constitution at the article 32 which renders clear the right of each individual (Italian or non) to receive unconditional treatment freely or under the payment of small compensation (so-called *ticket sanitario)* regardless of age, gender or economic conditions.

[18] The Italian Constitution also recognizes the right of the patient to self-determinate himself, specifically at the article 32 c.2 when it is stated that no one can be forced into a treatment he/she does not want *("Nessuno può essere obbligato a un determinato trattamento sanitario se non per disposizione di legge.")*

accept the donation, even though it signifies the endangerment of his life. The physician, in the specific case, has to inform the individual or the family of the consequences of the action, leaving, however, the possibility to refuse the treatment (so-called "informed consent"). The second guideline for doctors is that of "beneficence". It signifies that doctors have a duty to perform the best interest of patients and to adopt the best cure possible to assure the wellbeing of the individual. It mostly means that his actions are directed to provide benefits to the patient, but it also means the duty to balance benefits and risks in evaluating treatments. A specular principle to be respected is that of "non-maleficence", which outlines the duty of the physician to produce no harm to the patient: it means not to kill, not to produce unnecessary pain or suffering, and to avoid offense. It could seem absurd to make explicit these principles, but in the practice these guidelines are fundamental. To clarify this aspect, let us imagine a case in which doctors have to decide the treatment of a terminally ill patient. Medicine encourages the pursuit of the wellbeing of the individual, meaning that the doctor should be continuing to try to save the patient's life at any cost. However, the treatments cause the patient unnecessary suffering and probably will end up with the death of the patient anyway. Without the principle of maleficence, the doctor would be forced to cause the patient unnecessary pain that would produce no results, and this is the reason why the precept was introduced. Finally, the last guideline produced by Beauchamp and Childress (2001) is that of "justice", which morally forces doctors to be fair in the treatment of patients, equally distributing benefits, risks, resources, and costs among individuals. The principle is strongly linked with non-discrimination since doctors cannot perform differences based on race, the color of the skin, gender, religion, and economic or any other discriminating factors. A long-lasting debate in the US has emerged especially because of this last principle since many citizens have advocated that the system is not fair at all, and justice is just an abstract ambition that is not respected in the practice. If we think about the configuration of the American system itself, in which only those who can afford

insurance can get access to medical treatment, we can easily conclude that only rich people can benefit from healthcare treatments, while poor people are excluded from them based on their economic status. Data confirm this rather general statement. As a matter of fact, digging deeper into the system, we will notice that almost 30 million people[19] in America are uninsured: this slice of population is mainly composed of people ranging from 19 to 64, mostly Black or Hispanic, with an income-to-poverty ratio that is below 100% or between 100% and 399%[20]. From these data, we can, indeed, achieve some important conclusions that indicate that in the American healthcare system having one (or more) of these conditions can lower your possibilities to receive care. As we saw, unfairness is not only limited to class but also other discriminating factors such as gender, race, and ethnicity. As Putsch and Polotti (2004) point out in their paper, many authors have identified race prejudice as a key determinant in the clinical decisions of physicians, which are biased when deciding the treatment of an Afro-American individual. For example, Kahl & Al.[21]conducted research based on Medicare data in which they analyzed the frequency of services provided. They discovered that lower allocation of diagnostic and therapeutic resources was attributed to poor and African Americans. These phenomena trigger, according to the authors, "lack of trust and perceived racism" that discourage parts of the population to get access to supporting programs or buying insurance. In addition to these cultural inequities, the system suffers from institutional factors (Putsch and Polotti, 2004) that hinder its fairness. The most noteworthy is political resistance - especially coming from the Republican party - to support universal healthcare coverage. This reluctance to approve a universal healthcare system is mostly caused by the power and interests that are catalyzed by healthcare in the United States. A powerful activity of lobbying is produced by insurance companies who, throughout the years, have strongly discouraged the

[19] United States Census Bureau (2020). *Health Insurance Coverage in the United States: 2019.*
[20] U.S. Census Bureau, Current Population Survey (2020) *Annual Social and Economic Supplement (CPS ASEC).*
[21] Putsch and Polotti (2004) cite their speculation on the issue in their paper.

adoption of universal healthcare since major interests would be compromised: just to provide the reader with some examples, UnitedHealthcare Group – the biggest health insurance company in the US - earned 201 billion in U.S. dollars in 2018, followed by Anthem (USD 90 billion), Aetna (USD 60.6 billion) and Humana (USD 53.7 billion)[22]. These data undoubtedly point out the huge mole of affairs that surround the system and that prevent politics to implement more inclusive healthcare. One effort to extend healthcare to a bigger part of the population was tried by the Obama administration, but, as we will see in the next chapters, the reform is still far from instituting universal coverage for all.

To conclude this part on bioethical and medical principles in US healthcare, we can say that, although principles indicate the path to be followed by physicians, there are still some controversies that require more detailed study, to make practice closer to theoretical grounds.

2.2 The historical progress of healthcare in the US

We now analyze US healthcare from an evolutionary perspective, which helps us to better understand how the system has become the way we know it nowadays. In this section, I intend to shed light on the different healthcare reforms that have been drafted in the last century and have had a crucial implication on the model. I will start this journey from the beginning of the 20th century, with President Theodore Roosevelt and his way of seeing healthcare, to come to the most recent legislation on healthcare – Obamacare - that will be the focus of the following chapter. Many have been the reforms that were made – or, at least, tried – by US governments over the past century: the path was tortuous and, as we will see, is still in progress nowadays.

[22] Statista (2020). *Largest health insurance companies in U.S. 2018, by revenue.* Published by John Elflein, Feb 18, 2020

Starting from Theodore Roosevelt is no coincidence: Roosevelt was the first president of the United States to start understanding the importance of healthcare in federal activity. The beginning of the 20th century was a period of renovation: progressive pressure to implement new socially protective measures were coming from European countries (notably from England and France) and the first public welfare states were constructed in many nations in the world. The first programs to ensure universal coverage were released and a new trust in the hand of the State was instilled to allow the most indigent citizens to receive healthcare. Theodore Roosevelt noticed this new push toward the adoption of new measures of social protection and started his campaign to create universal coverage also in the United States. The first of the two Roosevelt presidents was elected in 1901 and remained in the White House until 1909: in this period, he encouraged the adoption of universal coverage and released many reforms to protect citizens from malpractice in healthcare and the food & beverage sector. Among these reforms, it is worth recalling the Meat Inspection Act (1906), which required all sellers of meat to respect certain standards of hygiene and meat maintenance conditions to sell their products in the market[23]. Despite his efforts to create better health conditions for his citizens, he struggled to make his ideas pass in Congress, where he fought against strong anti-universalistic powers. To overcome the impasse achieved in Congress, he, therefore, issued many executive orders and created many presidential commissions to support his ideas: the main targets of his campaign were "pollution abatement, soil reclamation, and flood control"[24].

Theodore Roosevelt's battles for healthcare and social protection were continued some years later by his relative, Franklin Delano Roosevelt. The second Roosevelt was elected in 1933 and remained in office until the end of the Second World War (1945), becoming the president with the longest mandate in US history. His long stay in the Oval Office allowed him to write the Social

[23] O'Toole, P. (2019). *Theodore Roosevelt Cared Deeply About the Sick. Who Knew?* The New York Times.
[24] ibidem

Security Act in 1935 and the Wagner National Health Act in 1939, which both had a significant impact on US healthcare. In particular, the Social Security Act is remembered because it established benefits for elderly workers and unemployment insurance for mothers and children, blind people, and the handicapped[25]. In the bill, that was signed into law in 1935, however, the efforts to create universal healthcare were, again, suppressed by Congress, which sent back his proposal. FDR also established the Department of Health and Human Services (HHS), to ensure the good delivery of health services and sustained advances in medical science.[26] Along with these reforms, FDR is mostly remembered for his "New Deal", a plan enacted in 1933 to save the US from the financial and economic crisis of 1929. The "New Deal" marks a consistent passage from the *laissez-faire* model to a new stronger role of the federal government who is directly involved in the economy. The plan starts a new phase for the USA, since, from that point on, the federal government expands its range of intervention and massively regulates the crucial sectors of the economy, among which we can also encounter the healthcare, that enters in the agenda of all following administrations. In particular, the New Deal introduced the Social Security Act, a comprehensive law that included different measures concerning employment and health. Health is to be found at:

a) Title VI—Public health
b) Title XVIII—Health Insurance for the Aged and Disabled
c) Title XIX—Grants to States for Medical Assistance Programs
d) Title XXI—State Children's Health Insurance Program

and will be recalled later when addressing healthcare law.

FDR was followed by Henry Truman, who continued to fight for universal healthcare, without significant results. Truman is remembered for establishing the National Institute for Mental Health (NIMH) and is considered the father of the Medicare program[27], that, however, became reality only some years later,

[25] U.S. National Archives & Records Administration. *Social Security Act 1935.*
[26] HHS website. *About us.*
[27] Markel, H.(2014) *How Medicare came to be, thanks to Harry S. Truman.* PBS. Webarticle.

when President Lyndon B. Johnson finally created it along with Medicaid, signing both into law in Missouri in 1965. Their creation was far from easy: strong was the opposition of the AMA and insurance companies, that believed these programs were reducing the quality of service because more people were allowed to receive care. Another reason, maybe even more pressing than this, was that their profits would be lowered since many citizens were now included in the Governmental programs and were not required to buy private insurance. Despite these issues, the law passed in the House with 313 votes in favor of 115, and in the Senate with 68 votes against 21[28].

Other proposals for universal coverage came in the following years from Senator Ted Kennedy and President Jimmy Carter, but there were no substantial advances. Worth a note is the effort of Richard Nixon, which enlarged the criteria to be included in Medicare, by allowing also people under 65 with renal disease or other disabilities to enter the program. "Nixoncare", however, was not just about that: Nixon wanted to enforce the relationship "employer-employee", by forcing employers to grant insurance to all full-time employees and by encouraging employees to share part of the cost. Moreover, Nixon wanted stricter control on insurance companies, that had to grant care without a health background check. Nixoncare eventually failed, mostly because of the scandal – Watergate – that stormed the President, but his vision paved the way for the future Obama's Affordable Care Act of 2010.

Before "Obamacare", also President Clinton tried his healthcare reform, which is recalled as "Hillarycare", after the name of his wife and head of the task force on National Health Care Reform, Hillary Clinton. The Clintons once again tried a comprehensive reform that wanted to achieve healthcare coverage for all. It was an ambitious plan since it focused on comprehensive benefits to be achieved by all the population. Oberlander (2007) describes the Clinton Health Security Act as an attempt to:

[28]Social Security Association (SSA). *Vote Tallies for Passage of Medicare in 1965*. Legislative History.

"(…) *secure universal coverage, regulate the private insurance market, change health care financing through an employer mandate, control costs to levels enforced by a national health board, and transform the delivery system through managed care".*[29]

However, their requests were believed as excessive and failed to mobilize the support of Congress. Despite the inability to make the law pass, Hillarycare paved the way for Obamacare to become reality in 2010. The Patient Protection Affordable Care Act, or Affordable Care Act (ACA), was the only major healthcare reform US has seen after Lyndon Johnson's Medicare and Medicaid act in 1965. More than 40 years were required to accept a more comprehensive plan that ensured more coverage for individuals, still without universal healthcare for everybody. The ACA enlarged the criteria to get access to public programs and forced every citizen to get insurance. However, the long-debated universal plan is still a utopia, blocked by the major interests of the system's stakeholders. We will see in detail the actions undertaken by the Obama administration in chapter 3; for now, it suffices to assert that the ACA encountered many difficulties in its implementation and is still under scrutiny. President Trump fought against this act, trying to establish its healthcare reform without success. *What would then be the future of US healthcare in the following years with President Biden on the stand? Will he be able to establish universal healthcare?* I will try to make my predictions in chapter 3.

[29] Oberlander, J. (2007). *Learning from Failure in Health Care Reform*. The New England Journal of Medicine; 357:1677-1679 DOI: 10.1056/NEJMp078201

2.3. Healthcare law

So far, we have analyzed the evolution that has characterized US healthcare history in the past decades, concentrating on crucial steps for the formation of the current healthcare system. In the past subsection, we understood the importance of mediation for certain reforms to be accepted by Congress, interest parties, and public opinion, and we have underlined the difficulty of making shared decisions and conjugating different ideas and programs.

We now turn our attention to specific laws that were released by presidential administrations of the past, to understand which are the milestones for the formation of the system of healthcare we know nowadays: the US healthcare – as we will see - is a highly regulated and articulated sector, due to the centrality of its role for the public interest. Some of the regulations we will mention are already familiar to the reader, since they were in part mentioned in subchapter 2.2, but will now be further and better explained here. We will divide this subsection into three parts, to address different subjects: the first part will analyze the regulations that were issued to protect the patient and to assure the fulfillment of his/her rights and wishes; the second part will be dedicated to the essential rules released by the federal government to assure free and healthy competition in the market and to allow citizens to decide which is the best insurance company/hospital/medical facility for their needs and finances; finally, we will concentrate on the rights of the workers in the healthcare industry, recalling the most important legislation regarding this matter. Each section will report the laws related to each topic in chronological order, to allow the reader to follow the evolution of the legislation smoothly, understanding the steps that have preceded its current status. It is important to note that these parts will only touch the most significant laws in the healthcare sector, but the US legislation related to healthcare is a vast topic that is not limited to them.

We start our analysis with the regulations that are strictly related to healthcare and the protection of the patient. In particular, we begin with the Hill-Burton Act, which passed in Congress in 1946 and remained active until 1997, when funds were stopped by the federal government. The act is particularly noteworthy since it introduced new resources to improve hospital structures and medical facilities among the different American states. Loans and grants were provided to modernize and construct new and more efficient structures for patients' care, and, in exchange, hospitals and medical facilities were asked to assist indigent people who could not afford health insurance. Eligibility criteria were issued to get access to the service and were based on federal poverty guidelines.[30] The Hill-Burton funds are also mentioned in the Public Health Service Act at title VI, where it is stated that financial support is granted to hospitals in exchange for some protective measures for patients. In particular, these requirements are a) provision of emergency treatments, also to those who cannot afford them; b) provision of service to any category of patients without discriminations based on gender, race, color, national origin, creed, or any other discriminating factor; c) participation to Medicare and Medicaid programs; d) creation of reimbursement plans that are not under the actual cost of the service; e) posting of community services in English, Spanish or any other language that is spoken by at least 10% of the local population, to favor small communities of foreign origin to better understand them.[31] Therefore, we can state that this act was an important step that was undertaken to favor the access of poor people at least to emergency treatments and to reduce, in part, discriminations in services. From the side of hospitals, it allowed renovations and more innovative structures to organize more sophisticated R&D and to improve facilities and medical structures.

The second act that will be presented is the Emergency and Medical Treatment and Active Labor Act (1986), also called AMTALA, a milestone in the patients'

[30] Health Resources and Service Administration (HRSA). *Hill-Burton Free and Reduced-Cost Health Care.* Web section.
[31] HHS.gov, subsection *Medical Treatment in Hill-Burton Funded Healthcare Facilities*

treatment in the US. The act is a federal law that was issued in continuity with the Hill-Burton Act to allow all citizens to receive emergency care, despite their ability to pay. EMTALA revolves around the concept of "trust": the provider of the service is forced to give care to all patients that have trusted them for their wellbeing and are bind by an antidumping clause, that prohibits them to refuse to admit Medicare patients. The ratio of this measure was that, before it, hospitals refused to admit Medicare patients because of the low reimbursement that the government provided them and preferred to admit patients who were insured with private companies to receive higher premiums. After 1986, this is not possible anymore, and all hospitals are required to accept all patients, including those of the Medicare program. Under the act, hospitals are required to perform a medical screening exam and determine if the patient presents emergency conditions. If there are none, the obligations of the hospital cease to exist. On the other hand, if the patient is critical, the hospital is required to treat and stabilize the patient and/or to transfer the patient to another facility that can treat the patient in a better way[32]. If the hospital does not respect these guidelines, it risks violation fines up to $100,000, along with the termination of the Medicare provider agreement and a possible suit for personal injury in civil court. There are also consequences for the physician who refuses to treat a patient under these circumstances: he/she risks a fine of up to $50,000. Moreover, the facility who is eventually damaged by the refusal of the first hospital to accept a patient can enact a lawsuit for damages. [33]. Therefore, the act was crucial to improve the acceptance of Medicare patients and to allow everyone to receive emergency treatment despite the individual's inability to pay for it.

The third milestone in the patients' care is the Patient's Bill of Rights, released in the 1970s and then revised in the 1990s to allow every patient to receive basic

[32] CMS.gov (2020). *Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19)*. Ref: QSO-20-15 Hospital/CAH/EMTALA

[33] American college of emergency physicians (n.d.) *EMTALA Fact Sheet*.

information about his/her health status and the costs of each treatment he/she receives. The major objectives of this act are to allow every patient to be informed about every aspect that concerns him/her, from the diagnosis to the actual treatment. The other goals are to allow the patient to "feel confident in the US healthcare system" and to "stress the importance of a strong relationship between the patient and their healthcare providers"[34]. If we take as an example the Patients' Bill of Rights of the State of New York (Niles, 2018: 284), we can easily read a list of 19 rights that are designed for these purposes. The major area of intervention is the information of the patient. The hospital or medical facility must provide information about a) the name and position of the doctor and the hospital staff in charge of the patient's care; b) the diagnosis, the treatment, and the prognosis; c) the proposed procedures or treatments; d) the possibility of refusing resuscitation and allow natural death (DNR); e) the possibility to refuse treatment and possible implications; f) the costs of the treatments - that must be explained in a detailed bill. In addition to them, there are other areas of intervention that concern access to emergency treatment, respect, and non-discrimination, possible complaints, the possibility to make his/her wishes about organ donation explicit, and other rights reserved to patients (i.e., a clean and safe environment, a non-smoking room, an interpreter if rights are not understood, allowance of visits). Even though every state has its own Patients' Bill of Rights written in its form, the content does not vary significantly and is practically the same in other bills. The Patients' Bill of Rights remains one of the pillars in the healthcare sector, since - as we understood - it regulates the complex matter of rights and duties in the patient-physician relationship.

Another consumer law that concerns healthcare is the Children's Health Insurance Program (CHIP), issued in 1997 by the Clinton Presidency and included in the Title XXI of the Social Security Act. The act is a pillar for the healthcare protection of children: it allows young individuals to receive public insurance until the age of 19 when the family does not have the requirements to

[34] Health source global (n.d.) *Patient's Bill of Rights. What is the Patient's Bill of Rights?*

get access to Medicaid, and, at the same time, cannot afford to pay for private insurance. Thanks to this program, 9.6 million children[35] receive care, despite the parents' ability to pay. Every state decides autonomously how to implement the program, and which benefits to provide to children, and in which form. Eligibility criteria are, on the other hand, decided by the federal government and require the child to be under the age of 19, not eligible for other governmental programs, an American citizen or allowed immigrant, and living in a family whose income is in the range of inclusion required by the State. The program covers in almost all states "routine check-ups, immunization, doctor visits, prescriptions, dental and vision care, inpatient and outpatient hospital care, laboratory and X-ray services and emergency services". [36]

One final law that is worth mentioning in healthcare consumer protection is the Benefits Improvement and Protection Act of 2000. This act allowed to lower the costs for Medicare payments and ensured more therapeutic services. Moreover, it forced private and public insurance companies to give notice of the end of insurance coverage before its expiration, to allow individuals to cover the costs and restore the protection. (Niles, 2018: 281).

The second part of the paragraph is dedicated to the most important laws to ensure the protection of fair competition in the market. Antitrust laws were released to guarantee that patients were free to choose the best option available in the healthcare market and to prevent insurance companies and medical facilities to set prices and undermine competition between agents. Moreover, they limit monopolies, cartels, and trusts not only in the healthcare sectors but in all marketplaces. The first antitrust law we are discussing is the Sherman Act of 1890, which was promoted by senator Sherman under the Harrison Administration. The act is for sure the milestone of all antitrust policies in the US and signs the start of a new era for trade and commerce. The Sherman Act, even though it is appliable to all segments of the economy, will now be analyzed in the

[35] Medicaid.gov. *Children's Health Insurance Program (CHIP*).
[36] Healthcare.gov. *The Children's Health Insurance Program (CHIP)*. Informative web page.

healthcare sector. In particular, the act abolishes monopolies in healthcare and has the goal to abolish all price-fixing maneuvers (i.e., trusts between insurance companies to fix the prices at a certain level to lower competition and prevent costumers to freely choose the best alternative available in the market.). In addition, the Sherman Act targetes boycotts, making them illegal. Boycotts can be defined as actions to sabotage a competing hospital/physician/practitioner to discourage its entrance into the healthcare sector and to prevent the establishment of its activity.[37] Boycotts are also the refusal to deal with an individual belonging to a certain group.[38] The violation of the Sherman Act can bring both civil and criminal charges: in addition to civil enforcement actions, each state's attorney general office has an antitrust division that is deputed to dispute all antitrust violations. In cases of severe violations, criminal charges can lead to prison, with reclusion up to 10 years.[39] Antitrust laws are not done with the Sherman Act of the end of the 19th century but continued also in the 20th century to improve it. In particular, the Clayton Act of 1914 was introduced to enforce already existing antitrust measures. It focuses specifically on mergers and acquisitions when those lower competition and create monopolies (Section 7). In the healthcare sector, the main recipients of this act are hospitals, that have to request permission for M&As to the Antitrust Division of the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC)[40]. There are no criminal charges for the violation of the act, but there can be civil counteractions and individuals can sue for damages if they encounter problems caused by a merger or an acquisition.[41]

On antitrust legislation related to healthcare, it is worth mentioning also the Hart-Scott-Rodino Antitrust Improvement Act: it was approved in 1976 to

[37] A similar definition was provided by Wong & Wu (2017) citing the words of Professor Wallers. In his words: "*any decision by a group of "competing" physicians to exclude another physician (from a hospital, group practice, or other organization) would be a group boycott.*"

[38] Niles, 2018

[39] Federal trade commission website– Antitrust laws

[40] The commission was instituted in 1914 as well to ensure free competition in the markets and to check for illegal practices and to protect consumers. It is still in place and functioning.

