

Implications of a Universal Healthcare System in the United States: Why
Individual Health Is Now of National Concern

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ABSTRACT

In 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. This paper explores the implications of these new healthcare policies in the United States, given that a universal healthcare system has already been put in place. More specifically, it explores the question “Does the new ‘universal healthcare’ system bring with it obligations for citizens participating within the system to be more conscientious about their health and lifestyle choices? And if so, on what grounds?”. I argue that individuals have strong social and moral obligations within a universal healthcare system to take the minimal provisions required for staying healthy (eating healthy, exercising, getting vaccinations, smoking cessation, and attending routine “check-ups”) in order to not burden others with easily avoidable healthcare costs. These new obligations are grounded in the duty of fair play stemming from the fact that health insurance is a cooperative scheme. Furthermore this paper will show that when a universal healthcare scheme is in place, the healthcare resources become a ‘common good’ which is susceptible to a collective action problem known as ‘the tragedy of the commons’, and thus also give recommendations for its solution. The solutions that I endorse, although designed to address the free-rider problem recognized by David Winkler, shows that Winkler’s solution goes too far by indiscriminately punishing every unhealthy individual within a universal healthcare system.

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Introduction. There is extensive literature about whether or not healthcare is a right, however this paper will set aside the question to focus on another related issue: whether or not access to healthcare resources brings with it strong social and moral obligations. This paper starts with the assumption that, regardless of whether or not healthcare is a right, if a country has the ability to offer affordable healthcare to its citizens, it should make the effort to do so. This rests on the idea that public health is a good in itself, a notion which will be expanded upon in the next two sections. This paper will then go on to show that fair play obligations apply when one is participating in a cooperative insurance scheme, to the conclusion that universal healthcare intensifies the social and moral obligations for individuals to perpetuate healthy lifestyles. Participating members of a universal health insurance scheme have an obligation to others who are also sharing in the benefits and burdens of the healthcare system, to do what is minimally required to maintain a basic level of personal health. Furthermore, the new healthcare system is at risk of turning into a ‘tragedy of the commons’ scenario unless something is done to curtail unnecessary medical expenditures and dissuade free-riding. Those who believe that healthcare is a right will be able to follow these arguments, given the system currently in place. Others who believe that healthcare is not a right but rather a privilege, and are unhappy with the new healthcare system in the United States should nonetheless agree that with having access to healthcare comes a personal responsibility for the controllable aspects of one’s health, which the arguments in this paper intend to show.

“The World Health Organization’s 2000 overall ranking of national healthcare systems placed the U.S. system 37th (out of 194 member countries), despite having the highest per capita spending. [Additionally,] the Commonwealth Fund’s study of seven developed countries’ healthcare systems placed the U.S. sixth in terms of quality but dead last in every other category-

efficiency, access, equality, and health outcomes.” (Morrisette, et al. 2013) The recently passed Patient Protection and Affordable Care Act (ACA) is an attempt to address these unsettling statistics and, though designed to provide subsidized access to healthcare to 30 million currently uninsured individuals, the ACA will still leave another 20 million uninsured individuals in the United States even after its implementation. (Manchikanti, et al. 2013) One of the provisions in the act mandates that all citizens purchase health insurance, a controversial stipulation which was later upheld by a Supreme Court ruling which concluded that the health insurance mandate is comparable to a federal tax and is therefore a legitimate requirement to make of all U.S. citizens. The ACA, now legitimately including the individual insurance mandate, has also changed the nature of health insurance by requiring insurance providers to reduce the costs of their plans and extend their coverage, thus making healthcare “universally” accessible for all citizens either through private insurance companies or state-sponsored health exchanges.

Unfortunately, the sustainability of this new healthcare model rests heavily on the behaviors and lifestyle choices of citizens involved. There are worries that a newfound sense of individual entitlement to healthcare that the ACA will foster, along with the current minimalist attitudes towards personal responsibility for one’s health, will combine to yield a healthcare system that still underperforms and overspends. In order to keep the ACA a viable option, individuals will have to start taking more responsibility for their personal health so as not to unduly burden others who are also paying into the health insurance systems. If citizens cannot curtail their poor health habits such as tobacco use, lack of physical activity, poor diet, and excessive alcohol consumption; the new universal healthcare system will put unnecessary and ever-increasing financial burdens on the prudent to finance the cost of risk takers.

Healthcare is a Common Good. ‘Common goods’, proper, have two qualities; they are rival and non-excludable. A rival good, is a good that can only be consumed by one person at a time. Once one person consumes the