[41] Niles, 2018

improve the legislation related to M&As and competition and requests that every hospital that wants to merge or acquire a new facility has to submit the proposal to the FTC and DOJ before the actual tender offer. In this case, we talk about pre-merger (or pre-acquisition) notification, which serves as a regulator and prevents anti-competitive maneuvers. In particular, it ensures that in a specific geographical area competition is still guaranteed and that there are no monopolies.[42]

The final part of this subsection is devoted to the most significant legislation that was issued to protect workers in the healthcare industry. The matter is very sensible, especially in this period, when COVID-19 has brought up some critical questions related to the protection of workers that are in strict contact with highly infective diseases and long work hours to cure patients. Employment-related legislation, however, is not a recent matter and dates back to the middle of the 1960s, when the Civil Rights Act was signed into law by President Johnson. The act is quite famous since it was the milestone for the attribution of civil rights to the Afro-American community and marked a huge step in the battles for racial equality. Title VII of the act is crucial in this analysis of healthcare since it fought discrimination of all kinds in working places – thus, also in healthcare – and allowed equal opportunities of employment. Moreover, the act battled against sexual harassment in working environments, condemning both sexual favors in exchange for promotions and hostile environments that cause an unfavorable working condition. The act also instituted a commission (Equal Employment Opportunity Commission) that is still in place and guarantees the respect of all the measures contained in the brief.[43] Other acts followed the Civil Rights Act in the next years, to ensure more and more protection to the increasing needs of workers and to put a restraint on discrimination. For instance, the Equal Pay Act of 1963 helped to reduce differences in salaries between male and female employees, allowing fair pay for

[42] ibidem

[43] Civil Rights Act (1964), title VII, SEC. 2000e-4. [Section 705]

everyone; the Age Discrimination in Employment Act (ADEA) of 1967 was issued to ensure protection for workers older than 40 to limit discrimination related to age during job selections; finally, the Pregnancy Discrimination Act of 1978 was introduced to limit discriminations related to women's pregnancy status.

Another legislation that marked a significant step in the protection of workers in the healthcare industry was the Occupational Safety and Health Act (1970): the law ensured the safeguard of doctors, nurses, and all healthcare workers from possible disease or infection contracted at work and from possible injuries due to unsafe environments. The ratio of the measure was that the medical staff can get in touch with dangerous substances or with infectious patients and, therefore, it was necessary to find some tools to protect them. Moreover, the aim was to instill in providers a general duty to guarantee environmental standards of minimal protection for workers[44]. Not only providers have duties, but also workers, which are required to report to their supervisor potential dangers or unsafe conditions. In addition to this kind of support, personal protective measures (PPE) were imposed to prevent contact with hazardous substances. PPE has now become everyday equipment for all individuals due to the COVID pandemic, but, back then, this was a huge leap in the healthcare industry.

Finally, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was introduced in 1987 to guarantee healthcare coverage to employees who left their working position. COBRA was passed to allow individuals to preserve their employer's insurance even when they changed job in exchange for a contribution in the overall expense (102% of the full price[45]). This act helped to combat the fear of job locks that pressured people not to leave their work because of the fear of losing their healthcare insurance.

To sum up, this subchapter was helpful to create a broad picture of healthcare law in the United States and, if combined with the previous paragraph, can be used as a reference to construct a comprehensive framework

[44] Niles, 2018
[45] ibidem

to depict US healthcare from a historical/evolutionary perspective. In the eyes of this goal, the next section will be crucial to denote which are the main actors involved in the system and their role in the provision of healthcare to finalize a complete overview on the topic and to possess all the necessary information to fully understand how governmental programs are constructed and how they were changed by Obamacare (ch.3).

2.4. Actors involved in the system

We have repeatably mentioned many stakeholders working in US healthcare, but we never analyzed them in detail to understand their role in the system. Some of them are intuitive: consumers and providers of healthcare are at the center of all speculations about healthcare and represent the two extremes of the healthcare supply chain. Among the consumers, we can encounter not only patients but also their family, that is a huge influence in their decisions. Moreover, firms can be also considered consumers of health, since they are deeply involved, as we will see, in the creation of a web of health assistance to their employees. From the part of providers of healthcare, hospitals - where doctors and nurses operate - are the major agents, but their contribution is supplemented by other actors, such as nursing homes, private clinics, and other medical facilities. From one side, therefore, we can encounter the consumer of healthcare, that receives the benefits but has also to pay to receive them, and from the other side the providers of healthcare, that receive paybacks for the services offered to consumers.
However, stakeholders are not done: healthcare is composed of many other agents that make it complete and functioning.

We start by analyzing insurance companies, that in US healthcare play an essential – and in certain cases, controversial – role in providing coverage. We

have already cleared up how the US system is a mixture of private and public forces that formally collaborate to manage healthcare. In reality, however, the healthcare market is highly competitive and brings together forces that were born to "fight" against one another to attract more individuals. Health insurance companies compete to get more people to sign in for insurance since it is their primary source of profit. People, enrolling in a plan, pay premiums that are based on the benefits that they are willing to receive compared with the monthly cost of the insurance. There are various plans with different prices that are based on the costs/benefits to be paid/received. Traditionally, there are four categories of plans offered: Bronze, Silver, Gold, and Platinum. Each category differs from the others for the number of resources covered by the insurance company but not for the quality of the services provided. The Bronze plan will allow the individual to get less coverage from the insurance company and more out-of-pocket expenses but has the lowest premium, while the Platinum has the highest insurance coverage and lowest out-of-pocket expenses but the highest premium. In between, the silver and gold plans, that have more benefits than the Bronze one, but lower than those given by the Platinum. Each individual is free to choose which is the best fit for him/her, comparing plans but also insurance companies. Employers play also a crucial role in insuring citizens, because, in many cases, they provide insurance to their employees along with their contract. It is registered that more than 158 million people get employer-sponsored insurance (roughly 49% of the total population)[46]. The main private companies in the sector of healthcare insurance are CIGNA, Kaiser Foundation, AETNA, UnitedHealthcare, Humana, Care Plus, and BlueCross BlueShield. The latter is particularly interesting, since BlueCross and BlueShield started as two separate entities, and then came together to form a unique non-profit association of insurance companies. In addition to private actors, individuals can decide to subscribe to a plan with public insurance companies, that pertain to their State.

[46] Kaiser Family Foundation. *Health Insurance Coverage of the Total Population.* Data are referred to 2019.

Moreover, citizens can get enrolled in public programs (i.e., Medicare, Medicaid, CHIP, or others) that allow them to receive help if they belong to certain categories of income, age, or other parameters. As we noted above, insurance companies are not always seen as positive entities: their bad reputation is due to the high percentages of rejection of claims brought up by the insured. The situation has worsened with COVID-19 when big battles were started due to the fact that insurers were denying the inclusion of COVID-19 in already existing plans. Therefore, companies and individuals had to pay additional costs, and this resulted in big profits for private insurers.[47] Moreover, as we noted in paragraph 2.2, their action of lobbying has prevented the extension of public programs to larger pieces of the population and has therefore questioned the moral integrity of their actions.

To supplement the role of health insurance, the Government has increased its influence in healthcare by implementing Medicare, Medicaid, and other public programs, which we will analyze in the next paragraph. The role of the public administrations in this sector is widely diffused among local territories. We can divide their actions into two parts: the federal government is deputed to the distribution of resources and the creation of programs, while the implementation of the plans is left in the hands of state authorities and local administrations[48]. Therefore, healthcare is a matter of public interest that is intrinsically embedded in the local community and is also linked closely with citizens.

Another important part of healthcare is composed of professional associations operating in favor of doctors, nurses, and hospitals. The reader is already familiar with the American Medical Association (AMA), which was previously mentioned and that defends the interests of doctors and physicians practicing medicine in hospitals or other medical facilities in the United States. The AMA, born in 1848, is a strong influence for the sector, since it releases

[47] Abelson, R. (2020). *Major U.S. Health Insurers Report Big Profits, Benefiting from the Pandemic.* New York Times.
[48] Niles, 2018

guidelines and ethical principles (see paragraph 2.1) helpful for doctors to perform their jobs. In addition to the AMA, associations were created to defend the interests of other groups: for instance, nurses can address the American Nurses Association (ANA), which absolves the same role of the AMA in protecting, in this case, the interests of nurses. Professional associations do not only protect categories of employees, but they were also created in favor of hospitals and non-profit organizations operating in healthcare. Hospitals benefit from the action of the American Hospital Association (AHA), while non-profits can direct their claims through the American Health Care Association (AHCA).

To conclude the framework on the agents of healthcare, we cannot exclude from our discussion the segment of education and training of professionals. United States education has always been considered one of the best in the world since many of its universities are listed in the first positions in international rankings every year. In 2020's QC World University Rankings, 6 out of the first 10 positions are covered by US universities (Harvard, Stanford, Johns Hopkins, UCLA, Yale, and University of California), signaling the quality of the US medical education, given also by the strict selection criteria. Despite the high quotations of these universities worldwide and the global recognition of the quality of their programs, some questions have emerged in these years, specifically related to the high costs of enrollment. To provide the reader some numbers, tuition in private schools like Harvard is around 90,000 - 100,000 dollars a year[49], while public schools' average tuition is around 35,000 dollars a year[50]. Despite the financial support provided through bank loans the average total debt for a medical student after the end of his studies is around 200,000 dollars[51] [52]. In light of these costs, we can recall the argument we raised in paragraph 2.1 related to justice also here discussing healthcare education. In

[49] Harvard website. Tuition section.
[50] UCLA website. Tuition section.
[51] Goldberg, E. (2019). *I Have a Ph.D. in Not Having Money.* New York Times.
[52] To make a comparison, in Italy public universities costs are between €500 and €1,000 a year, depending on the income provided by the family, while if we take as an example Bocconi– a private university - costs are around €13,000 a year, still far from American's average costs.

particular, a system that precludes access to (medical) education– and thus, also to the medical profession – can be considered unfair, since it excludes students based on their possibility to pay. Moreover, given the certified shortage of doctors and qualified medical staff in the USA[53], *is it feasible for the system to leave the costs of enrollment this high?* We will develop further evaluations on this and many other controversial aspects of US healthcare later, in chapter 3.

2.5. Governmental programs: Medicare and Medicaid

Healthcare, as we saw, is a complex system of interconnections between different agents, among which we can find also the Government, that has created some tools to help the parts of the population that have more difficulties in purchasing health insurance on their own. This is the rationale for the existence of Medicare and Medicaid, which were started in 1965 by President Lyndon Johnson and that are now the milestones of public healthcare protection in the United States. The two plans address to different needs of the population since are based on two targets. Medicare is born with the initial purpose of supporting people over 65 in their old age, while Medicaid's purpose is to protect all citizens with low income in a state of need, regardless of age, therefore being more family-centered. While Medicare is managed by the Centers for Medicare and Medicaid, Medicaid is ideated by the Federal government, but in practice managed and implemented by the various States, that decide the criteria of inclusion and the benefits to allow, in addition to the minimum required by the Federal law. Medicare and Medicaid differ not only in the targets but also in the structure, and in the services that are given. For this reason, it is helpful to analyze them in detail.

[53] Boyle, P. *U.S. physician shortage growing.* AAMC website.

Medicare was initially thought for the help of elderly people to allow them to receive basic care in a facilitated manner. Nowadays, it is extended to cover additional categories of people, among which we can find patients with chronic conditions or with disabilities under 65 and end-stage renal disease patients[54].
The program's structure is quite complicated since it is based on 4 different parts: part A and part B concur to create the so-called "Original Medicare"; part C is called "Medicare Advantage" (MA), and part D allows patients to get outpatient prescription drugs at a lower cost. Medicare does not cover all costs of services, but it is designed to fulfill part of them. Going into the detail of each part, part A is dedicated to hospital coverage, assisting in case of hospitalization, and, in some cases, covering some expenses related to home help. Part B allows to receive medical services, such as physician visits and preventive services, by covering part of the doctor's medical bill. Part A and Part B are called "Original Medicare" because they are the parts that were created and implemented since the establishment of the program in 1965 and because they allow to be insured against basic healthcare risks by getting access to the most common services. Part C, called "Medicare Advantage" is another way to get access to part A and part B, by subscribing to a facilitated healthcare policy with a private insurance company. In this way, allowed citizens have access to both part A and part B benefits and can also use part C accredited facilities. Moreover, in many cases, they can benefit also from part D, which helps – as noted above – to cover outpatient prescription drugs. Part C was introduced in 1997 with the Balanced Budget Act, while part D was implemented in 2006.
People enrolled in Medicare in 2020 are more than 61 million[55]: Original Medicare enrollees are roughly 37.7 million, while Medicare Advantage subscribers are around 21.5 million[56]. These numbers are expected to grow in the next 10 years, to achieve more than 80 million beneficiaries in 2030[57],

[54] Kaiser Family Foundation report. *Characteristics of Medicare Population*. Figure 1
[55] Kaiser Family Foundation (2020). *Total Number of Medicare Beneficiaries.*
[56] ibidem
[57] MedPac report. (2015). *The next generation of Medicare beneficiaries.* Chapter 2.

signaling a rising trend that is turning to more elderly population benefitting from the program, with a consequent increase of the costs of the program itself. The topic of financing is therefore essential since the US needs to understand whether the current number of resources collected is enough to guarantee the survival of the plan. Nowadays, part A is mostly funded by payroll taxes on earnings paid both by employers and employees (both pay 1.45% for a total of 2.9%) with exceptions on higher-income employees that pay more (2.35% on earnings).[58] Part B is funded by general revenues (73%), premiums paid by the subscribers (25%), and other sources (2%); the same happens for part D with a slightly different distribution (74.5% with general revenues, 25.5% with premiums).[59] For what part C concerns, it is financed by general revenues, premiums, and payroll taxes, since it is the sum of the previous programs. *Will the system be able to support the rising costs with these resources or will it take more to continue the program?* The answer is complicated, because – as previously mentioned in chapter 1 - the population is aging, increasing the burden on almost all welfare states and healthcare programs, and few young generations are replacing their role in the workforce, reducing the contribution for the financing of the welfare programs. It will be therefore crucial for the newly elected President Biden to find a way out of a quite pressing matter for the system.

The other program enacted by the Federal Government is Medicaid. The reader should not confuse it with Medicare, since the two measures are quite different not only in the targets to which they address but also in the services provided and in the way they are financed and administered. Medicaid has the purpose of protecting the poorest population by ensuring coverage for most medical expenses. Medicaid is designed at a federal level but leaves in the hands of the States the burden of its implementation: each state decides the criteria of inclusion, as well as the services it wants to provide to the enrollees. The

[58] Kaiser Family Foundation (2015). *A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers.*
[59] ibidem

beneficiaries of these programs are not only indigent adults but also children (CHIP is part of Medicaid), pregnant women, and the disabled[60]. To be eligible for the program, each individual has to submit proof of his/her state of need: test means include income screenings, family status, and evaluation of assets. Each state decides income levels of inclusion and determines other criteria of selection: for instance, in many cases, Medicaid requires to be resident in the state in which you apply and to be in a certain range of age[61]. States also decide which services to provide: generally, Medicaid guarantees hospital services, access to nursing and healthcare facilities, and X-rays or other routine procedures. To get access to the program, enrollees benefit from it even before the actual acceptance of their application under the assumption of "presumptive eligibility" that allows them to receive care even though their status of need is not yet verified. The administration of programs is left to State agencies that are supervised by the Department of Health and Human Services (DHHS), while the financial support is provided by the State budget. Here again, the problem of resources needed is pressing, since nearly 71 million people[62] are enrolled and more are expected to come.

Some controversial aspects about Medicare and Medicaid have been found throughout the years and the Affordable Care Act tried to fix them to enlarge their beneficiaries. We will inspect the actions undertaken in 2010 in the next chapter that will be dedicated to understanding the efforts pursued by the Obama administration to ameliorate the healthcare system we have fully described in this chapter. As we will see, for many aspects, Obamacare has produced positive benefits for the US healthcare sector, but for others, it has raised criticisms from the public opinion, insurance companies, and politicians.

[60] Medicaid.gov. *Mandatory eligibility groups*.
[61] Medicaid.gov *Eligibility section.*
[62] Medicaid.gov. *September 2020 Enrollment Report*

CHAPTER 3 - THE MODERN US HEALTHCARE: THE "OBAMACARE"

The third chapter will be now involved in underlining the major changes brought up in March 2010 by the Affordable Care Act (ACA), enacted by President Barack Obama during his first mandate. The ACA is the only big reform of healthcare since 1965, when Medicare and Medicaid became valid, signaling the traditional difficulties that healthcare reforms encounter before being even signed into law. As we noted above in chapter 2, the obstacles faced by American administrations are mostly coming from interest parties that exercise strong lobbying against all actions that can lower their influence in the system.

The Affordable Care Act, extensively known as "Patient Protection and Affordable Care Act", or more commonly "Obamacare", is an ambitious project, born with the goals of ensuring access to healthcare to a larger part of the population. Thus, the proponents' aim was to allow more and more individuals to get insurance or to be covered by Governmental programs, improving their healthcare condition but, at the same time, increasing the burden on hospitals and medical facilities, as well as on public administrations and finances. Due to the mounting costs of the ACA, the opposition - especially coming from the Republic party - was strong but the act became reality anyway, with measures being still active nowadays. The following Trump administration tried to abolish the ACA by establishing its reform, but significant results have not been witnessed. It is now President Biden's turn to decide what will be the future of the Affordable Care Act in the next years: healthcare is now one of the most pressured sectors of the economy, given that the COVID pandemic has emphasized all the criticalities of an already fragile system. Moreover, the pandemic triggered not only a sanitary but also an economic crisis, that can

compromise the sustainability of all the programs in action nowadays, by employing even more and more resources to fund them.[63]

Healthcare is therefore the "hot topic" of these last months, requiring further speculation and analysis. The chapter will try to elucidate the reader on the Affordable Care Act after a decade of its implementation, trying to capture the pros and cons it has brought with itself. In understanding its goals, structure, and results we will then have a broader picture of US healthcare as it stands now, and we will investigate which are and will be the next steps to undertake to solve its remaining issues. Indeed, in this framework, we will debate not only about the current state of the art, but we will also depict a possible evolution of healthcare in the United States, considering the recent political developments that have brought Biden's settlement.

The structure of the chapter will be as follows: the analysis will begin with the outline of the goals of the act, followed by a critical analysis of its structure and content. The second part of the chapter will delineate the critical aspects of Obamacare with particular attention to the constitutional challenges it has encountered following its implementation. Moreover, I will elaborate on the public perception of the act, clarifying the opinion of citizens and doctors regarding it. In the third and last part of the chapter, I will – as anticipated above – turn the attention on the future of the healthcare sector in the US, by speculating on the efforts to change it by the following administrations. Finally, an overall evaluation of US healthcare will be performed using the Iron Triangle of Healthcare: at the end of this chapter, we will have all the information necessary to produce a comprehensive wrap-up on the sector that includes considerations on its quality, costs, and access. This very last paragraph will also be interesting in light of chapter 4, which will compare different OECD's

[63] I remind the readers that the USA is the country with the worst economic expense in healthcare in the world, with more than USD 11,000 per capita spent on healthcare compared to the average of OECD countries that is less than half of it. We denoted some of these figures also in the introduction of chapter 2, outlining the difference in expense between OECD member states. These data are available on the OECD website, in the health spending section.

healthcare sectors in the world: *can other countries be an example for the United States?* We will discover it later.

3.1 Goals of the act

The Affordable Care Act (Public Law 111–148) marked a consistent step towards a more inclusive healthcare system, fostered and encouraged by President Barack Obama, who saw in the act a milestone of its Governmental program. The Affordable Care Act was introduced after a long period of absence of healthcare reforms: the previous healthcare law was released in 1965, with the introduction of Medicare and Medicaid by President Lyndon Johnson. Barack Obama already manifested his proposals for a new system during the electoral campaign of 2008, proposing expanded income eligibility to existing healthcare programs (CHIP and Medicaid) and a new direction oriented to the involvement of a larger slice of the population in the healthcare flow, thanks to a mix of private and public actors collaborating. Its electoral campaign marked the importance of instituting universal coverage, in contraposition to the ideas of Senator McCain, its political challenger, that wanted an expanded health insurance system, but not necessarily an expanded healthcare to all individuals.[64] When Obama was elected as President, it was, therefore, no surprise that in his settlement speech he repeated the importance of a new and universal health care reform twice, underlining how this was a core goal of his upcoming government. [65]

Rice et Al. (2018) underline in their paper some key and interesting considerations on the period before the introduction of the ACA. Before 2010, United States did not force its citizens to purchase healthcare insurance: as a matter of fact, being insured was at the discretion of each individual, that could

[64] Collins, S. & Al. *The 2008 Presidential Candidates' Health Reform Proposals: Choices for America.* The Commonwealth Fund.
[65] Obama, B. *2008 Presidential Speech*. Retrieved from: l

decide autonomously whether to buy one, enroll in a public program (if eligible), or also not to possess insurance – and, therefore, coverage - at all. This autonomy of decision toward the topic had, of course, its consequences. As a matter of fact, at that time, half of the adult population and 30% of indigent people were uninsured, rendering almost 45 million people[66] completely lacking insurance. This situation produced a domino downfall of uninsured families: when a member of the family encountered a serious healthcare problem, the family had to pay out-of-pocket expenses that drowned the rest of the members in personal bankruptcies, jeopardizing the members' economic survival. In this system, another crucial fact to underline was related to the premiums charged by insurance companies. Before the ACA, having a pre-existing condition implied that the insurance company could charge more to grant coverage, in light of the higher danger of illness the candidate could have in the respect of a healthy one. This rendered it even more difficult for sick people to purchase insurance because they had to pay more to have it. Pregnancy was also a discriminant factor: a fertile woman had to pay more to be insured since her burden to the sanitary system could be higher. This very last statement could seem absurd to most of the readers: in reality, this happened systematically, signaling the preposterous discrimination between men – who, of course, could never get pregnant, and therefore paid less - and women.

All of these question marks were the starting points of the ACA since Obama and his entourage wanted to address these issues to construct a better and more leveled playing field for citizens of all kinds. The goals of the act were, therefore, a direct consequence of the problems underlined. The very first aim of the program was to allow more people to have access to health insurance. To achieve this goal, other actions had to be undertaken. Firstly, it was fundamental for people to be informed about what the market offered, and therefore to have all the information necessary to make a decision that was coherent with their needs and income levels. Secondly, another aim to accomplish was to make

[66] Rice et Al (2018).

healthcare cheaper, preserving the quality of providers, but allowing more people to get access. As we stated in chapter 2, US healthcare is one of the most expensive systems in the world and this makes it difficult to support it in the long term. Lowering its costs was, therefore, crucial to allow the system to survive and people to enter the system in the first place. Another important goal of the act was to encourage more preventive care, for more citizens to get access to periodic screenings and check-ups. This proposition was at the heart of the reform, since, before the introduction of the ACA, in-time intervention lacked, resulting in premature deaths. In this sense, The Harvard Business Gazette (2009) quoted a famous study performed by The American Journal of Public Health[67]: the study underlined that 45,000 deaths a year happened because of lack of insurance. This means that, if insured and therefore accessing healthcare structures, 45,000 people a year would have survived thanks to preventive care. The article also quotes professor Wilper, a teacher at the University of Washington School of Medicine, that said:

"We doctors have many new ways to prevent deaths from hypertension, diabetes, and heart disease — but only if patients can get into our offices and afford their medications."[68]

The citation is emblematic since it underlines with clarity the role of preventive care in modern medicine: if a person gets access in time, this can save his/her life. It was, therefore, the purpose of the ACA to enlarge the population of insured people, and also to reduce the percentage of people dying because of no access to facilities and care.

[67] Cecere, D. (2009) *New study finds 45,000 deaths annually linked to lack of health coverage.* Harvard Business Gazette.
[68] Professor Wilper quotation through Cecere, D. (2009) *New study finds 45,000 deaths annually linked to lack of health coverage.* Harvard Business Gazette.

All the goals we underlined so far were the rationale for the measures implemented by the Obama administration in 2010. We will indicate them in detail in the following paragraph.

2.2. Structure and content of the ACA

To understand the impact of the Affordable Care Act on citizens and on US healthcare, in-depth knowledge of the Act is useful to underline the major provisions undertaken with it. This paragraph will describe for each of its ten titles the most essential measures that were introduced in 2010: the analysis will be far from including all of the dimensions touched by the ACA but will be focused mostly on those that changed the way the US healthcare was constructed and those who had a stronger impact on the lives of the American individuals.[69]

The Act became effective on March 23, 2010, when President Obama signed it into law. For Democrats, the reform was seen as the beginning of a new era for American citizens, since, at least in its purpose, it was conceived as the last step to achieve universal coverage for everybody. The President and his VP, Joe Biden, announced it to the press calling it "a historic day for the United States"[70], signaling the big hopes that were installed in the Act to change the troubling US healthcare situation.

Even though the ACA started in 2010, not all the measures included became active in that year, but a consistent part became effective only in 2014.

The act is divided into 10 titles, each one addressing a different purpose. Each title is then divided into subtitles, which are classified with letters: each

[69] The analysis will be based mostly on the ACA's full law that can be found in the US Healthcare website and was written by the attorneys and staff of the House Office of the Legislative Counsel (HOLC). It is not the official version of the act, but however it is provided for the public's knowledge and can be considered equal to the certified versions offered by the Government.

[70] The White House (2010). *President Obama Signs Health Reform into Law.* Video. Retrieved from: https://www.youtube.com/watch?v=nIwM0gkLF0s

subtitle clarifies for each title the most important topics analyzed, clarifying the measures to achieve each general purpose. Each subtitle can also be divided internally into different parts that carry a number: this division does not happen always but is used in some subtitles where the measures are numerous and better understandable if divided into macro areas. For each part – or if not present, for each subtitle – sections contain the actual measures implemented by the Government, completing a quite complicated structure that, however, gives coherence to the act, clarifying the key provisions enacted. After having provided to the reader some notions about the ACA's structure, we now turn to the actual content of the act, analyzing each title in detail.

Title I of the ACA is named "Quality Affordable Healthcare for All Americans": its name is emblematic since it already gives us a feeling of its content. As a matter of fact, the goal of the title is to ensure a better and more affordable system of healthcare for US citizens, allowing it to be more quality-oriented as well as to allow more citizens to get access. It is based on the topic of "shared responsibility", which means that all the agents involved in healthcare must collaborate to accomplish the original purpose of the provisions. In particular, it involves not only the public administrations but also - and more importantly - the citizens, that are empowered and made responsible for their actions, as well as the insurance companies that must act in good faith and cease to discriminate against people based on factors that are not relevant for their coverage. The first title contains seven subtitles: each one addresses a different set of actions undertaken to ensure the broader goal is accomplished. Subtitle A and B determined the immediate actions that the Government wanted to undertake to provide more coverage for Americans. Going into the detail of these actions, the ACA has forbidden to rescind from healthcare coverage and assisted those people who had a pre-existing condition and were therefore excluded from insurance companies. Moreover, pre-existing conditions were not a possible exclusion criterion for children anymore and young adults also could be included in the healthcare plan of their parents until they reach 26 years of age. To

improve the information in the healthcare system, documents were standardized for consumers of healthcare to compare policies more easily and therefore, being able to decide more practically which was the best alternative for their family. Furthermore, a website was made available to all citizens to help patients to navigate the complexity of the system, identifying which was the best alternative available in the market for each patient's economic situation and needs. Moreover, the ACA instituted a cap on insurance companies that could not exceed a certain amount of non-medical expenditure and were obliged to use the profits coming from policies in actual healthcare. Finally, the subtitle instituted some measures to reduce bureaucracy in healthcare and make enrollment simpler. Subtitle C "Quality health insurance coverage for all Americans" addressed the market reforms that were being enacted in the years following 2010 to make the market broader and more affordable. In particular, from 2014 - that is another key year for the ACA since many reforms started from that point on – discriminations would be reduced because insurance companies were forced to accept to cover also individuals that had pre-existing conditions, that before the act, were excluded. Therefore, premiums would not vary on health status anymore, but the discriminants would be only family structure, geography, actuarial value, tobacco usage, and age.[71] Also, pregnancy was excluded from being a pre-existing condition and insurance companies were forced to level the premiums between men and women. In addition, those who wanted to preserve their previous plan because they were happy with it, could do it. (so-called "Grandfather provision")[72]. Subsection C clarified also which were the minimum limits of coverage of the four plans among which individuals could choose. From that point on platinum coverage must provide the patient 90% of the total expenses, the Silver 70%, Bronze 60%. This means that insurance companies were and are obliged to provide a Platinum plan with 90% coverage for the individual, and the patient has to pay out-of-pocket only for the

[71] Title I, Subtitle C, part I. SEC. 1201
[72] Title I, Subtitle C, part 2. SEC. 1251

remaining 10%. The same applies to the other plans. It was a big improvement for insured people since insurance companies now have minimum coverage criteria to satisfy to be compliant with the legislation. Also important in this first title was subtitle E[73], which had which purpose of granting more affordable coverage by establishing new rules for refundable tax credits. In particular, Americans could benefit from tax credits when their income was below 400 percent of the federal poverty line[74]. Subsection F has brought up the concept of "shared responsibility" we mentioned before. Starting from 2014, the individual himself had the duty to enroll in a program, that could be both with a private insurance company or a federal agency. The essential point to get is that everybody should be insured in some way, and therefore protected at least against the most common healthcare problems. This duty was instilled within the responsibility not only of insurance companies, that as we have seen before, had new impositions to comply with but also within patients (and companies) that were forced to get insurance for themselves or their employees. If they did not get insurance, they would be fined small amounts of dollars, which increased each year. Each adult not insured would pay 95 dollars a year or 1% of his income in 2014, 325 dollars a year or 2% of his income in 2015, 695 dollars a year or 2.5% of his income in 2016. This measure excluded those who could afford coverage, but it was also true that they could be enrolled in the Medicaid program and get coverage from the federal state in which they lived. Thus, the measure targeted mostly those who could afford coverage but decided not to get it. The same can be said for companies, especially those with more than 200 employees, that were forced to ensure their full-time employees with an insurance plan that was qualitatively and quantitatively adequate. If individuals were not insured or received inadequate coverage, the company could be fined

[73] Title I, Subtitle. E, part 1. SEC. 110

[74] The federal poverty line is a federal measure that is used to classify individuals based on their level of income. The FPL divides individuals and families based not only on their income gained in the year but also on the number of individuals that form the family. For example, in 2021, a family composed of three individuals that earn $ 88,000 overall is included in the 400% of the FPL. (For further information see the tables provided by Medicaid.gov.).

up to $3,000 for each employee who did not receive care or that had found a more convenient plan in the marketplace. Subtitle G ended the first title, signaling some general achievements healthcare needed to gain: governmental transparency (sec. 1552), access to therapies (sec. 1554), equity (sec. 1556), and non-discrimination (sec. 1557).

Title II was named "The Role of Public Programs". It underlined the other important goal of the ACA, which was to expand the coverage offered by public agencies to allow more citizens, especially those who have a low income, to get access to basic cures. To do so, the ACA expanded eligibility criteria to include more population and underlined the federal responsibility to support these people and to cover for the cost of this expansion. The keywords of this title are simplification, expansion, new services offered, coordination, and quality. Simplification means granting easier access to Medicaid and CHIP, for people to have a feeling of safety in accessing programs.[75] Simplification was enacted through the institution of a website run by the federal government that allows people to confront plans and decide which is the best alternative for them. Secondly, Medicaid was expanded to cover more residents. In particular, all individuals up to 133% of the poverty line were included in the program, and the federal government committed to pay for 100% of their coverage between 2014 and 2016.[76] Along with Medicaid, also the CHIP program was expanded, to allow more children to get access to medical assistance.[77] Subtitle D clarified the improvements in services that were offered: new community-based services and support were at the basis of the new Medicaid that clarified also the role and concept of medical assistance that became a benchmark with defined requirements to provide. Coordination is also the center of this second title since the ACA (in subtitle H) wanted to establish better coordination between the central government and all states to provide more uniform healthcare, that can

[75] Title II, Subtitle C.
[76] Title II, Subtitle A.
[77] Title II, Subtitle B.

create a more cohesive approach, that takes care also of those who are dually eligible candidates.[78] Finally, the subsection, established new criteria to improve the quality of Medicaid. In particular, the subsection underlines the necessity of recommended measures to adopt in the assistance of the adult population in need, establishing at the same time a "Medicaid quality measurement program" to track the performances in terms of quality of Medicaid accredited facilities.

Title III was even more centered on the quality and efficiency of healthcare than title II: it was entitled "Improving the quality and efficiency of healthcare" and aimed at improving the delivery of healthcare by supporting and informing patients in a better and more coordinated way. The title focused especially on improving the quality of Medicare and Medicaid programs and delivering services of quality also for indigent people. To achieve this broad goal of the title, Obamacare introduced a program to link Medicare and Medicaid to quality by establishing standards of care ("value-based purchasing program"[79]) and by releasing reports on doctors who cure these types of patients. These reporting initiatives were included in what is called the "Physician Quality Reporting Initiative"[80] and aimed at abolishing the practice of Medicare/Medicaid patients dumping because of the low premiums released by the States. In addition, the ACA's action aimed at strengthening also the quality of the infrastructures deputed to healthcare at a federal level: these measures included, - among others - hospitals, nursing homes, home health agencies, and rehabilitation facilities.[81] Title III concentrated also on creating a new model to cure patients: the program was targeted at improving research and new testing methods to ameliorate delivery and payment of services. The goal was to achieve a more patient-centered model through primary care, that consisted of new techniques to

[78] Dual eligible candidates are people who are eligible to be enrolled in both a Medicare and Medicaid program. The Act wants to coordinate payment for dual eligible beneficiaries, in order for them to have benefits of both programs and pay for less out-of-pocket expenses.

[79] Title III, Subtitle A. SEC. 3001

[80] Title III, Subtitle A, Part 1. SEC. 3002

[81] Title III, Subtitle A. Part1. SEC. 3004-3005-3006

prevent illness before it is too late, requiring more in-depth interventions.[82] The third title focused also on improving care for rural patients[83], and on developing better payment accuracy[84]; however, the other big macro area of interest in this title regards the new Medicare Advantage (part C)[85] and Medicare Prescription Drug Plan (part D)[86]. The first decreased premiums for part C enrollees and pushed insurance companies to spend at least 85% of earnings in actual care, reducing overhead expenses. The latter - regarding part D - lowered the costs for enrolling in the prescription drug's part by lowering the slice that was paid by the individuals (lower manufacturing costs) and by increasing the coverage paid by the Government. In this way, the so-called "Donut Hole"[87], will be closed in 2021: this means that the gap that was previously paid by the beneficiaries will now be completely paid by the federal government, significantly decreasing costs for patients. Title III ended with some other measures to accomplish Medicare sustainability (Sub. E), and other technical improvements for enhancing quality through community-based services (Sub. F; G).

Title IV concentrated on the issue of chronic diseases and, in particular, it wanted to tap the problem of prevention in healthcare, to reduce mortality due to lack of preventive measures. The first tool implemented was the "Prevention and Public Health Investment Fund", a fund that was constructed to develop investments in preventive care and assistance. This modern approach wanted to raise awareness on the crucial role of prevention and wanted to encourage individuals to submit themselves to preventive check-ups to combat diseases. In this initiative, public authorities had to collaborate with private institutions and

[82] Title III, Subtitle A. Part 3. SEC. 3021-3027

[83] Title III, Subtitle B. Part 2

[84] Title III, Subtitle B. Part 3.

[85] Title III, Subtitle C.

[86] Title III, Subtitle D.

[87] The donut hole is defined as "the coverage gap in your Medicare Part D prescription drug benefit — the point where your prescription drug expenses exceed the initial coverage limit of your plan but have not yet reached the catastrophic coverage level." (Medical Resource Center, glossary)

conduct educational campaigns to sensitize the population on the matter.[88] Secondly, new access to clinics was encouraged through programs aimed at increasing preventive services: in particular, the ACA improved access to school-based health centers, oral healthcare facilities, and Medicare/Medicaid centers. [89] Finally, subtitles C and D were focused on the creation of healthier communities through immunization campaigns, activities to increase wellness and healthy living, and reduction of barriers for disabled individuals. [90] Moreover, preventive measures were encouraged through the establishment of entities deputed to research on preventive care for individuals and the evaluation of prevention and wellness best practices in firms and companies.

Title V was based on the healthcare workforce: the need to construct a more innovative and well-functioning environment was at the basis of this title, since it encouraged education and formation in healthcare, to increase innovations in the sector. What the ACA has done is the establishment of a "National Health Workforce Commission" that was deputed to the evaluation of the efforts of doctors, hospitals, and facilities not only in being innovative but also in the way they carried out their jobs. In this way, facilities and hospitals were classified accordingly to their ability to provide effective care and this helped patients to be more aware of the healthcare they were receiving[91]. In addition, the following subtitles (C-D) were centered on the improvement of access to medical schools: federal loans were granted to more students thanks to the enlargement of the inclusion criteria, and nursing programs were enlarged to encourage more young adults to enroll in these programs. The ratio of the measure was the lack of doctors and nurses who graduated from medical and nursing schools: this was a huge problem for US healthcare since that few new entrants in healthcare decreased the efficiency of hospitals and medical facilities. The measure was not quite effective, especially during the COVID-19 pandemic,

[88] Title IV, Subtitle A, SEC. 4001-4004
[89] Title IV, Subtitle A, SEC. 4101-4108
[90] Title IV, Subtitle A, SEC. 4201 – 4207
[91] Title V, Subtitle B, SEC. 5101-5104

since many have quarreled about the lack of doctors and nurses during the crisis and about the inability of hospitals to face the huge increase of patients. Finally, the last part of Title V aimed at supporting primary care through the training of new primary care doctors [92]and again, to improve access to healthcare services through new funds for healthcare centers and states that excelled in the education of the new healthcare workforce.[93]

Title VI tapped one of the main goals of the act, which was transparency. Its name "Transparency and program integrity" already mentioned a lot about the content that was analyzed inside its subtitles and sections. Transparency is meant to provide more information to the public, for all citizens to be more aware of the possibilities offered by healthcare's federal programs and about insurance policies. Moreover, the title encouraged more integrity in performing the job, trying to reduce abuses and frauds. Subtitle A focused on reports made to inform patients about physician ownership and investments, including also information about gifts and money transfers from drug manufacturers. Subtitle B debated on transparency in the nursing homes and facilities, making information about ownership available for the public. In addition, standardized complaint forms were introduced, and a website was developed to compare facilities. (Part 1-part2). Improvements in staff training were also encouraged (part 3) and background checks on employees of long-term care facilities were released to increase the awareness in patients and their relatives. The other subtitles of Title VI were still focused on the improvement of patient-centered research and on enhancing integrity in providing care to Medicare, Medicaid, and CHIP patients. [94] Worth a note is the "Elder Justice Act", included in this title at the subtitle H. The goal of the act was to prevent abuse and neglect against the most elderly population by granting awards to those facilities that are

[92] Title V, Subtitle F. SEC. 5501-5509

[93] Title V, Subtitle E SEC. 5401 – 5405; Title IV, Subtitle G SEC. 5601-5606

[94] Title VI. Subtitle E. SEC 6401-6411.

particularly involved in the care of elderly people and that provide great care to them.

Title VII confronted the theme of innovation, by fostering new medical therapies and by allowing more affordable medical treatments to children and poor communities.

Title VIII re-investigated the topic of community-based assistance by establishing a "national voluntary insurance program for purchasing community living assistance services and support" (the so-called CLASS act). The act aimed at assisting underdeveloped communities by establishing an insurance plan to provide community living assistance to these populations.

The two final titles regulated revenue provisions and the imposition of fees on healthcare (Title IX) and strengthened the improvements on quality and affordability mentioned in the previous titles (title X).

3.3. Constitutionality of the act

The Act raised several questions that were never approached in United States legislation before. There were three major areas of discussion that triggered controversies in the houses of law. As we have understood in the previous paragraph, the ACA instituted the so-called "individual mandate", that forced all individuals to buy insurance or to pay an economic penalty for their voluntary exclusion to coverage. This was a way for Obamacare to expand the number of individuals purchasing health insurance and to reduce the uninsured, but on the other side, this measure was "punishing" individuals for not getting covered by making them pay for their denial. The second issue that Obamacare brought up was related to Medicaid expansion. We have cleared up before that States were required to accept to expand Medicaid and enlarge the access criteria to make more people eligible for the program. However, if they refused to do so, they

risked losing all federal funding for Medicaid. The latter case raised more than one issue, especially related to federalism and national policy: *can the Federal Government withhold funding from states that refuse to expand Medicaid? Has Congress the power to overcome the decision of the single states in the matter of choosing how to define healthcare inclusion criteria?* The two problems shed light on two economic issues that, however, impact the freedom of self-determination: the first concerned the ability of individuals to decide whether to buy insurance or not, and therefore on freely deciding for their own life; the second controversy impacted on public finances, by restricting funds, but also on the ability on the single states to decide their healthcare system. There was, in addition, a third problem with the ACA, that triggered a religious concern among corporate environments. The Affordable Care Act forced businesses to provide coverage for contraception: this meant that all businesses had to include contraceptive methods in their healthcare plans, without extra payments from employees. The latter measure was not welcomed by religious corporations, which saw in the Act an imposition that overcame the freedom of choice and that went against religious beliefs.

All these problematic areas resulted in the Act's first question of constitutionality (No. II-293), which was argued in Congress on March 26-27-28, 2012, and concluded with the final decision of the Supreme Court on July 28, 2012. The parties involved in the dispute were, on one side, 26 states led by Florida that advocated the unconstitutionality of the act in the parts concerning both the individual mandate and the Medicaid expansion, while, on the other side, the counterpart was Kathleen Sebelius - Secretary of the U.S. Department of Health and Human Services - defending Obamacare's constitutionality. The lawsuit was called "National Federation of Independent Business v. Sebelius" but is mostly remembered as the "Florida v. Sebelius" case, as the State of Florida was the main actor involved. The legal battle started in the District Court of Florida in 2011 where the State questioned the constitutionality of the act in two different aspects: firstly, it argued that the individual mandate was not

constitutional since it was Congress' abuse of power in exercising the Interstate Commerce Clause[95]. Florida argued that Congress could not impose fines on individuals deciding not to purchase healthcare insurance, since they were not in a commercial contract yet (they did not buy yet, thus they were not involved in a contract) and therefore Congress had exceeded its authority by imposing a regulation that got in the way of individual liberty. The counterpart reacted by stating that not buying - or choosing not to buy- insurance did not exclude an individual from the stream of healthcare since everybody in some stages of their lives requires healthcare at some point. Thus, Congress had the right to use this power, since they were just regulating the time in which that power was used.[96] The second aspect debated in the suit was, as we said, Medicaid expansion. Florida reputed the Medicaid expansion as unconstitutional since it forced States to expand criteria under the threat of losing all the funding for Medicaid. For Florida, Congress was, once again, overcoming the boundaries of the law, since it was interfering with the states' freedom of choice in legislating for healthcare[97]. Obamacare's supporters refused the allegations. The District Court ruled against the ACA, stating that the individual mandate was unconstitutional since it did break the interstate commerce clause, and it struck down the entire act since the individual mandate was not severable and impacted all the ACA's content. The 11th Circuit Court of Appeals legislated against the constitutionality of the individual mandate, but the latter was severable and, therefore, it did not impact the whole Act, that remained active. The different rulings required the opinion of the Supreme Court, who was asked to resolve the controversy and ultimately decide whether the act was constitutional or not. The judges of the Supreme

[95] The US Congress has only enumerated powers, listed in the Constitution at article I, Sect. 8, Clause 3. Among these powers left in the hands of Congress, the Constitution highlights the right to regulate "interstate commerce", which means it has the power "to regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes." The commerce clause is therefore the power to regulate interstate matters that impact on commercial contracts, justifying legislative powers of the federal government and restricting the single States' legislative power.
[96] The explanation was provided by Constitutional law professor Elizabeth Price Foley (FIU university) in an interview released in February 2012.
[97] ibidem

Court[98] were divided in the choice and split in two, supporting two different streams of decision. On one side, those in favor of the constitutionality (one was Judge Ginsburg), supported the act, stating it was in the power of the Federal Government to impose fees to those individuals who decided not to purchase insurance, since the fee could be assimilated into a tax, to pay to the Government, and therefore it was in the power of the Congress to institute it. The opposite opinion, supported by Judge Scalia, claimed the act was unconstitutional in its totality, since, if considered constitutional, would have declared that the powers of the federal government were not limited and enumerated anymore, and the Congress could have imposed whatever choice it wanted based on this decision. Judge Scalia, to clarify its argumentation, used the comparison with broccoli, which then became the symbol of this law case. "If Congress forced people to buy health insurance - he claimed - it could force people to buy almost everything, including broccoli since everybody has to buy food sooner or later".[99] Four judges supported Ginsburg's opinion, while four supported Scalia's argumentations: it was, therefore, Judge Roberts' choice to decide about the controversy. He voted in favor of the constitutionality, supporting the liberal view of Ginsburg. The individual mandate was constitutional and was considered – quoting the sentence - a "valid exercise of the power of interstate commerce" since it functioned as a tax. However, the Medicaid expansion was seen as unconstitutional, since it did not leave the choice to states who did not want to expand eligibility criteria and took back also the other funds, thus coercing them into a choice. What Congress could do was to take back only the funding for Medicaid expansion, but not the overall program's funds.

In 2014 the Supreme Court was asked, once again, to pronounce itself on the Affordable Care Act. This time, the topic was the imposition on businesses to

[98]The Supreme Court of 2012 was composed by Judge John Roberts, Chief Justice of the Court, Antonin Scalia, Anthony Kennedy, Clarence Thomas, Ruth Bader Ginsburg, Stephen Breyer, Samuel Alito, Sonia Sotomayor and Elena Kagan. One judge was of Afro-American origin (C.Thomas), and one of Latin American descendance (Sotomayor). Ginsburg and Breyer were nominated both by Bill Clinton. (Retrieved from: supremecourt.gov/justices)

[99] Stewart, J.B. (2012). *How Broccoli Landed on the Supreme Court Menu*. New York Times.

include all employees in health insurance programs that were also providing contraceptives. The (third) main problem of the Act was born because of the religious orientation of some companies that refused to accept the decision because they claimed it was contrary to their religious beliefs. Among the 40 companies that filed lawsuits against the Affordable Care Act, the most significant was Hobby Lobby Stores Inc., a retail company based in Oklahoma. Hobby Lobby has several stores in all of the United States and is a private company owned by Evangelical Christians. The firm's religious ownership was contrary to the decision of the ACA to provide contraceptive measures because it did not want to be complicit with the decision of women to use contraception and therefore asked the Supreme Court to resolve the controversy. The Supreme Court was again split into two different streams of thought: the first stream supported the ideas of Hobby Lobby, claiming the ACA was overstepping and was imposing the religious orientation of companies; the counter argumentation, supported mostly by the female judges, argued that the imposition to include contraceptives in healthcare plans was finally supporting women's rights and it was, therefore, a big win for the community at large. Moreover, it was not an imposition on the business, but it left in the hands of the employees to decide whether to include it in their employer healthcare plan or not, thus being an individual choice to accept it or not. The Supreme Court ruled against the ACA (5 vs 4), claiming the act was getting in the way of the freedom of privately held corporations and non-profit organizations to exercise their religious interests. The "contraception mandate" was therefore inapplicable since it violated the Religious Freedom Restoration Act. [100] After the pronunciation of the Supreme Court, Judge Ginsburg, one of the female Judges that voted against Hobby Lobby's claims, affirmed that "*The court, (…), has ventured into a minefield*" where all religiously held corporations could now advocate for the denial of certain rights to their employees. For example - she claimed - this could open the door to Jehovah's Witness businesses to refuse to grant access to blood transfusions for

[100] Molinari, E. (2013). *La riforma sanitaria. Aborto e pillola Obamacare sotto processo*. L'Avvenire.

their employees or Scientologists to refuse to give antidepressants, advocating the same claim of Hobby Lobby.[101]

The dilemmas that revolved around the ACA were not finished with these two judgments. One of the most debated cases regarding Obamacare was "King v. Burwell" which brought up a new challenge of constitutionality for the Act. In this controversy, the main topic of discussion was related to the individual mandate and the possibility of people who were neither enrolled in employer-sponsored programs nor eligible for Medicaid to get access to state-subsidized insurance plans and receive premium tax credits. The problem of this case was coming directly from the law itself, which said that:

"The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—
(A)the monthly premiums (…) which cover the taxpayer, the taxpayer's spouse, or any dependent (…) of the taxpayer and which were enrolled in through an Exchange established by the State (…)"[102]

The key point was that, according to King - the plaintiff - the law itself determined that only those who were enrolled in an exchange established by the State could get access to the subsidies, while those who lived in States (like Virginia, the center of the controversy) that had federally run exchanges would have been excluded from receiving them.[103] This single sentence opened up the argument that the Supreme Court was asked to resolve: *were only those living in states granting state-run exchanges allowed to receive subsidies?* The Obama administration claimed it was not what the law wanted to affirm and that both states with their marketplaces and states with federal exchange systems were allowed to offer subsidies. The decision pronounced by the Supreme Court was

[101] Burwell v. Hobby Lobby Stores, Inc., (2014) 573 U.S. 682. Dissent opinion.
[102] 26 U.S. Code § 36B - Refundable credit for coverage under a qualified health plan.
[103] Mochoruk, B. & Sheiner, L. (2015). *King v. Burwell explain*ed. Brookings Institution.

in favor of the Obamacare supporters (6 in favor v. 3 against), re-affirming the right of all citizens to receive financial support, despite the origin of their state's marketplace. The opposite decision would have opened up to new – possibly dangerous – scenarios: Blumberg et Al. (2015)[104] claimed that, if the Supreme Court had taken King's side, nearly 8.2 million people would have lost their insurance, producing higher costs for coverage for all the population. Thus, the consequences would have been catastrophic not only for indigent people but for all the population at large.

If the reader thought the King v. Burwell case was the very end of the disputes over Obamacare, he/she would be deeply astonished by the news that the ACA is undergoing through another passage in front of the Supreme Court in more recent times. As a matter of fact, in 2020, the Affordable Care Act was once again questioned in the individual mandate and went through another analysis in front of the highest court of the United States. The U.S. Supreme Court of 2020-2021 is, however, very different in its composition in the respect of the previous Supreme Courts that have examined the ACA in the past: while in 2012 and 2015 the approach was more liberal, the current Court can be considered more conservative, at least in its composition. Judge Ruth Ginsburg, traditionally a liberal Judge, was succeeded at her death in 2020 by Judge Amy Coney Barrett[105], nominated by President Trump along with Judge Gorsuch (in 2017) and Judge Kavanaugh (in 2018). Their nomination could suggest a more Republican approach to decisions that could rule against the Affordable Care Act. The challenge of constitutionality was raised after the decision of the District Court of Texas (a traditionally Republican state) in the lawsuit Texas v. Azar to declare the individual mandate unconstitutional and therefore to struck down the entire

[104] Blumberg et Al. (2015). *The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 million More Uninsured and 35% Higher Premiums.* Robert Wood Johnson Association.

[105] Her nomination was strongly contrasted by the Democratic wing of the Senate, because it was seen as an attempt of President Trump to influence the ruling of the Court in favor of the ACA dismantling. However, the Senate confirmed her nomination for the role (52 in favor, 48 against), and she is now an effective member of the Supreme Court. (Fandos, 2020. *Senate Confirms Barrett, Delivering for Trump and Reshaping the Court.* New York Times)

Act. After the sentence, other states (mostly of Democratic orientation) led by California have appealed the decision, stating that the dismissal of the law could implicate more than 20 million Americans losing their healthcare insurance.[106] The individual mandate was again declared unconstitutional, but this did not imply that all of the Act could be considered as such. The final word is now left in the hands of the Supreme Court who is asked to pronounce itself on the matter. The decision is not taken yet, and will probably be available by June 2021; however, the arguments were already heard in November 2020, before Joe Biden was elected President. The big question is: *can the rest of the law live without the individual mandate supporting it?* Making forecasts is difficult now because there are many aspects to consider. The Trump Administration repeatedly attacked the law, being one of the first times in which the Federal Government does not support a federal law. Trump and the states against the Affordable Care Act claim the act is not constitutional if the individual mandate is not in place anymore. Moreover, the three new Republican Judges can now direct their votes against the law, dismantling all its provisions. However, on the other side, the settlement of Biden into the White House gives now more strength to the ACA, explicitly supporting Obamacare, and therefore changing the opinion the federal government has taken in the last four years. The Justice Department is now backing up the ACA, reversing the position it has assumed during the last presidency. The final word is left to the Supreme Court's nine Judges, who are asked to decide whether the ACA's beneficiaries can retain their healthcare protection. If the ACA is overturned, the part that now insures citizens with pre-existing conditions will be in jeopardy and many could risk losing their protection. Moreover, there would be new questions to answer: *is COVID-19 a pre-existing condition that does not allow to get insured?* Further news will be available in summer 2021, but with a ruling against the ACA one thing is sure: US

[106] Rapfogel, N. & Gee, E. (2020). *The Health Care Repeal Lawsuit Could Strip Coverage from 23 million Americans.* Center For American Progress.

healthcare will not be the same, possibly triggering protests among citizens losing their protection.

3.4. Public opinions

Now that we have debated deeply about the Affordable Care Act, it is now time to understand the feeling that the population has over this series of reforms. Discussing Obamacare, as we noticed, is a web of intricate matters, and some of them are still unresolved yet. *What is then the general understanding that American people have over it? Has it improved the lives of Americans?* Many of the readers - seen the significant improvements in the number of citizens insured in the United States over the past decade - may think the general opinion over the Act would be favorable to its introduction and implementation, and in many cases, it is so. However, after 10 years since its approval in Congress, Obamacare has also collected a lot of detractors that want to develop a new model to replace Obamacare. To have a clear picture of the public opinions over the Act it is essential to start by clarifying the approach that will be used. The analysis will take a double direction: from one side, it will consider the feeling of citizens/patients when approaching and using the tools of the reform, while on the other side it will consider the comments of doctors, that are involved in the bureaucratic flow of Act and can provide an insight on the procedural parts of the ACA. This double analysis will help to have a complete framework of the law and will be helpful also in light of the last paragraph of this chapter, which will evaluate the system as a whole.

The discussion starts with the patients' side of the story. To allow the reader to possess a useful tool to analyze the patients' thoughts over Obamacare we will inspect three different dimensions that are relevant in this topic. Opinions, I underline, are influenced – sometimes, even biased – by the context

in which a person lives (the society in which he/she lives, the people frequented, age and economic status) as well as from the political views possessed. This is why my analysis will be focused on examining the general opinions over the Act with an eye over these dimensions, which are relevant also to understand the forces that sometimes can get in the way of impartial analysis. Starting with a general feeling over the Act, we can retrace significant data from the Kaiser Family Foundation polls, released in March 2021[107], that kept track of the evolution in the public opinions over the Act a decade after its passage in Congress. The chart shows a rather divided population, with opinions split into two parts. *In-favor* opinions are slightly higher than *against* opinions: in the last two years, the favorable population ranged from 48% in June 2019 to 53% in December 2020, while the unfavorable opinions – considering the same period – went from 42 to 34%. Positive feelings about the ACA are especially related to the quality of the healthcare received and the professionalism of doctors and nurses that assist patients. The negative claims about the Act are especially due to costs, that are still high and deemed incomprehensibly incomparable with other OECD countries. The detractors' decrease in 2020 can be in part associated with the discussion in Congress over the last challenge of the constitutionality of the Act, which was due at the end of 2020. It was probably influenced by the question-marks over Judge Coney Barrett's nomination to the Supreme Court, which, for many, was seen as an attempt of Trump to overthrow the verdict. Moreover, the threat over the ACA's dismantling brought the public opinion to a new conception of the Act itself, wanting to safeguard it, especially in the part where it grants coverage despite pre-existing conditions in place. As a matter of fact, regarding the latter provision, the majority of Americans[108] claim that, despite the general feeling about the ACA, this provision should be kept in place, even if the Act is deemed unconstitutional. Indeed, the threat of millions of Americans with pre-existing conditions (or relatives with them) to lose their

[107] Kaiser Family Foundation (2021). *KFF Health Tracking Poll: The Public's Views on the ACA.*

[108] Hamel, L. et Al. (2020). *5 Charts About Public Opinion on the Affordable Care Act and the Supreme Court.* Kaiser Family Foundation.

coverage due to the dismantling of the Act can direct public opinions towards a more favorable view of the ACA as its whole. If we take into account public opinions over the Affordable Care Act from its implementation till now, we will see a fluctuating trend: right after the Act's implementation there was a peak in the favorable population (50% v. 35%), while in 2015 there was an overturn in the percentages, and for the first time, the unfavorable population was higher than the favorable one (42% negative v. 35% positive). This phenomenon coincides, once again, with the questions over the ACA's constitutionality, in particular with the King and Hobby Lobby's claims, in both cases dismissed. The continuous lawsuits that Obamacare was going through could have probably triggered a rather negative feeling over the Act, justifying this change of direction in the population. In the next years, however, the Affordable Care Act gained ongoing consensus over time, underlining a rising trend that supports the idea that 2015's negative period was just a momentum that passed rapidly.

As noted above, significant conclusions can be drawn from demographics, geography, and political views of the population. Starting from politics, a rather important result is that 85% of Democrats think the ACA should be kept alive, while only 18% of Republicans believe in it.[109] This data indicates that political orientation strongly influences the evaluation of this law and can drive to different conclusions based on it. Moreover, it was also found out that the majority of Democrats believe it would be more useful to build on Obamacare to improve healthcare while Republican supporters encourage the ideas of restructuring healthcare by demolishing Obamacare in its totality and building a new model.[110] Furthermore, a rather new approach to analyzing public opinion is also to inspect how the news and TV shows debated on the ACA. The news coverage over Obamacare was examined by Gollust et Al. (2017) [111] that explains

[109] Kirzinger, A. et Al. (2020) *KFF Health Tracking Poll – February 2020: Health Care in the 2020 Election.* Kaiser Family Foundation.

[110] ibidem

[111] Gollust, S.E., Baum, L.M., Niederdeppe J., Barry, C.L., Fowler, E.F. (2017) *Local Television News Coverage of the Affordable Care Act: Emphasizing Politics Over Consumer Information.* Am J Public Health. 107(5):687-693. doi:10.2105/AJPH.2017.303659.

the different aspects to consider when referring to the topic. It was demonstrated that generally, the American news covered more circumstantial facts about the Act rather than actual provisions. As a matter of fact, the news opted to discussions based more on the number of insured, the repealing of the law, the political agreement/disagreement over the Act rather than on actual healthcare resulting from Medicare and Medicaid improvements, making people less aware of the possibilities offered and, at the same time, directing their attention on the contextual factors surrounding Obama and the law. The study also found out that some states are generally keener on supporting the Act (such as Arizona, Hawaii, Nevada, and North Dakota) while others have rather different interstate results, signaling how the coverage varies among different territories. Demographics also helps in understanding the general feeling over the Act. Black people generally approve the Act more than Whites: as a matter of fact, Whites' disapproval reaches 50% of the total, while Blacks' disagreement is only around 20%.[112] This can be justified by the more favorable conditions set in place for Black and Latino communities that are more likely to be insured under Obamacare than in the past. All these considerations contribute to developing different views over the Act so that it is not possible to find a shared perspective on it.

The second stream of opinions considered in this subchapter is those of doctors that, as we introduced at the beginning of this part, are essential to understand whether the ACA is functioning not only for patients but also for workers in healthcare. Many physicians are not happy with the ACA for what concerns bureaucracy and the reimbursement rates granted by the government to physicians who treat Medicaid and Medicare patients, which are considered too low and too slow to support the system. As resulted from a video interview conducted by The Heritage Foundation (2012)[113]Doctor Martha Boone claims it is now impossible to carry out an independent activity because the low

[112] Dalen J.E., Waterbrook K., Alpert J.S. (2015) *Why do so many Americans oppose the Affordable Care Act?.*Am J Med.; 128: 807-810

[113] The Heritage Foundation (2012). *Obamacare's Impact on Doctors.*

reimbursement rates coming from the Government are not enough to cover the costs of overhead that originated from the activity (i.e., rent, additional administrative personnel). To make up for it – she claims - a doctor would have to cure at least twenty patients every hour to earn enough money to support the whole business, at the expense of the quality of patients. Moreover, the slowness of the process makes it impossible to respect payment timelines to employees and personnel. Boone finally underlines the dark prospects for incoming future doctors, with hundreds of thousands of dollars spent in their education, who cannot return on their educational investment: this can lower the appeal of the profession and therefore cause a future shortage of physicians. A similar view is shared by Doctor Hill, interviewed by CNN[114], that claims that healthcare, after the advent of Obama, has become more centered around bureaucracy than around actual healthcare and has put pressure on doctors to fulfill the requests of the Government more than they have to fulfill those of patients. A counter opinion is provided by another physician also interviewed by CNN[115], Doctor Nanda. He claims that the ACA was very beneficial for poor and indigent people that can now be treated inside the hospital's walls. In addition, he underlines how Obamacare is just the first milestone of a new wave of reforms that will come in the future and will improve and integrate the Affordable Care Act. Thus, here again, is very difficult to find a shared opinion among doctors as well: physicians, like patients, are driven by their different attitudes, ideologies, and scientific understanding. Young doctors are in general keener on approving Obamacare more than their older colleagues[116] and again, politics plays a huge role in the orientation of doctors toward the act: Democrats have a more liberal view, while Republicans are more skeptical.

To conclude, it is rather difficult to concretize a clear picture about US healthcare's public opinion, especially because everybody has its personal view,

[114] LaMotte, S. (2017). *What doctors think about the Affordable Care Act*. CNN.
[115] Ibidem
[116] ibidem

influenced – sometimes biased - by their personal experience, knowledge, information, and ethics. It is, however, helpful to approach the topic to understand how much the American population is split over healthcare, and to get a feeling of the centrality of the topic not only for policymakers but also for the general public. Now more than ever, healthcare has gained the stage in the public debate, after years of stall: COVID-19 has pressured all states of the world to assess the efficiency of their systems and a more informed population has understood how the topic is directly relevant for their lives.

3.5. Trump's reforms and prospects with the election of Joe Biden

President Trump was never a fan of Obamacare: since the beginning of its electoral campaign in 2016, he attacked the reform, highlighting the huge burden that the public finances had to support to enact the measures encouraged by his predecessor. In particular, he contrasted the obligation for companies to ensure all their employees' medical coverage and the expansion of Medicaid- the milestones of Obamacare – claiming they were driving the American business and economy to collapse. Indeed, it was no surprise that Trump, on his first day as a President, issued an executive order (nr. 13765) that "minimized the economic burden of the Affordable Care Act", without, however, specifying the actual actions that would have been implemented to do so[117]. It was a demonstrative measure to underline which were the intentions of the administration regarding the ACA. This executive order was just the first step of a long journey that, in the mind of Trump, had to produce a new, more cost-efficient healthcare through the dismantlement of the previous Act. The "American Healthcare Act" or "Trumpcare '' was proclaimed for long as the new

[117] Katz, M. (2017) *What Does Trump's Executive Order Against Obamacare Actually Do?* New York Times.

milestone for American healthcare, by reducing its costs and by setting up new criteria for enrollment based on age, rather than on income. In its intentions, it wanted to reduce Medicaid expansion, which was seen as too expensive, and it wanted to suppress the individual mandate, especially in the part regarding penalties for not enrolling in any insurance program. Moreover, Trump's wish was to give back some autonomy to insurance companies to impose higher premiums on elderly individuals: he wanted to differentiate citizens in new age categories to impose lower premiums on younger individuals. To make up for the reduction of these provisions, alongside the introduction of Trumpcare, the administration wanted to introduce tax cuts for all incomes above 200,000 dollars by 0.9%: this measure was benefiting rich citizens, as underlined by Senator Bernie Sanders[118] since it allowed them to economize on taxes, while poor people were paying health insurance more. Trumpcare was, though, never realized in practice: it passed in the House of Representatives, but the Senate did not approve the reform, leaving it written into the paper but not effectively active. The debate around it, however, was intense, and, once again, it raised some important remarks on healthcare. Trump's attempt to dismantle the ACA can be considered an action to reverse the trend begun by Obama towards universally oriented healthcare. As we noted above, when hearing about universal healthcare - that seems taken for granted in some states in the world – most Americans are skeptical. This skepticism is originated by the lobbying of interest groups that strongly pushes against its introduction, and by the fact that healthcare in America is not seen as a right of each citizen (i.e., in Italy, the right to health is embedded in the Constitution), but rather a commodity, for which each individual has to pay to get access to its services. Therefore, this cultural difference gets in the way of a universal approach, that seems, for a consistent part of Americans unacceptable. Trump exploited this individualistic mindset to his favor, by appealing on the part of the population that is traditionally against

[118] Senate Budget Committee hearing (2017, May 26). Retrieved from: https://www.youtube.com/watch?v=VexKDujKGpw

universal healthcare; however, the ACA made it clear how much is difficult to go back to the previous setting, since the majority of the population has now benefitted by the improvements in healthcare brought up by Obama and contrasts its abolition.

Even though Trump did not succeed in introducing his AHCA, he managed to enact certain changes to the initial Affordable Care Act overcoming Congress and intervening directly through executive orders. Firstly, as we have seen in the previous paragraph, he supported the campaign to repeal the individual mandate and he explicitly took the side of the State of Texas, which deemed the Act unconstitutional. The case is still pending and can undo all the Obama provisions, but this time, it seems clear that, in case of an unfavorable verdict, President Biden would not hesitate to restore some of the previous provisions. Secondly, Trump began a campaign to lower the enrollment in the ACA: he reduced the funds for advertising campaigns and decreased the period of enrollment (from 90 days to 45 days). Moreover, he limited funds for the information program (so-called "navigators"), from 62.5 million dollars to 10 million dollars. Finally, the Republican Administration decreased the public exchanges, making plans less affordable, and therefore, less appetible for citizens.[119] [120] [121]Thus, even if there was no change in the healthcare reform, in practice the actions of the former President were undermining the ACA, intervening on the image and the funds of the Act.

The 2020's elections, however, were won by Joe Biden - a democrat - and marked a consistent change of direction from previous years. Biden was vice-president in the Obama administration and a profound supporter of the Affordable Care Act. When he was sworn in as President, it was therefore clear the direction the Presidency was going to take. On his first day in the Oval Office, he signed two executive orders that re-opened the enrollment period (that was

[119] Rice, T. et Al (2018). *Universal coverage reforms in the USA: From Obamacare through Trump.* Elsevier. Health Policy 122, 698–702

[120] BBC World News (2019) *Obamacare: Has Trump managed to kill the Affordable Care Act?* 7

[121] Thomson, F.J. (2020). *Six ways Trump has sabotaged the Affordable Care Act.* Brookings.

shrunk by Trump to 45 days) allowing citizens to get access to the Health Insurance Marketplace.[122] Trump refused to take on this action, even though he was pressured by public opinion, strained by the COVID-19 pandemic. [123] Biden, as he directly admitted, did not do anything new to the healthcare sector, but he just re-enlarged the possibilities to enroll in Medicaid and publicly funded programs, by restoring some of the previous enrollment conditions denied by the Trump Administration. What is clear from his actions, and what was largely forecasted before and after his election is that he - once more - reverted the trend of the previous administration towards healthcare. Being a supporter and one of the creators of the ACA, he will certainly secure the old provisions and probably make another step towards a more inclusive system that protects the parts of the population that are more in need of health assistance. This does not mean that the debate on healthcare is finished: with the COVID-19 pandemic, healthcare certainly remains the top priority of his government, as it is certified by his vaccines campaign, which for now, has produced incredible results. The United States is, in fact, one of the most advanced countries in the vaccination campaign, having administered till March 2021 more than 430 million doses. With roughly 2,5 million doses administered each day, the US aims at concluding the campaign in 5 months (supposedly May 2021), being one of the first countries in the world to be COVID-free. [124] Moreover, a consistent part of the Federal States (i.e., New Jersey[125]), offers vaccines also to uninsured people, making a step towards a more universalistic approach. *Will it be the final step towards universal healthcare in America?* Probably not, since the culture cannot be changed in a day, and the supporters of the current approach are still a lot. However, the direction this Administration has assumed will supposedly enlarge the access and the affordability of the system, with an eye to minorities, as the new Cabinet

[122] The White House (2021). *FACT SHEET: President Biden to Sign Executive Orders Strengthening Americans' Access to Quality, Affordable Health Care.* Briefing Room. Statements and Releases.
[123] Luhby, T. (2021). *Biden signs executive order to reopen Affordable Care Act enrollment*. CNN.
[124] Bloomberg statistics (2021). More Than 430 million Shots Given: Covid-19 Tracker.
[125] New Jersey COVID-19 information hub.

composition suggests. In fact, for the first time in America's history, the Cabinet secretary is openly gay, and five members are women. His vice-president, Kamala Harris, is an Afro-American woman, and his wife, Jill Biden, is the only first lady in history that is still working while being in the White House. A huge step forward, I would say, not only for healthcare, since it opens up to minorities' and women's interests, continuing the descendants left by Obama, but also for society at large since it could be the start for a more equal society. Let us hope all the positive expectations are attended in the next 4 years.

3.6. Evaluation of the US healthcare system using the *Iron triangle of healthcare*

We now approach the final part of this chapter, which will examine what we have seen so far by making an overall evaluation of the US model of healthcare. In this paragraph, we will take into deep consideration what we have discussed about the Affordable Care Act so far, since the reform is now mature and well-integrated in the US healthcare system, and therefore it is significant to understand if it has improved healthcare as it was wished by its fathers.

This analysis will use a diffused model for the evaluation of healthcare systems of the world: the Iron Triangle of Healthcare. The tool was developed by William Kissick in 1994[126], through his famous book "Medicine's Dilemmas". The Iron Triangle of Healthcare is constructed as follows: Kissick considered three dimensions that are relevant for the evaluation of a system of healthcare. The first one is access, which includes the capacity of the system to provide healthcare to its patients and to include as many as possible in the flow of healthcare. The second dimension is quality and considers the ability of the

[126] Kissick, W. (1994) *Medicine's Dilemmas" Infinite Needs Versus Finite Resources*. Yale University Press.

system to be efficient in the delivery of healthcare and to provide the best cures possible. The third (and final) dimension is that of costs and takes into account the expenses the system has to provide the services it offers. The three dimensions, taken simultaneously into consideration, provide a framework of the healthcare system analyzed, since they touch the essential requirements a healthcare system needs to have to deliver assistance to patients in an effective way. Kissick's view of these dimensions, not by chance, is explained in a triangle. If we think mathematically this will easily make sense: the sum of the angles of a triangle is 180 degrees, and it does not change with the form the triangle assumes; however, each triangle can have different distributions of angles (90°-60°-30°), (60°-60°-60°),...etc. Therefore, if we think about healthcare, we consider that each angle equals a priority, and the sum of them is the overall healthcare provision. To be efficient, a system needs to be good in all three of them. However, if a system wants to improve one of them (perhaps two), Kissick claims the remaining priority will decrease its angle, decreasing its efficiency. To provide the reader a clarifying example, let us think about a system that wants to improve in its quality. Undoubtedly, to do so, it will need to invest money in new hospitals, facilities, doctors, and services: this will impact the economic resources of the system since it will necessarily need to use more of them to fund the new improvements in quality. Therefore, costs will be higher, and the overall environment will be impacted. This example significantly explains what Kissick suggested in his book, underlining how the three dimensions are not only intertwined but also that acting on one produces inevitable consequences on the others. We now verify if the assumptions of Kissick apply also to the healthcare system of the United States, drawing important conclusions from the previous paragraphs of this chapter and from what we have explained in chapter 2.

We start by analyzing the access dimension of the US healthcare system. For sure, access improvement was the major goal of the Affordable Care Act and of the Obama administration, which considered the increase of insured citizens as an essential condition to be improved with the reform. This is clear from the

major efforts produced in the field: new Medicaid expansion to include larger slices of the population, new public marketplaces to compare healthcare insurance, abolishment of pre-existing condition exclusion clauses, advertising campaigns for enrollment, and new regulations for employers to increase access to employer-sponsored programs. All of these provisions were developed to reduce the number of individuals uninsured and to increase awareness in citizens, to help them choose the best insurance fit. Public programs also helped by enlarging the inclusion criteria to enroll in both Medicaid and Medicare and children's inclusion in parents' healthcare plans until reaching 26 years of age favored a more youth-oriented approach. All of these conditions produced strong results in terms of individuals insured. The number of uninsured in the US dropped steadily since 2010: in 2010, the number of people insured in the US was around 50 million[127], while in 2021 just 30 million people lack coverage[128], meaning that almost 20 million people gained insurance thanks to the ACA.[129] Encouraging numbers also come from coverage of adolescents and young adults, with significant percentages of individuals under 26 getting covered under ACA provisions. As a matter of fact, in families with incomes over 400 percent of FPL and between 138-400 percent of the FPL young adults' coverage improved by including respectively 10 and 11 percent more youngsters in parents' healthcare plans.[130] Less significant results are witnessed in the coverage of adolescents that are members of families with lower incomes, since, probably, they benefited from Medicaid and other subsidies even before Obamacare. [131] The overall evaluation of the ACA under the access dimension, is, so far, positive. However, until now, we have consciously excluded one of the most significant

[127] Statista (2021) *Number of people without health insurance in the United States from 2010 to June 2019(in millions)*

[128] Commonwealth Fund (2020) *The Affordable Care Act at 10 Years: What's the Effect on Health Care Coverage and Access?*

[129] No other major phenomenon can explain this sudden drop in insured people other than the Affordable Care Act implementation in 2010.

[130] Gehr, J. (2017) *Why the Affordable Care Act Is Critical for Young Adults*.

[131] Ibidem

considerations to be said about access in the United States, that however, we have repeatedly mentioned throughout the whole thesis: universal coverage. Obamacare did not succeed in providing universal health care to everybody, even though the act undertook that direction. This a very important consideration to note when referring to healthcare access in the United States and cannot be forgotten in the overall system evaluation. The U.S.A. remains the only industrialized country in the world without universal healthcare coverage: the dual system private-public, even though it was improved, does not allow everybody to get coverage. As we noted above, almost 30 million people remain uninsured: the percentages dropped since 2010, but the problem remains active. It is the opinion of this author that positive feedbacks on access cannot be provided until universal care is established and until when all the population can benefit from healthcare assistance. Healthcare in America is still a luxury for many adults that are neither beneficiaries of public programs nor have enough economic capacity to purchase insurance. Though the ACA improved significantly this dimension, we cannot still claim the US has solved the issue, and essential steps have to be undertaken to consider the population "stuck in the middle ''. Insurance companies remain a huge deterrent for universal healthcare since strong lobbying is exercised against the achievement of this goal. Moreover, their increasingly higher premiums discourage many individuals to even try to get insurance: the US Bureau of Labor Statistics (2020)[132] underlines that the average annual premium for a US worker is around $1,4 thousand a year for individual coverage and around $5 thousand for family coverage with employer-sponsored healthcare programs. For individuals without work, and with no access to Medicaid or Medicare benefits, the costs of purchasing insurance without employer backup are exponentially higher, and therefore inaccessible. The risks that people incur for not having healthcare insurance are, of course, linked with their physical survival, but are also extremely intertwined with their economic status. If you think, for example, that a 15-minutes ride with

[132] US Bureau of Labor Statistics (2020). *Medical care premiums in the United States, March 2020.* m

ambulance can cost up to $2,5 thousand[133] , you can just imagine what can cost a surgical procedure or a long-stay hospitalization; for sure, these huge amounts can produce family bankruptcies and reduce people to poverty very easily. In light of these arguments, we can draw important conclusions: though access has significantly improved after the Affordable Care Act was introduced, the United States is still far from a top-level evaluation in this dimension, in light also of the performances of other OECD countries, such as Switzerland or Germany – that we will analyze in chapter four - that provide universal coverage at lower costs for everybody.

Access goes in parallel with quality, the second dimension analyzed in the Iron Triangle of Healthcare. Evaluating the quality of healthcare is helpful to clarify if the system works efficiently and provides effective care to its patients. It is a relevant dimension that must be acknowledged alongside access and cost since it is interconnected and directly influenced by both of them. Many improvements were consolidated around the concept of quality and inclusivity and enhancing the quality of services in the healthcare system was one of the most significant goals of the Obama administration. As a testimony of this concern for quality, it suffices to read the first title of the reform: "Quality Affordable Healthcare for All Americans". The Affordable Care Act was designed not only with the idea of supporting all Americans in healthcare coverage, but it had also the aim to improve the outcomes for patients by allowing them not only to access cures but also to be assisted in a better and preventive way. At this point, it is useful to remind the top measures adopted. President Obama pushed towards a patient-centered approach, based - as we have seen - on preventive care. The latter was important because it could prevent diseases and therefore improve the quality of life of individuals. Prevention was a good tool to enhance quality, since it stressed hospitals less, and individuals avoided potentially dangerous consequences. Preventive screenings such as HIV and diabetes tests,

[133] Rosenthal, E. (2013) *Think the E.R. Is Expensive? Look at How Much It Costs to Get There.* New York Times.

chronic disease screenings, and end-stage renal disease check-ups allowed to reduce mortality rates for preventable diseases and achieved a higher quality of care. Moreover, Obamacare adopted a more inclusive approach for women and minorities: for the first category, the Government prohibited insurance companies to charge more to women just because they could get pregnant and included contraceptives in the healthcare plans. Contraceptive improvement reduced costs for women since they could get them without out-of-pocket expenses, saving women cumulatively 1,4 billion dollars on birth control pills.[134] Furthermore, mammograms were included in procedures granted by all insurance plans to prevent breast cancer. To testify the improvement in the quality of healthcare for women, a study conducted by Eliason (2020)[135] outlines a huge improvement in statistics for maternal outcomes: states who have expanded Medicaid were able to reduce maternal mortality much more than states who did not expand it. The improvement was especially witnessed among Black or Hispanic mothers, that are now keener on undergoing prenatal testing and check-ups. For minorities, Obamacare promoted community-based services to increase the quality of healthcare also in rural areas and to provide them the necessary services. The measure allowed 25 million people living in rural areas not only to be insured but also to get quality assistance and preventive care through family doctors.[136] The result of all these measures has to be put into numbers to be significant. That is why it is crucial to assess quality taking into account life expectancy in the US in the last decade, along with the analysis of mortality rates. These instruments are essential to understand the positioning of US healthcare in OECD countries, and they are helpful to track the progress throughout the time of healthcare quality measures undertaken with the Affordable Care Act. Life expectancy at birth in the United States increased since

[134] National Women's Law Center (2019). *New data estimates 61.4 million women have coverage of birth control without out-of-pocket costs.* Report.
[135] Eliason, E. (2020) *Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality. Women's Health Issues. 30(3):147-152. doi: 10.1016/j.whi.2020.01.005.*
[136] Families USA (2017) *Cutting Medicaid Would Hurt Rural America.* Fact sheet.

2010 from 78.4 years to 78.8 years[137], signaling a positive trend. Still, if compared to other countries, it is one of the lowest in the Western world. The average is 80 years old[138], and some countries achieve even higher numbers (i.e., Italy's life expectancy is around 83 years old). This means that, although the efforts have been important, the US is still lagging behind in this field. More access means also more quality since it grants people the possibility to prevent disease and to enact cures in advance. In terms of mortality rates, as testified by Miller (2019)[139], the ACA significantly contributed to a slowdown of deaths in the United States: the study outlines those 9,200 fewer deaths were witnessed among older low-income adults from 2013 to 2017, outlining a decreasing trend. States who did not adopt Medicaid expansion acknowledged more deaths for preventable diseases (+ 15,600 preventable deaths), signaling the fundamental importance of prevention. Finally, expanded coverage for adolescents and young adults produced positive results in terms of infant mortality that decreased in association with the introduction of the Affordable Care Act. [140] Overall, as we have discussed so far, the ACA brought significant results in terms of quality of treatment for patients. But quality lies also in the structural organization of the system and the efficiency of its bureaucratic apparatus. And, in this field, the United States is still in dire straits. The Affordable Care Act is said to be aggravating the difficulties in the bureaucratic flow between doctors and the Government: the mole of documents that doctors and patients have to read and sign is rising more and more, and this gets in the way of smooth service. We have also clarified this issue in the paragraph "public opinions" when we have ascertained that physicians find it very difficult to perform their job well and, at the same time, fulfill the bureaucratic flow of documents. Moreover, reimbursements for Medicaid and Medicare are slow, and doctors tend to refer

[137] U.S. Life Expectancy 1950-2021. Chart

[138] OECD (2020) Better life index.

[139] Miller, S. et Al (2019) Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data. National Bureau of Economic Research.

[140] Ibidem

patients that are insured with private companies rather than enrolled in public programs causing worse care for these categories of patients. Therefore, again, the ACA improved many aspects related to the quality of the system, but, at the same time, this huge mole of provisions sometimes slowed down the apparatus and made it less efficient. Regarding quality, one last topic is innovation. US innovative efforts are widely recognized around the world: US healthcare, in its best clinics, performs highly innovative procedures that are difficult to be found in other parts of the world. As pointed out by Girvan (2020) "The United States ranks 4th in the World Index of Healthcare Innovation", being one of the best countries in the innovative therapies and surgeries, scoring 54.96[141], and in Science and Technology use, scoring 75.1[142], the highest percentage. However, as pointed out in the index, the system is fiscally unsustainable in the long run, meaning that the innovative efforts produced are stressing the system, deteriorating its economical long-term survival.[143]

From what we have said so far one thing emerges strongly: the costs for individuals and the overall system are huge and worsening every day. We pointed out in the second chapter how much the US spends on healthcare: more than 16 percent of its GDP (more than 10,000 dollars per capita), the highest percentage in the world. Just for ACA's implementation the US spent 128 billion dollars[144] in 2019, the cost of three budget packages in Italy. Yet, the system does not cover everybody, and people and companies have to pay for healthcare. Some provisions reduced certain costs for individuals (i.e., Medicaid part D regarding prescription drug coverage saved around $26 billion for beneficiaries[145]) but, as noted above, costs remain high. This consideration confirms the initial theory pointed out by Kissick in 1994: the Affordable Care Act for sure improved – even

[141] Girvan, G. (2020) *United States: #4 in the World Index of Healthcare Innovation.* Freopp report.
[142] ibidem
[143] ibidem
[144] Commonwealth Fund (2020) *The Affordable Care Act at 10 Years: What's the Effect on Health Care Coverage and Access?*
[145] *CMS.gov. (2017) Nearly 12 million people with Medicare have saved over $26 billion on prescription drugs since 2010.*

though it did not resolve - the priorities of quality and access, but aggravated the third dimension, cost control. Thus, the policy improved just one (maybe two) main areas of healthcare, but it lacked to consider the economic impact of such decisions, or better, it acknowledged that costs cannot be controlled if we want to improve the access and the quality of services.

To conclude this third chapter, what we can say is that it is difficult to make an overall balance of the healthcare of the United States since many aspects are still controversial and difficult to assess. However, if we have to balance its pros and cons one thing is certain: the Affordable Care Act brought significant results that made US healthcare fairer and more accessible for a vast part of the population. The path to become the best system in this world is still long and will take more than a few years to advance. *Would it be possible to finally make it universal? Will it still cost more than in any other part of the world or will someone be able to make it efficient and affordable at the same time?* These are the questions that Biden's administration will have to solve urgently, seeing the importance that healthcare has assumed nowadays with the worst pandemic the modern world has witnessed in contemporary history. Moreover, the Affordable Care Act turmoil is not finished yet: the third Supreme Court verdict is still pending and expected to come in Summer 2021. If the ACA is repealed, the Biden/Harris duo will have to reconstruct the system, rethinking it from its basis once again. More news is expected to come, only time could tell us if all the previous questions will have a final answer in the near future.

CHAPTER 4 - COMPARING HEALTHCARE ACROSS OECD COUNTRIES: IS THERE ONE BEST WAY?

The final chapter of this thesis will culminate the analysis by comparing healthcare systems across the world. The task is far from easy, since - as noticed in the previous paragraphs – healthcare is a multifaceted matter, that ranges from healthcare *scricto sensu* to encounter many other aspects concerning economics, finance, and sociopolitical interests.

To complicate an already intricated task, the years 2020 and 2021 have made us live one of the most tragic pandemics of history: COVID-19. The virus has put under pressure all systems of the world, highlighting the importance of constructing a solid basis for our healthcare systems, which are still too fragile to approach these dramatic phenomena. This author has repeatedly asked herself whether to include COVID-19 in the speculative efforts of this chapter and, more broadly, of this thesis. From one side, excluding the pandemic from the overall argumentations would have been unfair to the period of history we are currently living in: in fact, COVID is now part of our lives and has deeply questioned the settings society has created to confront such disastrous events. From the other standpoint, however, centralizing all the attention on Coronavirus would have deviated the analysis in another direction, shifting the focus on the pandemic rather than on healthcare models. Therefore, I decided to consider the Coronavirus pandemic only marginally: the main goal of the chapter (and thesis) is to compare healthcare systems in the world. COVID has interested almost all countries and systems: its impact is therefore widespread and equally relevant everywhere. Therefore, all systems have been confronted with the same challenges, and no drastic changes in their overall configuration have been witnessed. Thus, COVID will be included in the analysis only for what concerns

the efficiency of the systems analyzed: it will be a relevant factor to test whether a certain healthcare model was better structured than others to confront a sudden and catastrophic event. However, while analyzing each single case study, we will use pre-COVID data, that are more relevant to understand the evolution of each system and to intepret why certain decisions were made to improve their configurations. In performing such comparisons, I will use as a theoretical basis the paper written by Reibling et. Al (2020)[146], which aims at categorizing healthcare models using comparative institutional analysis, together with a more health policy orientation, which takes into account the complexity of policies and reforms that governments put in place to achieve certain results in terms of innovation and efficiency. The categorization will help to draw important conclusions about each case study: at first, each category will be analyzed on its whole; then, the discussion will be more specific, concentrating on a reference state that adopted such configuration. Each example will be explored from the ground up: I will start by clarifying for each selected nation the main characteristics of its healthcare model and its structural organization, analyzing its behavior in terms of supply, public-private mix, access, primary care orientation, and quality/performances. All discussions will be based on official reports and data released by the OECD and the UE since they are precise and trustworthy tools to build the analysis. Finally, I will make my evaluation of each model, taking into consideration the problematic areas that are still to be solved. This final chapter will be far from exhaustive, since – as I repeated many times during the thesis – dimensions to be considered are almost infinite if we take into account all the linkages healthcare has with other sectors. However, the goal is to provide the reader an effective comparison that underlines the key points to grasp when exploring the world of healthcare. Before drowning in the actual content of the chapter, I remind the reader that, in evaluating each case, some considerations – though based on actual results - will be strictly personal of this

[146] Reibling et Al. (2019) Worlds of Healthcare: A healthcare system typology of OECD countries. Elsevier

author and should be taken as such. We now start by underlining what comparative institutional analysis means, and why it is a good method to compare healthcare models.

4.1. Comparing healthcare systems using a comparative institutional perspective: the "Reibling model"

Comparing is always a difficult task, especially when talking about institutions. Multiple definitions are available for the term "institution" and are useful to understand why they matter this much in our society. An interesting overview of the functions and intrinsic nature of an institution is summarized by the definition provided by Jonathan Turner (1997:6), a former sociology professor at the Riverside University. He defines an institution as:

"*a complex of positions, roles, norms, and values lodged in particular types of social structures and organizing relatively stable patterns of human activity concerning fundamental problems in producing life-sustaining resources, in reproducing individuals, and in sustaining viable societal structures within a given environment*."[147]

Another significant definition of institution is provided by Neil Komesar (2001):

"Institutions for me are large-scale social decision-making processes—markets, communities, political processes, and courts. I use the choice among these institutional processes to clarify basic issues such as the roles of regulation, rights,

[147] Turner, J. (1997). *The Institutional Order*. New York: Longman.

governments, and capitalism. These processes are alternative mechanisms by which societies carry out their goals"[148]

Both definitions include multiple points to be examined: first, institutions are agglomerations of resources, both human and material ones, that must be integrated coherently to create a well-functioning organization. Secondly, they are based on norms and values, which create a specific setting that, when put together, helps to install a specific configuration, different from any other configuration it can be witnessed. Thirdly, all these features contribute to the creation of social structures that are constructed in that particular environment to allow the institution to survive and continue its activity, in the respect of all the patterns indicated by the norms, behaviors, and resources found by the individuals involved. Finally, institutions tend to replicate behaviors that, when tested, have produced positive results. However, despite their replicative nature, institutions are not fixed over time[149]and are inclined to change and adjust themselves according to the needs they have to fulfill. The classic image of an institution is the government, as it is the set of multiple individuals that are grouped and build structures to fulfill certain goals. However, institutions are not limited to that: they are also families, work, and sport environments, that construct specific patterns of behavior and related means to achieve certain results.

The center of attention of this chapter – and thesis – is welfare and healthcare institutions, as they are the black boxes of behaviors and structures that are constructed to fulfill the demand for social protection in society. Healthcare institutions are both public and private, as we underlined multiple times in this thesis, but they are linked also to other institutions (i.e., family, business) that cannot be completely excluded from the analysis. The difficult task, when analyzing such institutions, is to compare them coherently, to include

[148] Komesar, Neil K. (2001) *Law's Limits: Rule of Law and the Supply and Demand of Rights.* Cambridge University Press, 31
[149] Coase, R.H. (1937), *The Nature of the Firm.* Economica, 4: 386-405.

all the relevant dimensions of analysis. Of course, the comparison of different institutions is always flawed, since it is almost impossible to take into considerations all the variables that concur to create such a setting. However, comparative institutional analysis tries to synthesize the relevant dimensions to compare different institutions including all fundamental topics and finding common grounds to be as objective as possible. Such analysis is repeatedly used by economists, sociologists, and jurists to construct clear pictures on relevant fields, and to scientifically compare realities that, otherwise, would be incomparable. The comparative institutional approach has two main functions and ambitions: firstly, it is born to provide "*useful metrics for making institutional comparisons*" [150] and secondly, it is an efficient tool to compare different "*social arrangements*"[151]

These are the reasons why this author chose this type of analytical process to compare healthcare systems across the OECD world. As a basis for the comparison, the primary source for the following analysis will be the article "*Worlds of Healthcare: A Healthcare System Typology of OECD Countries*", written by Professor Nadine Reibling et al. (2019). The article was fundamental to classify countries and to have a clear picture of healthcare in the OECD area. It is therefore important to summarize here its most important findings, which will be the pillars of the classification and analysis written also by this author. Reibling et Al. (2019) identify from the start their *modus operandi:* they structure their analysis not only on existing comparative institutional studies, but they also integrate some useful ideas coming from the health policy research debate. Such integration to the common comparative institutional work is the peculiarity of the paper since it also takes into account the relevant dimensions coming from healthcare policy: as a matter of fact, the healthcare policy perspective "*investigates how care is a field of expanding knowledge, innovation, and complexity is organized and oriented towards healthcare performance*" (Reibling

[150] Coase, R. (1960) quoted by Cole, D. (2013) *The Varieties of Comparative Institutional Analysis.* Articles by Maurer Faculty.834.
[151] ibidem

et. Al., 2019:1)[152]. This means that not only the analysis will include actual configurations and results but will also take into account the perspectives enhanced by the policies and programs that are (or will be) implemented by the governments to progress in the field of innovation, knowledge creation, and performance improvement. OECD statistics are therefore integrated with considerations regarding actions in place by the governments to improve social protection and healthcare management and combine different data.

Five dimensions will be investigated to come to a conclusion. The first is "*supply*", namely the set of human and capital resources employed to fulfill healthcare needs. In this case, the relevant indicators will be the per capita spending and the percentage of GDP employed, as well as the number of beds per thousand inhabitants and the number of doctors and nurses per thousand individuals. The second dimension is the "*private-public mix*", the division of healthcare resources, agents, and facilities between private and public actors, as well as the partitioning of responsibility between private and public entities. Thirdly, "*access regulations*" will be investigated: this means outlining the basic rules to access the system and the eventual lacking factors that impede access to certain categories of people. In the access part, it is important to understand whether the healthcare system is universal (it grants coverage to everybody) or it is destined only to a certain part of the population, also to understand the overall fairness of the model. The fourth perspective is the "*primary care orientation*", which is the willingness of the system to protect its citizens before the actual illness comes, by instituting a web of screenings and tests, able to detect it before the actual outbreak. Finally, the last dimension analyzed is the overall *performance* of the system, which means detecting how well the system is functioning and absolving its role to protect its citizens. This topic is investigated through life expectancy ratios, illness ratios, quality of life indicators that include alcohol and tobacco abuse, and mortality rates related to preventable diseases. The final output of such analysis is the creation of five

categories, under which OECD countries are divided and can be grouped. Each category has peculiar traits that distinguish it from the others. However, in each category, there are different states, with different healthcare models, that, though can be assimilated and resemble each other in the most relevant dimensions, are still different from one another. Therefore, in theory, each category is heterogeneous from the others, and homogenous inside, but in reality, some commonalities can be found also in countries pertaining to different groups as well as some differences can be witnessed between nations that have, theoretically, the same overall configuration. The suggestion of this author is, therefore, not to take these categories as universal and set in stone, but rather a broad representation of the actual reality of healthcare.

The categories produced by the study are the following. The first is the supply/choice-oriented public type, a model that concentrates its efforts on a broad supply of services (high resources employed, a lot of services provided) but a rather low preventive direction. In this category, we can find Australia, Austria, Belgium, Czech Republic, Germany, France, Ireland, Island, Luxembourg, and Slovenia. The second category is the performance and primary care-oriented public type, which has a strong preventive ambition, and a significant interest in delivering quality healthcare. Examples of such categories are Finland, Japan, Korea, Norway, New Zealand, Portugal, and Sweden. The third type is that of regulation-oriented public systems, with the medium supply of services, maximum access to cures, and medium performances and primary care orientation. In this cluster, we can retrace Canada, Denmark, Spain, Italy, The Netherlands, and the UK. The fourth group, constituted by Estonia, Hungary, Poland, and Slovakia is the low supply and low-performance mixed system: this typology of countries has a low supply of services with limited resources, and low performances in terms not only of prevention but also generally in the delivery of healthcare. The final category is that of supply and performance-oriented private systems, which is specular to the previously mentioned supply and performance-oriented public system, with the difference that the system is

in practice privately organized, with the limited intervention of public authorities. In this system, we can include the United States and Switzerland.

Such categories outlined above will be the starting point of the following discussions: this author will take a reference case for each category and analyze in detail the healthcare system in place, understanding if the categories indicated by Reibling et Al. (2019) are respected. Each category will have a specific paragraph, with a specific inherent case study, except for one: the supply and performance-oriented system. This decision is originated from the fact that this category was deeply scrutinized in the previous paragraphs when discussing the United States healthcare model and it will therefore be repetitive to open the topic again. I will respect the dimensions indicated by the authors in the analysis (i.e., supply, private/public mix, primary care orientation and access, performances) since I believe they are important dimensions to put under scrutiny each model and not to deviate the analysis outside the scope of this study. However, I will add to them an overall description of each model at the beginning of each paragraph, to grasp the overall organization of each healthcare system and a closing part that outlines the problems that each reference case has to overcome to increase its efficiency and coherence. I will use OECD and UE data as well, by integrating it with personal considerations and analysis. Moreover, I will consider also some of the most relevant policies connected to the dimensions, to have a clear picture also of what the future can reserve for each healthcare example analyzed. The following four subsections will contain intrinsic comparisons between countries (especially comparing models that can be assimilated in certain aspects) and will be the basis for a closing evaluation of best practices and problematic areas that are still witnessed in all the models. The final paragraph will also be a personal reflection on healthcare nowadays, and broadly on welfare policies: *is there a best way to protect individuals against social risks? What will be the new frontier for the improvement of such a topic?* These will be the core questions to be answered in my final argumentation.

4.2. Supply/choice oriented public type: Germany

The first reference case analyzed will be that of the German healthcare model. Germany can be included in the first model described by Reibling (2019) as the "Supply/Choice oriented public type": its main characteristics are a rather generous supply of services, a large inclusion of the population, a medium-to-high level of financial and human resources employed to guarantee the well-functioning of the system. Financing mainly comes from public resources, and it is based on a fee-for-service logic. Regulation in provider's choice is low and citizens have a large possibility to choose where to get medical assistance. However, this category is also centered on low preventive efforts and lower quality compared to other system typologies. We now see why Germany was included in such a category and how the system is constructed in this specific case, highlighting the crucial aspects to consider.

Germany has a universal healthcare model: this means that all individuals are granted access to healthcare. However, the German model is constructed on an insurance base: this signifies that access is granted to all individuals that possess health insurance, making the systems resemble that of the United States we have discussed in the previous chapter. However, the two approaches are radically different since the German model is, as said, universal, while on the contrary, the United States is still experiencing huge percentages of uninsured people. This German universality in access is due to the imposition of mandatory insurance: individuals are not, as it happens in America, encouraged to buy insurance, but they are forced to do it by federal laws. This makes the system *de-facto* universal because every citizen buys and therefore possesses health protection. Germany's healthcare, though resembling the U.S., is much more inclusive: public support in affording insurance is high, making it very easy to buy it. Moreover, insurance is, for most of the part, granted by non-profit organizations called "sickness funds", that are heavily regulated by the Federal

government and have to undergo serious scrutiny by public authorities. For this reason, though these sickness funds are private institutions, they can be assimilated into quasi-public organizations. Sickness funds in Germany are more than a hundred (109 to be exact), but they used to be much more when modern healthcare was established back at the beginning of the 20th century. This high number of organizations ensures fair and ongoing competition, but, as we will discuss, is also an impediment because it complicates the system and increases bureaucracy. Sickness funds cover almost 87% of the population[153] while the rest is covered by other health protection schemes reserved to certain categories of interest groups (i.e., military). Sickness funds in Germany can be divided into two main categories: SHI and PHI. SHI is the acronym for "Social Health Insurance" and covers the majority of the population. SHI is destined to employed citizens and is financed using mandatory income-related contributions that are paid by both employer and employee. SHI is granted by non-profit organizations that, as told above, are heavily regulated by the law. This renders SHI a quasi-public insurance type since its implementation is strongly organized by the central government and few is left to the single non-profits. Competition is ensured by the huge number of organizations involved and regional associations representing doctors' interests bargain with SHI non-profits to negotiate contracts and premiums in the representation of patients. PHI is the other main agglomerate of health insurance institutions. PHI stands for "Private Health Insurance" and is the mechanism under which most self-employed citizens insure themselves. PHI is destined for those individuals that earn more than 60 thousand euros a year or are self-employed. There are some advantages in enrolling in PHI, even though it is less convenient in economic terms: PHI ensures fewer individuals, which means that waiting lists are shorter; moreover, PHI premiums are higher and therefore most doctors privilege these types of patients since they can earn more from them. Of course, this impacts the large

[153] OECD/European Observatory on Health Systems and Policies (2019), *Germany: Country Health Profile 2019, State of Health in the EU*. OECD Publishing, Paris, https://doi.org/10.1787/36e21650-en.

majority of the population enrolled in SHI since it is clear that it favors the richer ones, serving unequal treatment based on income. The German system is organized in three different levels: the federal government (first level) is destined to policymaking, producing ground rules to be respected by every single agent of the market. The second level of organization involves the different *Länder*, that are asked to organize hospital activity and financial investments. Finally, the third layer is that of self-governance bodies, which are asked to translate the objectives and ground rules described by the Federal Government into real practice for organizations and patients. This construction allows to uniform the goals to achieve around the *Bundesstaat* but, at the same time, gives autonomy to each Land and organization to decide how to achieve such results between the boundaries imposed by the *Regierung*[154]. Again, some similarities with the USA can be easily witnessed, since also in the United States each federal state has the autonomy of decision, following the prescriptions of the central authority. However, we have to recall that, while in Germany most of the sickness funds are non-profit (therefore, they have not the goal of producing profit), in the United States it is quite the opposite: most insurance companies are for-profit and evaluate their business based on the economic and financial results achieved during the fiscal year. This makes a huge difference in terms of how the system is organized: non-profits in Germany are quasi-public and not profit-oriented and have and want to direct their resources almost completely to patient care, strictly following the directives of the central authorities; meanwhile, in the US insurance companies are profit makers and independent private organizations and, therefore, their main goal is to be profitable. The Government and the States can (and do) limit the action of these organizations but cannot enter into the detail of how they conduct their business and achieve their economic results. Moreover, in the USA, insurance companies control the market strongly, and their interests sometimes overcome those of patients. Therefore, the German model is more regulated in this sense but imposing stricter conditions on

[154] Government

insurances. Some scholars and journalists[155] [156] have argued that the German system can be a good example to improve American healthcare since there are linked aspects in the systems[157]. To affirm that, it is useful to discuss a bit more on other specificities of the German system, connected to supply, private/public mix, access regulation, primary care orientation, and performances.

From the supply side, we can state that the resources used by the system are high, and the investments in healthcare are strong. Excluding the COVID-19 pandemic, if we take into account the percentage of GDP employed by Germany in healthcare in 2019, we will see that the *Bundesrepublik* positions itself as first in the European Union[158]: against an OECD average of 8.8% of GDP spent on healthcare[159], Germany has used roughly 11.7% of its GDP on healthcare[160], two percentage points more than most of OECD members. This means that the resources per capita spent are also higher in Germany (6,600 dollars per capita in DE against OECD average of $4,200 dollars per capita)[161]. For sure, this huge number of resources guarantees the complete coverage of the population and allows them to spend more on hospitals and human resources. Germany has the highest number of beds per thousand inhabitants in the EU (8 beds every thousand citizens)[162], and the highest number of doctors (43)[163] and nurses (12)[164] every thousand inhabitants. These numbers testify to the huge amounts of money spent on healthcare and how Germany is centered on human resources

[155] Daw, D (2019) *A Better Path to Universal Health Care*. New York Times.
[156] Khazan, O. (2014). *What American Healthcare Can Learn from Germany*. The Atlantic.
[157] Germany and the United States are both federally organized that grant high autonomy to each single state (or *Bund*). They are both multi-payer systems organized on a mix of private and public institutions that provide healthcare protection and they are both constructed on the model of insurance.
[158] OECD/European Observatory on Health Systems and Policies (2019), Germany: Country Health Profile 2019, State of Health in the EU. OECD Publishing, Paris, https://doi.org/10.1787/36e21650-en
[159] OECD. (2019). OECD Data. *Health spending chart.* % of GDP
[160] ibidem
[161] OECD. (2019). OECD Data. *Health spending chart.* US dollars per capita
[162] OECD/European Observatory on Health Systems and Policies (2019), Germany: Country Health Profile 2019, State of Health in the EU. OECD Publishing, Paris, https://doi.org/10.1787/36e21650-en
[163] ibidem
[164] ibidem

spending. However, one of the problems the system can witness in the future is the decreasing number of General Practitioners (GP): though it is still high if compared to other OECD countries, the students enrolling in general practice are less than the past and the aging of the population requires more and more in the future.

The other dimension to be analyzed is the private/public mix. We have already cleared out that Germany is a mix of private and public actors coordinating their activities for the well-functioning of the system. However, as explained before, private organizations are heavily controlled and resemble public institutions. That is why Germany was included by Reibling (2020) in the supply/choice oriented *public* type since most of the business is conducted by public organizations or private (non-profit) organizations strongly limited by the control of public authorities.

For what concerns access to healthcare, Germany grants to all the population the cures necessary for their well-being, by imposing mandatory health insurance with mandatory income contributions. Germans report satisfaction in meeting their medical needs, signifying that the population has easy access to cures and facilities. Moreover, the high number of doctors and nurses allows good assistance to patients, and generally waiting lists for specialist's appointments are short. As noted above, PHI patients are subject to a faster access to visits than SHI patients, making the system slightly unfair and based on income differentiations. However, it is worth noting that the German authorities grant conspicuous safety nets to cover the indigent population, and this lowers the possibility of family bankruptcies due to healthcare[165]. The main dusty area in this field is related to the access by refugees, asylum seekers, and irregular immigrants: for them, it is much more difficult to access healthcare service since they cannot purchase insurance and sometimes they are not employed with regular contracts. This can be one of the major drawbacks of the

[165] In USA, for example, healthcare debt is still one of the major causes of family bankruptcies, due to the low safety nets granted by public authorities and high costs of cures. *See*: Gottlieb S. (2000). *Medical bills account for 40% of bankruptcies*. BMJ (Clinical research ed.), 320(7245), 1295.

system: apart from moral considerations related to the topic, if we think for example at COVID-19, the limited access to hospitals offered to this part of the population can be significantly dangerous not only for them but also for all the population, since these people are not allowed to access drugs and medical facilities, spreading the virus rapidly. Therefore, what seems a marginal point becomes a huge flaw of the system for the collectivity at large.

In terms of primary care orientation, Germany is still lagging behind many UE countries: even though rates for preventable deaths and treatable diseases are slightly lower than the UE average [166], percentages are still higher than other Western Countries. To make up for it, in 2015 the Government has released the Healthcare Promotion Act[167] which aims at:

"(strengthening) cooperation on health promotion and diseases prevention measures, statutory health institutions as well as a private establishment are to be included in fulfilling these actions. Preventive measures include vaccinations, routine health check-ups, health insurance may provide bonuses for vaccinated."[168]

Results are to be witnessed in these years, especially for what concerns vaccinations related to COVID-19. Before the act, vaccines were not mandatory, and become such only after 2015. With COVID-19, the topic has become crucial: at the date of this analysis, COVID vaccinations in Germany are still to take off, with roughly 10 million people receiving at least one dose[169] against the total population of 83 million.[170]

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[166] OECD/European Observatory on Health Systems and Policies (2019), Germany: Country Health Profile 2019, State of Health in the EU. OECD Publishing, Paris, https://doi.org/10.1787/36e21650-en

[167] The real title of the act is "*Das Gesetz zur Stärkung der Gesundheitsförderung und der Prävention (Präventionsgesetz - PrävG)" published* on Bundesgesetzblatt Teil I, 2015-07-24, vol. 31, pp. 1368-1379

[168] International Labor Organization (2015). *Database of national labor, social security and related human rights legislation: Germany.* Retrieved from: https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=101578

[169] Data refer to statistics provided by OurWorldinData (2021, April 11th).

[170] *See* the German Federal Statistical Office webpage

The last point of discussion for the German model of healthcare is related to the overall performance of the sector, which can be investigated through the analysis of life expectancy and mortality rates.[171] Life expectancy in Germany is around 81.1 years old[172], slightly higher than the UE average, testifying that the system is accomplishing the goals of improving the lives of its citizens. For what concerns preventable diseases, mortality is around 83 cases per 100,000 people[173] (in the USA is 112 every 100,000) and maternal mortality is around 6 every 100,000 people [174]. Infant mortality achieves 3.3 cases every 1,000 live births[175] (in the US: 5.8). The most diffused causes of illness are ischemic heart disease and stroke along with lung cancer,[176] which, however, is decreasing, at least in men[177]. Though most of the population reports being in good health in general[178], poor diet, alcohol consumption, and cigarette use are the most common drivers of disease[179]. Especially for what concerns alcohol consumption, Germany ranks 5th in UE, and cigarette smoking, though lowering, has been replaced by e-cigarettes.[180] This signals that preventive campaigns are still needed to reduce these types of abuses and to educate people to conduct a healthier life, but on its whole, the model is producing good results in terms of maternal and infant assistance.

In light of these considerations, can Germany be a role model for the fragile US healthcare system? For sure, we have witnessed that the German model of healthcare is a positive example in its complexity: access is granted to everybody,

[171] Data refer to the period that preceded COVID-19. Now, percentages can be different, with higher deaths and lower life expectancy. Precise data, however, are not available yet.
[172] OECD/European Observatory on Health Systems and Policies (2019), Germany: Country Health Profile 2019, State of Health in the EU. OECD Publishing, Paris, https://doi.org/10.1787/36e21650-en
[173] Ibidem
[174] Ibidem
[175] Ibidem
[176] ibidem
[177] In women is slightly increasing in recent years.
[178] OECD/European Observatory on Health Systems and Policies (2019), Germany: Country Health Profile 2019, State of Health in the EU. OECD Publishing, Paris, https://doi.org/10.1787/36e21650-en
[179] ibidem
[180] ibidem

the private and public mix functions well to cover the complexity of the system, and performances and results are in line, if not better than the average of OECD countries, signaling that system are accomplishing its main goals. High per capita spending is still lower than the American one: this can be a point of reflection for current and future American governments since it signals the possibility to achieve universal healthcare with less economic strain. Moreover, the German non-profit configuration of health insurance companies can be an example for Americans: healthcare in the US is still too profit-oriented, leaving aside the real goal of healthcare – patients' protection. The shift to a non-profit configuration is certainly difficult in practice since the system is now too permeated by the economic interests of private actors, which are difficult to be changed due to their political and economic influence. However, the Government should engage in medium- and long-term planning efforts to encourage the constitution of non-profit sickness funds, by granting subsidies to compete with private for-profit actors, limiting their influence in the market. The German model, however, has some flaws too. Some problematic areas are still to be considered for a constructing evaluation of the system. We have clarified that the huge number of non-profit organizations operating in the sector is positive for what concerns the overall offer of healthcare services since it improves competition among agents of the market; however, the large number of interlocutors increases complexity in the market, making costs of bureaucracy rise. 37% of German claim bureaucracy is one of the major problems the healthcare system is experiencing, believing the mole of bureaucratic processes should be reduced to allow a faster delivery. Plurality of payers and providers leads also too fragmented databases, due also to low digitalization of services. That is why the Government has implemented a plan to increase digitalization in the sector in 2015 - the EHealth Act – and has started the progress to a more integrated system. Moreover, the analysis of sickness funds has highlighted the advantages of enrolling in PHI, rendering the system slower for SHI patients. Doctors prefer to acquire PHI patients rather than SHI because of the higher premiums granted. If you recall

what we have pointed out in the second chapter of this thesis, this happens also in the United States, where doctors, when asked to choose to visit people enrolled in Medicare and Medicaid (public programs) or people enrolled in private insurance, choose the latter ones, due to the higher premiums granted by private companies. Therefore, this is a problem for a lot of countries that include private schemes in the provision of healthcare. The solution is quite complicated, though: private companies can impose premiums discretionally and doctors are free to accept patients as they see fit. Moreover, encouraging doctors to prefer publicly insured patients through monetary rewards can easily produce a domino rise of premiums in private insurance companies, not only re-instating the previous condition but increasing prices for enrollees. Another issue to be analyzed for the German model is that of economic sustainability of the system in the future. As discussed also in chapter one, citizens are becoming older and older (life expectancy has been rising steadily for decades) and the number of resources spent is continuing to grow (with COVID-19 even more than expected). Germany spends much more per capita than any other nation in UE (not more than the US, though) and the rising demand for healthcare can rapidly escalate costs for public finances. Therefore, economic sustainability for the system remains one of the biggest question marks for the model. In addition, considering the mole of resources spent per capita, percentages of preventable deaths and disease are still high if compared to other countries in UE that have lower per capita spending.

Therefore, to sum up, the margin of improvements can still be witnessed even in the German model, though it can be considered a good example of healthcare in the OECD world.

4.3. Regulation oriented public type: Italy

The third type discovered by Reibling et al. (2020) is the regulation-oriented public system, an organization that builds itself on a publicly financed structure, highly reliant on public regulation and finances. This model possesses high access to regulation and limited choice of providers. Moreover, in the authors' representation, it does not have a huge orientation towards primary care and quality seems to be lower than in other types of models. Italy was included in such category, though results seem to be, in some aspects, better than forecasted by Reibling.

Overall, Italy seems to be a well-oiled system of healthcare: protection is granted to everybody, rendering the system universal. In Italy, health – and therefore, healthcare – is a right proclaimed also in the Constitution. We cited also in the previous chapters the fundamental role of art. 32 C. in making explicit the centrality of healthcare in the Republic:

"The (Italian) Republic protects health as a fundamental human and collective right, granting cures to the most indigent population (…) "[181] [182]

Access is therefore granted to everybody, also to non-citizens and refugees, that can benefit from primary assistance in all circumstances. The principles that are at the basis of the model are universality, equality, people centrality, socio-sanitary integration, and valorization of human resources[183] . Therefore, the law itself and the Government through its ramification render explicit how

[181] Art 32 C., c.1

[182] The reported sentence is a traslation of the original article, that says: "*La Repubblica tutela la salute come fondamentale diritto dell'individuo e interesse della collettività, e garantisce cure gratuite agli indigenti. Nessuno può essere obbligato a un determinato trattamento sanitario se non per disposizione di legge. La legge non può in nessun caso violare i limiti imposti dal rispetto della persona umana"*

[183] Salute.gov website. *Principi del Sistema Sanitario Nazionale*.

healthcare is, at least in theory, a priority for the Republic, which aims at providing high-quality, universal care to all.

Healthcare in Italy is highly decentralized, and a lot is left to local authorities, which decide how to finance programs and invest resources. The main actors of healthcare, along with the State, are the Regions, that decide which benefit package to provide to their citizens and how to organize the action of hospitals, facilities, doctors, and healthcare personnel. The "Sistema Sanitario Nazionale" (SSN) was established by L. 833/1978 and serves as an administrative tool to manage healthcare in the State: it is the system that organizes functions, structures, and activities that are fundamental for the physical and psychical well-being of the population. Its role is to provide care in all territories in a uniform way, by setting ground rules, procedures, and administrative tools to provide care. L. 833/1978 talks about "uniform levels of assistance" to indicate that the SSN provides minimum standard levels to be fulfilled by all regions and facilities in the provision of healthcare, setting parameters and ground rules to be followed. Originally, there were three layers of intervention: the central government, the regions, and local authorities. Now, however, the levels remain two: the central government which gives funds defines the minimum standard package (so-called "Livelli Essenziali di Assistenza", or LEA), and organizes the general administration.; the second layer is set on a regional basis and regions are responsible for organizing and providing the services through their local sanitary authorities and public/private hospitals. The L. 833/78 established the local sanitary authorities ("Unità Sanitarie Locali" or USL) that were the operative means through which the single territory offered care. Each of them was established in a local area ("Comune") and managed hospital care, family care, public hygiene, preventive medicine, and pharmaceutical services. All these functions included in L. 833/1978 were then integrated by the D.L. 502/1992: before this change, the USL was drowned in bureaucracy and suffered from lack of managerial control. Moreover, there were too many differences across regions, and this impacted healthcare as a whole.

Therefore the D.L. 502/1992 introduced the so-called ASL ("Aziende Sanitarie Local"), local "companies" of healthcare that had more decisional and administrative autonomy (as it happens in firms): this was a way to make local agents more independent and less reliant on the central government. Moreover, this helped to shift the focus towards a more technically driven management, that was less politically influenced. The SSN is publicly financed by general taxation and income taxes for people and companies. The benefits package (LEA), if compared to other countries, is quite composite and extensive, granting quality care, also in terms of prevention.[184] However, there are still high out-of-pocket expenses, that are paid in the form of a ticket (so-called "ticket sanitario"), that helps to cover the residual part of the intervention. Furthermore, because waiting lists for certain procedures are long, certain individuals prefer to use private options, increasing family out-of-pocket expenses[185]. The role of family doctors is fundamental for the system since they serve as "gatekeepers" for access to specialist care. Family doctors absolve the role of "prevention agents", helping to detect disease and direct the patient to more specialistic care. Generally, the system is, thus, quite complex but well integrated into the communities, and helps to reduce the burden on hospitals. After having provided a general introduction, we examine the performances of the system and the parts in which it is still underperforming.

We start by discussing the supply side. The level of resources used by the Italian system is slightly lower, but generally in line, with the OECD average. The percentage of GDP employed in healthcare was 8.7% (in OECD: 8.8%) with per-capita spending of roughly 3,500 euros. (OECD: 4,200 per capita)[186]. Healthcare is financed for one-third by citizens and two-thirds by public finances. Out-of-pocket expenses, as we noted before, are still high, especially for prescription

[184] OECD/European Observatory on Health Systems and Policies (2019), Italy: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://doi.org/10.1787/cef1e5cb-en.
[185] ibidem
[186] OECD. (2019). OECD Data. Retrieved from Health spending chart

drugs and ambulatorial dental care[187], and people pay part of the cures through sanitary tickets.[188] Daycare use has increased during the last decades, reducing the burden on hospitals and recovery time for patients, rendering the system leaner and less hospital-centered.

In terms of private and public mix, the system is mostly public, with a marginal role of insurance companies (roughly 2% of all sanitary expenses[189]). Hospitals, however, make people decide whether to receive cures under the SSN or to go privately and pay more but receive faster care, choosing also to which doctor to address.

The access dimension is quite simple in the Italian system: access is granted to everybody, citizens or non-citizens, Italian or foreigner. Protection is automatic and universal, meaning that there is no need to enroll in private or public programs to receive care. Free assistance is granted for almost all hospital and medical services and emergency treatment is provided to all. Tickets are due for prescription drugs, specialist care, ambulatorial care, and non-emergency services. Essential protection, as well, is given to all the people, immigrants included.[190] Waiting lists are managed through the so-called "Centri Unici di Prenotazione" or "CUP" and allow citizens to book an appointment for specialist care. In some cases, these waiting lists can be long, and therefore, patients have to wait months for treatment and book privately. A plan called "Osservatorio Nazionale Liste di Attesa" has been established to observe the trend of waiting lists and develop a program to shorten waiting time: the results indicate huge differences across regions, making clear how healthcare still suffers from huge

[187] OECD/European Observatory on Health Systems and Policies (2019), Italy: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://doi.org/10.1787/cef1e5cb-en.
[188] Fragile individuals and some segments of the population (i.e., elderly people) are exempt from paying. Moreover, tickets are not enforced in case of emergency treatment for all the population, citizen or non-citizen.
[189] ibidem
[190] Essential cures are assured by all individuals by D.L. 124/1998, entitled *""Ridefinizione del sistema di partecipazione al costo delle prestazioni sanitarie e del regime delle esenzioni, a norma dell'articolo 59, comma 50, della L. 27 dicembre 1997, n. 449.".* The D.L. made effective the provisions embedded in L. 449/1997.

disparities across territories, especially between Northern and Southern regions.[191]

For what entails primary care orientation, as noted above, prevention in Italy - despite Reibling's considerations – is strong, and this is testified also by the high life expectancy (83.1 years old[192]). Family doctors, as said before, are gatekeepers to access cures and are a huge preventive tool for the population, that can visit them whenever it is needed. Italy has the second-lowest mortality rate for preventable diseases in Europe[193], testifying that the model has established a great system of screening. Hospitalization for heart stroke is one of the lowest in Europe thanks to preventive check-ups but the same cannot be said for cancer screening, which is still underperforming if compared to other countries: however, mortality is lower than in other OECD nations, signaling that hospital care is good and provides great services.

In terms of mere performances, data of OECD indicate that Italy is one of the countries with the highest life expectancy of birth, second only to Spain. [194] However, again, differences are to be witnessed across regions, sex, and social status. For example, women live longer than men, and men with higher education live longer than men with a lower one. This is probably due to higher exposure to bad habits such as tobacco smoking, poor diet, and alcohol abuse, which are common factors of disease in OECD countries. The main causes of illness are strong, heart failure and lung cancer, though percentages are lower than in UE and decreasing year by year. Alzheimer's is a major cause of death in Italy, mainly due to higher life expectancy. Elderly individuals, in addition, suffer from a disability and chronic disease, and depression is seeing momentum, rising in the population, elderly and non-elderly. 41% of people in Italy are depressed, against

[191] CREA (2019). *Osservatorio sui tempi di attesa e sui costi delle prestazioni sanitarie nei Sistemi Sanitari Regionali: I Report*. Consorzio per la Ricerca Economica Applicata in Sanità presso Università Tor Vergata di Roma.
[192] OECD/European Observatory on Health Systems and Policies (2019), Italy: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://doi.org/10.1787/cef1e5cb-en.
[193] ibidem
[194] ibidem

29% in OECD average, being an indicator of uneasiness, due to precarious economic and social conditions. For what concerns performances related to tobacco abuse, Italy's percentages are slightly higher than UE average[195]: smoking remains a big issue among men adults, and adolescents, despite big efforts that have been implemented by the government to restrict tobacco selling and reduce smoking in public areas and enclosed spaces, and as well as continuous advertising campaigns to discourage smoking. Obesity percentages are lower than UE[196]but are rising especially in adolescents. This can be associated with low physical activity exercised by youngsters, especially by females (5% of the total)[197], that are discouraged to pursue physical activity due to lack of facilities, structures, and local female teams. For what concerns alcohol abuse, percentages in Italy are significantly lower than in UE[198], due to alcohol selling restrictions and healthy diets.

Despite good healthcare on its whole, Italy has significant efforts to undertake to reduce the gaps between regions. As noted before, disparities in the provision of healthcare are still witnessed between territories and are more consistent between North and South. Southern regions are, as a matter of fact, keener on suffering from infrastructural difficulties, as well as lack of personnel. Southern residents report higher levels of untreated medical needs and socio-economical backwardness is a huge restraint for the progress of medical procedures. COVID-19 made the gap even more evident, especially in the first phases of the pandemic: certain regions were less ready to confront high hospitalization rates and ICUs were not able to keep up with the intense rate of people who needed emergency services. Therefore, Italy needs uniform healthcare in all national areas to provide high standards of treatment and great access also in the South.

[195] ibidem
[196] ibidem
[197] Ibidem
[198] ibidem

An additional point on which Italy needs to focus is vaccination: low trust in vaccines was witnessed in the population, mainly due to scarce information and mistrust. Again, COVID-19 made this issue emerge with force: collective immunization is now essential to grant survival, also in economic terms. Even during the pandemic, however, disinformation continues and the constant incoherent opinions between scientists have increased mistrust. Large media exposure of virologists did not accomplish the role of reassuring that part of the population who was reluctant to vaccinate, especially because the voices involved in the discussion were too often contradictory and unclear. This was perceived by many as a confirmation of the unsafety of vaccines, rather than a reassurance of their goodness. The real goal is then to find a great and reliable communication, that helps to install trust in vaccines, specifying the role they play in safeguarding the health and the economics. The other big problem Italy needs to look at when analyzing healthcare is the sustainability of the system in the long run. COVID-19 has emphasized how troubling the system can be and how many resources have to be still invested in the future to improve healthcare - in Italy and in all countries in the world - to shift the focus from individual to collective patient care. Funds, however, are becoming scarcer and scarcer, putting at risk the economic solvency of the system. To complicate the scenario, the aging of the population, especially in Italy, is becoming a threat to the sustainability of the system, since in the future the model will need to face larger and larger numbers of patients, with facilities and healthcare workers that are becoming old as well. Moreover, healthcare is experiencing a low turnover of human resources, especially for specialistic jobs, since admissions are restricted and the limited places for specializing exclude a lot of doctors from the job, pushing them to emigrate (for instance, in Spain) to access the profession. This low turnover of the healthcare workforce will make human resources unsuitable to fit the larger needs of the population in the future, making medicine unable to progress thanks to newly graduated doctors.

Another big question mark of the Italian system is digitalization, which is still underperforming if compared to other OECD countries. In general, Italy suffers from low digitalization in all sectors, healthcare included. Differences between regions are still important also regarding this matter, and the South of Italy suffers more from this problem. A new program to digitalize healthcare ("Piano per la Sanità Digitale"[199]) was started in 2016 to encourage e-medicine and use ICT to encourage the installment of electronic clinics to transfer patient data from hospital to hospital easily. In 2020, Telemedicine entered the SSN with official directories released by the Ministry of Healthcare ("Linee Guida per la Telemedicina"). The goal of these guidelines was to make telemedicine official and recognized in facilities as actual medicine that, however, happens through online consultations and prescriptions. These were the first steps to undertake to make healthcare more digital, but they are still not sufficient to consider the topic closed. Some other steps have to be undertaken to improve the use of big data to track patients and monitor the progress of the disease. For example, the app "Immuni", which was thought and implemented to trace contagion for COVID-19, failed to accomplish its goal because of many reasons. The app was useful if at least 70% of the population had it and used it. However, people – especially the elderly ones – do not have smartphones or do not know how to use them, making it impossible to download the application. Moreover, the app worked with manual insertion of data: if one person was infected, he/she had to manually insert a code in the app. However, many people did not know how to do it and it was left to the individual choice to insert the code, making it impossible to know the effective number of infected people using the app. Finally, there was a big debate on information release, that could violate the privacy of individuals, by releasing personal information regarding their healthcare, and therefore, the app was released with limitations in the access of personal information. All these issues made the application failed, since it was unable to exploit the advantages of big data and lacked privacy protection for

[199] Ministero della Salute (2016). *Piano per la Sanità Digitale*. Documento programmatico.

individuals. Therefore, the big challenge is now to explore this field, which is still underdeveloped, to achieve better results for the collective good.

To conclude, the Italian system can be considered, in general, as a good model of healthcare, despite what the general public opinion may think about it. If we compare it to other healthcare models, we will make interesting considerations. For example, it spends much less than the United States healthcare and covers all the population automatically (in the US, as we have seen, this does not happen). Assistance is free for the most fragile population and the benefits package is quite composite and touches many fields of care. Despite what happens in Germany, the Italian system grants automatic access to cures to all individuals, also to non-citizens and illegal immigrants, being a real universal system. Finally, OECD ratings indicate better performances in terms of preventive care and mortality rates, and preventive efforts of family doctors are effective in reducing deaths for preventable diseases and hospitalization.
It is true that some fields are still lacking and underperforming, but, considering the overall setting and services provided to the public, the model of healthcare accomplishes its role. To improve its efficiency, uniforming healthcare between areas is essential to allow everybody to have access to the same treatments and quality and to make the system progress.

4.4. Performance and primary care-oriented public systems: Japan

The third type of healthcare model we will consider is the “performance and primary care-oriented public system”, which is represented by the Japanese case study. This model is publicly centered and financed but has the peculiarity to employ less money than the other public systems. Resources are heavily regulated by the central authority and choice is also massively controlled by the state. The system’s key highlight is primary care: its strong orientation towards

prevention pushes the government to employ lots of funds in out-patient protection and primary care. Moreover, the model's goal is to achieve high standards of care and quality through its national healthcare service.

The choice of analyzing the Japanese model comes from the important results that are witnessed among the Japanese population, which is considered one of the healthiest in the world. For sure, Japan has the highest life expectancy at birth in the world (around 84 years old[200]), and this has shed light on its healthcare model, to understand why Japanese people live that long. Their healthcare system grants a huge contribution to these percentages. It provides universal healthcare through a system of decentralized and shared responsibility, that takes into account a lot of actors and institutions. Planning and delivery are in the hands of both the central authority and local administrations, which are involved in decisions and support. Moreover, the delivery of healthcare is left to multiple suppliers and also companies play a significant role in the topic. Funded primarily through taxes and individual contributions[201], the system forces people to get health insurance to protect themselves. There are two main institutions involved in the provision of health insurance, included both under the so-called "Statutory Health Insurance System" (SHIS), that provides care to 98.3% of the population[202][203]: SHI and NHI. SHI is the acronym of "social health insurance" and is devoted to full-time employees of medium and large corporations. SHI is based on the principle of employment: if you possess a job, you are entitled to enter the program and benefit from it. NHI ("national health insurance") is destined for everyone else and is funded through contributions based on income. It is residence-based: every Japanese citizen can enroll in NHI. Benefits are the same both for enrolling in SHI and NHI and the package includes many procedures and visits, including dental care and mental treatments. Among the benefits, there can be found

[200] *See* World Bank (2018) *Life expectancy at birth, total (years) – Japan.*
[201] Tikkanen, R. et al. (2020) *International Health Care System Profiles: Japan.*
[202] ibidem
[203] The other 1.7% receives care through the Public Social Assistance Program, that is destined to the poorest part of the population

hospital treatment, primary and specialistic care, and prescription drugs. Premiums are paid on a monthly base and the government itself decides the number of such premiums. People are sometimes asked to pay little extras for certain services: however, out-of-pocket expenses have a cap over which they cannot go. Private health insurances exist, and they are employed by individuals to supplement public services, to have additional assistance in case of serious illness.

The Japanese system, as we highlighted before, is a mix of centralized and decentralized decisions: four are the main agents involved in the provision of care. The first main administrative structure is the Ministry of Labor and Welfare, which gives directives for public health policies and manages healthcare by providing funds to prefectures; secondly, the (47) prefectural governments play a significant position in the provision of healthcare, along with the municipal authorities. They are responsible for a certain prefecture and municipality and manage the administration and provision of services in that particular territory by developing healthcare delivery. They have high autonomy of decision and direct supervision on healthcare in that area. Finally, public health centers (i.e., hospitals, clinics) are also important in Japanese healthcare, since they are the final interlocutors for patients and the final healthcare providers.

After this general introduction to get the main characteristics of the systems, we concentrate on understanding why Japan was included in the "primary care-oriented type". As usual, we start by defining some key figures of the supply side. At the beginning of this subchapter, we have stated that countries included in such a category employ fewer resources than the others. It is relatively true for Japan if we consider countries with a relatively expensive healthcare system (i.e., Germany, the US). The percentage of GDP employed for healthcare in Japan is around 11, 1%[204], which is slightly less than in Germany

[204] *See* World Bank. Current health expenditure (% of GDP) - Japan. 2018 or latest statistics available

(11.7%)[205] and much lower than the United States' expense (16.8%).[206] However, considering all OECD healthcare spending, Japan spends much more than the average (8.8%) [207], much more for instance than Italy (8.7%)[208] and Hungary (6.4%)[209]. Per capita spending in Japan is around 4,800 dollars per capita[210], being slightly higher than the OECD average (4,200 dollars per person)[211]. Individual spending is rather low - 80,100 JPY, which equals 801 USD[212] -, with relatively low out-of-pocket expenses (14%)[213].

The private-public mix, as noted above, is quite composite, and distributed among private and public actors, with a stronger presence of the public. Private insurances supplement the services offered by the public authorities, which are, by the way, rich and diversified.

From the access point of view, Japan achieves universal coverage thanks to its SHIS; this means that the totality of the population is covered by the national healthcare system. The majority of the population is covered through work insurance provided by companies, while the rest is protected through NHI. The most indigent part of the population benefits also from safety nets, that reduce the monthly premiums through subsidies. In particular, these safety nets are destined for disabled individuals, the mentally ill, and specific chronic patients.

The strongest dimension of the Japanese system is prevention and primary care. Its strong orientation towards the topic has for sure contributed to one of the highest life expectancies of the globe. The system of preventive care is organized under the so-called "Health Japan 21" (HJ21), a program that aims at strengthening good health by improving lifestyles, increasing healthy diets, and

[205] *See* World Bank. Current health expenditure (% of GDP) - Germany. 2018 or latest statistics available
[206] *See* World Bank. Current health expenditure (% of GDP) – USA . 2018 or latest statistics available
[207] See OECD. (2019). OECD Data. Retrieved from Health spending chart
[208] Ibidem
[209] Ibidem
[210] Ibidem
[211] Ibidem
[212] Tikkanen, R. et al. (2020) *International Health Care System Profiles: Japan.*
[213] Ibidem

encourage exercise.[214] The program is a community-based effort to improve the lives of Japanese citizens, by installing healthier habits and by strengthening prevention. Moreover, under HJ21, a vast range of check-ups and specialistic visits are included, signaling the strong weight that is given to the matter. The peculiarity of the model is the absence of general practitioners: people are directly examined by specialists. On one side, it is a positive factor, since people receive immediate specialist care; from the other, it increases the burden on hospitals and specialized facilities, and people who do not require specialistic care are also directed to specialists, taking the place from those who need that care. Thus, from this point of view, this author prefers the Italian model, that - as we saw in subchapter 4.4. – makes use of GPs as gatekeepers to specialistic care. In this way, time is saved for those who do not need it, and the others can be better directed to the exam that is the most suitable for their needs. Moreover, a critic that is frequently moved to HJ21 is that the range of possible specialistic exams is too wide, and resources are wasted on too many topics, instead of concentrating on top priorities. For example, cancer screenings are standard and underdeveloped[215] (like in Italy), and more resources should be directed to the matter to reduce mortality. Thus, even though the model is very advanced in terms of primary care, the program should be revised to reduce unnecessary check-ups and concentrate on relevant dimensions. Despite this controversy, the model seems to serve its purpose. As highlighted at the beginning of this subsection, Japanese people are healthy as testified by OECD indicators like obesity rate and alcohol consumption that are well below the OECD average. The most common causes of illness are similar to the other OECD countries: hypertension, cardiovascular disease, cancer, and cerebrovascular disease. Chronic diseases are rising, especially because the population is getting older and older. The most striking fact to underline when talking about general performances of the system is the high suicidal rate witnessed in Japan - 14.9

[214] OECD (2019), *OECD Reviews of Public Health: Japan: A Healthier Tomorrow*, OECD Publishing, Paris. https://doi.org/10.1787/9789264311602-en
[215] ibidem

people every thousand citizens - ranking fifth in the OECD ranking.[216] To combat this issue, the government has instituted a law ("Basic Law of Suicide Prevention") to reduce social discomfort and provide quality support to the population[217].

On its whole, the system is well constructed and organized. This is testified, once again, by the performances achieved throughout the years, and by the good response at least to the first wave of COVID-19.[218] However, once again, some issues are present also in this model. Firstly, the country is the oldest in the world. From one point of view, this is for sure a great achievement in terms of healthcare, but from the other, it puts a big question mark on the sustainability of the system in the long term, given the rising number of people that will need care and the low percentages of birth rates, that are a commonality with Italy - another "old" country. The future urges Japan to improve its birth policies, to encourage families to procreate and to support a system that will require rising economical support (and therefore, more people that contribute through their work to finance it) and human resources capital. Moreover, another problem of the system is the coordination of different actors: it is certainly positive to leave autonomy in the delivery of care to municipalities and prefectures, but it can also bring to lacking coordination and differences between territories. Therefore, improving systematic coordination is fundamental to reduce fragmentation between different areas and to define minimum standards of care for all the facilities. Finally, a lacking dimension of the healthcare system regards the management of disasters. Japan is a "disaster-prone country", with regular episodes of earthquakes (the last happened on April 20th, 2021 only seven days before the development of this subchapter). It is therefore important to strengthen the already-in-place policies aimed at protecting the population from

[216] OECD/European Observatory on Health Systems and Policies (2019), Suicide rate rates. Chart.
[217] OECD (2019), OECD Reviews of Public Health: Japan: A Healthier Tomorrow, OECD Publishing, Paris. https://doi.org/10.1787/9789264311602-en
[218] Hornyak, T. (2020) *Why Japan, once a COVID-19 Success Story, Faces the Prospect of a Dark, Deadly Winter.* Time.

such disasters and to increase planning, investment, and education on this matter.

To conclude, comparing Japan to other OECD countries, we can argue that, in the end, the system can be a great example for the United States, firstly because it integrates private and public resources, protecting the totality of the population. Moreover, its indicators suggest general well-being that is, for now, not achieved in any other OECD country, especially in the US. Japan can be also a good reference for Italy since there are similarities in the composition of the population and territory. Having both high life expectancy (and therefore, rising numbers of elderly) and being both keens on experiencing natural disasters (Italy is also vulnerable to catastrophic events, due to fragile territories, prone to floods and earthquakes), Japan can set the path also for Italy to invest in disaster prevention. On the contrary, Italy can teach Japan a new method of primary care orientation, that is narrowly constructed on fewer but more effective and resource-saving screenings.

4.5. Low supply/ low performance mixed type: Hungary

This fourth category is classified as the low supply/low-performance type. This agglomerate includes countries with restricted amounts of resources to be employed in healthcare in terms of funds and human resources. Moreover, the quality of performances is low, and the level of out-of-pocket expenses is high. Access is granted to the population assuring universal coverage; however, the choice is massively regulated by the central government that determines which doctor and facility to use. Finally, primary care orientation is left aside, and prevention is enacted only limitedly.

The reference case that was chosen to illustrate this model of healthcare is Hungary. The system is constructed in a very centralized way, with a strong

control on regulations, facilities, and distribution of resources exercised by the government. The direction imprinted by the central authority is hospital-centric[219]: this means that the Hungarian healthcare model heavily relies on hospitals to cure patients, with low use of polyclinics, ambulatories, and private practice, which is employed only by general practitioners. Group practice is used very rarely, even though programs to establish them in rural areas have been encouraged and financed.

The central government provides strategic direction, financing, regulative directives, delivery of specialistic and out-patient care. The State offers also a single health insurance fund, in which the population can enroll and obtain healthcare coverage. Hungary, in this way, achieves universality, assuring all citizens minimum protection. The fund is managed by the National Institute of Health Insurance Management Fund (NEAK), which supports the State in administration activities, care coordination, hospital planning, and medical licensing, being a reference for local facilities and agencies. The main problem of the fund is the lack of resources employed: being constantly underfunded[220], huge budget constraints are imposed on hospitals, that have difficulties in providing care with limited resources. Hospitals, for this reason, are often constructing debt with suppliers that will difficultly be covered. Salaries of doctors and nurses are very low, and this has caused in the last decades a huge outflow of physicians to other European destinations, that offered them higher pays[221]. The government has tried to stop this emigration granting higher salaries to healthcare human resources, and the trend has been decreasing.[222]

[219] OECD/European Observatory on Health Systems and Policies (2019), Hungary: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://doi.org/10.1787/4b7ba48c-en.

[220] ibidem

[221] Varga J. (2017). Out-migration and attrition of physicians and dentists before and after EU accession (2003 and 2011): the case of Hungary. The European journal of health economics: HEPAC: health economics in prevention and care, 18(9), 1079–1093. https://doi.org/10.1007/s10198-016-0854-6

[222] Inotai, E. (2020) et Al. *Democracy digest: from doctors' pay rises to new restrictions, COVID stays centre stage*. Reporting Democracy.

The overall service offer is restricted to few benefits provided to the population, being a huge obstacle to high-quality preventive patient care.

From the supply side, as noted above, healthcare spending is not very generous: OECD data indicate per-capita spending of around 1,4 thousand euros[223], less than the average of OECD country (around 2,1 thousand euros, as mentioned in the other subparagraphs). The same can be said for GDP spending, which goes around 7.5%[224] (very much less than the US, Germany, or average OECD's GDP spending). Moreover, regarding GDP employed, the amount is flexible, since it depends on the overall quota the government wants to attribute to healthcare. Healthcare is assimilated to other welfare topics (i.e., pensions), and the quota given to healthcare depends on the priorities set by the government for that year. Thus, resource employment fluctuates depending on these kinds of policy directions. In terms of personnel, doctors per thousand inhabitants are 3.3[225], while nurses per thousand inhabitants are 6.5[226]: these numbers are well below UE average and indicate a shortage of human resources employed in the field. Moreover, the aging of the workforce is now compromising the future stability of the system, since lots of employees are now proximate to retirement age and few replacements are ready to take up their role. The profession of GP sees a lot of permanently vacant positions, and this gets in the way of enhancing prevention, focusing care only on hospitals. The situation is even more worrying in rural areas even though the government has put in place some programs to subvert the trend; for example, the Hungarian Village Program was established in 2018 to ensure new facilities and healthcare personnel to small villages and communities in Hungary, to close the gap with the more advanced cities and territories.[227]

[223] OECD/European Observatory on Health Systems and Policies (2019), Hungary: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://doi.org/10.1787/4b7ba48c-en.
[224] ibidem
[225] ibidem
[226] ibidem
[227] Budapest Business Journal (2018) *Gov't approves framework of Hungarian Village Program*. Web article.

For what concerns private and public mix, it emerges clearly from the analysis that Hungary's healthcare model is mostly reliant on public resources, facilities, and directives. Therefore, private organizations are very limited, and the public is generally cured in public hospitals. One can argue this can be a positive point, since it may give homogeneity to facilities and reduce social and economic differences between different people and territories. However, as noted above, large disparities are witnessed between rural and urban areas, and as well from central Hungary (richer) to Northern Hungary (poorer). Additionally, private practice is not very diffused, and this limits the autonomy of physicians in deciding treatments and managing costs, being a disadvantage for patients.

Discussing access regulations, we have stated Hungary has a universal healthcare system in which all citizens have the right to access medical life-saving treatments, preventive and pain- reductive care Thus, Hungary, from this site is more advanced than - for instance - the United States, spending much less and granting to everybody some sort of health protection. However, in terms of quality, big steps are still to be taken, making Hungary late if compared to other OECD countries, the US included. In particular, large disparities between regions and social classes get in the way of a uniform delivery of healthcare: even if only a few Hungarians claim not to be in good health, disease rates for cardiovascular and chronic diseases, as well as cancer rates, are very high. The situation is even more dramatic in peripherical areas where prevention is much lower. Therefore, even though access is granted to all the population, performances are weak and illness rates are high. Mortality for preventable and treatable diseases is one of the highest in the OECD group, and campaigns to discourage the abuse of alcohol and tobacco smoking are not as advanced as in other Western countries. Tobacco consumption is the highest in UE and smoking in enclosed places was banned only in 2012, almost 20 years after most of the Western countries[228] Life

[228] For example, in Italy the smoking ban in enclosed facilities was introduced in 2003 (L. 3/2003) but already in 1975 smoking was forbidden in public transportation and public spaces like hospitals, universities, museums and theaters (L. 584/1975). The first anti-smoking advertising

expectancy is 76 years old[229], 4 years less than the OECD average (80.1). Men are more inclined to live shorter, due to these abuses, poor nutrition habits, and unhealthy lifestyles. Huge differences in life expectancy are also shown depending on social classes (educated men are keener on living more[230]). Binge drinking in adolescents is very diffused and Hungarians practice low physical activity. Therefore, considering all these factors, preventive performances are very poor, and huge steps should be undertaken to discourage bad habits and uniform population treatment. Some efforts have been put in place by the government through various programs aimed at improving nutrition and increasing protection against infectious diseases. For the first goal, the government has introduced taxes on unhealthy food to discourage their consumption. However, this was a limited deterrent for the population, that continued to pursue their unhealthy habits. Moreover, a law to control trans-fatty acids was released, being one of the first and few countries with such advanced legislation on the matter. [231] For what concerns the latter goal – immunization against infectious disease – a vaccine campaign was established for vaccines to be mandatory for all children. In addition, Hungary has constructed an effective control mechanism that allows monitoring the status of vaccines in the country. However, vaccines for influenza are not very employed and some parents refuse to bring their children to vaccination. Vaccines are an interesting topic also nowadays due to COVID-19. Hungary leads the UE in COVID vaccines administered (almost 13 million people are immunized[232]), thanks also to the approval of the Russian Vaccine *Sputnik* and Chinese *Sinopharm* (not authorized in other UE countries). Though vaccines are proceeding, Hungary has the highest number of deaths for COVID in UE[233] putting under scrutiny the way

campaigns are witnessed around the '90s and discouraging messages are placed on cigarettes' packings.

[229] OECD/European Observatory on Health Systems and Policies (2019), Hungary: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://doi.org/10.1787/4b7ba48c-en.

[230] ibidem

[231] World Health Organization (2015). *Eliminating trans fats in Europe*. Article.

[232] See OurWorldinData statistics (2021, April 14).

[233] Euronews (2021) *Despite vaccination success, Hungary sets daily record COVID deaths.* Article.

the system – and, therefore, the government - are coping with the pandemic. Considering all these data reported in this paragraph, we can easily evaluate the system wholly by stating that Hungary, despite some efforts in the last years to close the gap with the other OECD members, is still lacking in some consistent dimensions. The limited priority given to healthcare in the last years is now brutally manifested in COVID deaths, signaling the inadequacy of the system to support this and other healthcare crises. Moreover, we have outlined that the long-term sustainability of the system is in danger, from both a fiscal/economic perspective to a human resources side. This unsustainability is particularly due to the huge number of hospitals present in the country, with low reliance on private group practice and associations. Being too many, resources are split into multiple parts, and then the slice each hospital earns is very limited. By reducing the number of facilities, hospitals can receive more funds and increase the quality of care, advancing in technological procedures, updating machines, and increasing salaries of doctors and nurses. Moreover, more autonomy should be granted to every single facility in deciding how to spend the resources and how to invest the funds, since this strict control exercised by the government leads to hospital indebtedness too often. From the digital side, steps should be undertaken to digitalize healthcare and increase eHealth (as suggested by the WHO in the report "Global strategy on Digital Healthcare"[234]).

Therefore, to sum up, what we have said so far, Hungarian healthcare has some deficits that get in the way of closing the gap with other Western countries, especially in the field of prevention. An action of privatization of facilities can help to provide financial and decisional autonomy and to increase the quality of care. Moreover, encouraging individual and group practice can reduce the gaps between different regions and territories, by installing more uniformity and minimum standards of care for everybody. Finally, preventive efforts should be increased to limit abuses and reduce mortality due to treatable diseases. Such

[234] World Health Organization Guidelines for the period 2020-2025. Report.

improvements can finally bring Hungary closer to Global and European standards.

4.6. Is there one best way?

We have finally reached the conclusions of this chapter related to healthcare comparison. We have seen different models of healthcare. Firstly, we have witnessed the German system, resembling in some broad traits to the United States' one, but with a significant difference: universal healthcare achieved by the system. Though in the German model private institutions are a huge agent of the market, the system remains mostly public or, at least, publicly regulated and controlled, while the United States suffer from still big influence from private insurance companies, that drag the interests of the entire system, and are only partially limited in their actions. Secondly, we have analyzed the Italian model, included in the regulation-oriented public type. Different from the United States and Germany, Italy has a very low percentage of insured citizens, since the system itself provides full coverage. The Italian model, compared to Germany and the United States, is more primary care-oriented since it constructs its system using general practitioners as doorkeepers for the access of specialistic care. Italy has much lower resources employed than Germany and the US, but contrary to the latter one, it achieves universal coverage. Then we have debated on the Japanese model: its peculiarity is a strong primary care orientation, that focuses mostly on specialistic care. Primary care is the highest in the OECD world, more than in Germany, the US, and also Italy. The model is centered on insurance, paid partially by the citizens through premiums, and partially by the government. The difference with the previous models is a very decentralized system (in part resembling the configuration present in Italy made up of "ASLs"), where all local authorities are strongly involved in the setup of the system, making it very responsive to local needs. Compared to the other models, results indicate that the strong primary care orientation has conducted to high life

expectancy and lower levels of alcohol abuse and obesity. Finally, we have taken into account the Hungarian model, which, when compared to the other four types, seems the most lacking one. Strong is still the factors that differentiate it from the other types: very low primary care orientation and quality, high levels of hospitalization, and very limited powers left to local authorities. The gap Hungary needs to close to be partially associable with other OECD countries is still significant and needs to be taken into consideration by the government, which has the responsibility of constructing a more leveled and up-to-dated model.

Even though some healthcare configurations seem – and are – better than others when comparing results and practices put in place to protect patients, all of them - as emphasized at the end of each paragraph - present some lacking dimensions, that are still a big impediment for the achievement of full efficiency. To answer the question that entitles this paragraph: no, there is no best way. All countries have flaws, and some of them are common to all. The problem of all types of models is to achieve long-term sustainability, not only related to the increasing economic resources that need to be employed to continue the activity, but also to human capital, which is decreasing year by year, questioning the capability of future systems to take the burden of following generations. Sustainability seems, therefore, the main obstacle that all systems have to overcome: lacking economic and human capital can drag all models to default since they will not be able to fulfill their role in society. Of course, it will impact all citizens, especially those who have not economic resources to afford higher premiums and access to private healthcare facilities. The problem became more evident with COVID-19, showing how the system can be dramatically impacted by huge numbers of hospitalizations, that are difficult to manage with limited human and capital resources. COVID seems, if seen in this way, an alarm bell, of what can happen if healthcare does not find new ways to be sustainable and to increase the people willing to work in the field. Healthcare is, therefore, strongly connected both to the economic situation and to the educational field, that have

to find new ways to include such topic in their debate. In particular, education has a strong responsibility towards upcoming new generations: encouraging young adults to undertake the medical career, both as doctors and nurses, means to improve also the access and affordability of universities, opening up to higher numbers of students. Moreover, superior education must be incorporated to offer better opportunities to practice in the field and better organization in the coordination between policies and actual needs. For example, in Italy, although doctors are becoming older and limited in number, the places to enroll in medical school are much lower than the numbers of students that are willing to become doctors. The race to gain a place is a contradiction to the actual needs of the system, which will require a higher number of doctors, that however, cannot enroll. Moreover, the vacant places in specialization faculties are much lower than the actual number of graduates in medicine. This means that some of them are not able to specialize in the field they are willing to because, once they graduate, there are not enough places in their wished specialistic department. It, therefore, happens that these doctors spend years as not-specialized physicians, using only part of their potential or emigrate to other states to specialize. Opening up new places for physicians is a measure that should be undertaken, in Italy, but also in other countries (i.e., Hungary), to stop emigration and to avoid the risk of a future shortage of medical personnel. Sustainability is also related, of course, to economic resources: it is highly correlated to the economic situation states are leaving, and countries that have higher public debts are for sure more in danger than others. However, the problem is widespread, since almost all OECD countries are witnessing higher debts and increasing public spending. Therefore, policymakers have to elaborate new models, that can cover everybody, but also reduce public spending to an acceptable level, that does not question the capability of the system to accomplish its role in the future (the so-called “intergenerational justice”).

Other difficult topics that are common to all countries are increasing socio-economic disparities that get in the way of a leveled provision of

healthcare. Almost all countries suffer from differences in the people who can receive care: the problem is more evident in those models that heavily rely on private insurance companies since people who cannot afford premiums are less protected by the state. In particular, the United States witnessed this phenomenon with a higher force than others, highlighting higher disparities based on income and high percentages of financial indebtedness related to healthcare. The USA also suffers from racial differences in the provision of care - as we analyzed in chapter three -, where the Afro-American and Hispanic communities are much less protected than the others. Therefore, the problem is not only economical but also cultural: it makes clear that huge steps have to be undertaken to allow all classes to achieve adequate protection. This implies giving more opportunities to minorities, that are still suffering from discrimination. Giving more to them in all fields will reduce also disparities in healthcare because higher incomes will mean higher possibilities to get access to cures and protection and higher education will increase awareness and reduce avoidable deaths that could have been prevented thanks to more educational efforts.

How can these main problems be reduced? It is not an easy question to answer, since the mole of actors and topics involved is enormous and this author has no aspiration to find a magic and rapid solution to improve healthcare. It takes time, and effort, that needs to be put in place by all states of the world, in a systematic and joint action. There is no place for nationalism anymore, especially when the lives of individuals are at stake. The previous sentence, however, is, for now, just a wish, since all countries are still too concentrated on their problems, instead of finding common solutions. For instance, during the pandemic, a real European lockdown was never accomplished, leaving to single states the decision to close and therefore, triggering disparities among the European States. COVID-19 pandemic has put pressure on policymakers to subvert the trend, and start real collaboration on the topic, that, before, was left almost entirely in the hands of single governments. As the article Giuseppe

Bronzini (2021)[235] pointed out, some light has been witnessed in Europe to start discussing common measures to be undertaken to construct a model of welfare that is pervasive and equal for all. New programs, such as *Sure* and the *Recovery Plan,* have been released by the European Union to distribute resources to all European countries, with particular attention to those who have suffered more from the pandemic. The measures that have been pushed by President Von der Leyen are unprecedented in the history of the European Commission, signaling the change of pace this presidency has imprinted in contrast with the previous ones. However, one cannot forget that to achieve such results, discussions were intense and not all states agreed immediately to distribute resources, making clear that some resistance is still present, and nationalism is still a strong obstacle for the formation of a powerful and systematic collaboration. Moreover, real integration is still lacking: discussions on European Health Records are still in the initial phases and will need more time to become reality. On the other hand, though, the "European COVID-free Passport" is due to become reality in summer 2021 and can be the model for further integration on data of healthcare models.

Another consideration related to collaboration that can be drawn from such analysis is that cooperation cannot be forged only among continental states, but also among countries far from each other and pertaining to different geographical areas. The pandemic has highlighted that distance is not as relevant as we imagined, and globalization - probably for the first time - has shown its dark side. Thus, the globalized world - so intrinsically intertwined - cannot think on areas anymore, but has to act on a global base, including everybody in the discussion, since excluding someone, can automatically produce effects on all others. Therefore, the approach must include also the poorest countries, to help them close the gap to the Western World. In this chapter, we have not talked about African and Southern American countries, since they are not included in

[235] Bronzini, G. (2021). *Il senso di Ursula per la solidarietà: verso un welfare paneuropeo?* QG: Questione di Giustizia. Article

the OECD statistics. However, if the impact of COVID was strong in the OECD world, it was devasting in such territories, that had lacking systems even before the pandemic and are now suffering even more. In Brazil, for instance, the pandemic decimated the population: images of mass graves are still fixed in our minds and remember us how healthcare, and more broadly welfare policies, cannot be thought as local anymore but must take into account also those who were left behind, including them in massive humanitarian and economical aids. Vaccination campaigns must be therefore started also in these areas, and not only for COVID-19 but for all diseases that can produce pandemics. In addition, wealthy states must engage in actions to help local governments to start infrastructural campaigns and to improve the overall situation in which these countries verse. In the end, despite all the negative consequences that COVID-19 brought to our society, it also helped us to realize how important these steps are for the well-being of all. Their survival is *our* survival.

CONCLUSIONS

We have now come to the end of this thesis, analyzing what healthcare signifies nowadays in our society. COVID-19 just shed light on a topic that was put aside for a long time. However, problems and lacking dimensions were present even before its advent, signaling the role it has always had in our lives. In this thesis this author has tried to synthesize in a few chapters the relevant dimensions to draw an exhaustive - but not complete - analysis, that had the purpose to describe and debate on the topics that have emerged in the sector in the last decade. Being incorporated into the category of welfare states, healthcare needed to be introduced by a more general approach, that summed up all the services that are thought by the public authorities to grant minimum standards of living to all the population. That is why the first chapter was dedicated to synthesizing the direction welfare states have assumed in the last decades, signaling the role they are now called to take on in the upcoming years. Welfare states have now to reconstruct themselves shifting the focus from mere "welfarist", based on a strict dependency culture, towards new models that are oriented to new strategies, based on collective and programmatic efforts to construct a fairer and more equal society. They are now called to reinstall trust in the future, by allowing new generations to achieve economic independence and prosperity.

The second chapter started to enter the core argument of this thesis: healthcare, and, in particular, healthcare in the United States. This country was chosen as an example for the complexity and peculiarity of its healthcare model, being the only system in the Western world not to possess universal coverage. The controversies of the model are a lot: higher spending than any other country in the world did not produce universal healthcare, and strong lobbying is still a

huge driver of resources in the system. Moreover, the prominently private system does not allow everybody to enroll in protection schemes, since it excludes a significant part of the population that does not have the economic possibility to afford such insurance premiums. Healthcare in the United States has had a strong boost when the Affordable Care Act was introduced in 2010. In the third chapter of this thesis, we have described the efforts put in place by the Obama Administration: surely the reform has produced significant results in terms of insured citizens, widening access criteria to public programs - Medicare and Medicaid - and setting the path to achieving universal coverage. Though the ACA has produced tangible progress, it did not convince everybody. The repeated questions of constitutionality of the act – one is still pending – have emphasized how controversial the topic of healthcare remains in the United States, and how different parties have multiple interests – social, ethical, political, and economic - that are difficult to make coincide. We have understood how healthcare in the US is still centered on profits and how insurance groups are strong in keeping their powerful role in the field, going to the detriment of the general public.

The fourth and final chapter has concluded the paper by constructing a comparative analysis of healthcare systems in OECD countries. The paper used as a reference – "Worlds of Healthcare: A Healthcare System Typology of OECD Countries" (Reibling, 2019) – helped to construct a framework to encapsulate the majority of healthcare systems in the world, by identifying groups of countries with commonalties in the provision of healthcare. The groups were starting points to identifies the pros and cons that are perceived in healthcare systems and served as a guideline to illustrate the complexity of the field, that builds on different assumptions and means to achieve protection. What emerged from the analysis of the five case studies (including the long-debated United States' model) is that all systems have strong dimensions, and, at the same time, are underperforming in some others when compared to other models. It is evident that no system is the best, and all of them adapted to the conditions

present in that country: different lifestyles, regulations, public perception of healthcare, and historical background. It is therefore easy to conclude that finding a "perfect" system that could be replicated in all states is practically impossible and that is why healthcare is so differentiated among countries. However, common problems such as the aging of the population, economic sustainability, unequal distribution of resources, and recently COVID-19, have to be solved with a programmatic and systematic effort, that includes all countries in a joint effort to harmonize priorities and to uniform themselves, not necessarily in the way healthcare is provided, but for sure in the results that are to be achieved. Some light in the UE has been witnessed with the plans implemented to face the pandemic but are not enough if left to a single and sporadic maneuver: actions have to be consistent and frequent and need to include also countries outside the OECD world (i.e., African countries and South American countries), to be widely diffused and to uniform the final output, that is to achieve high standards of living for everybody.

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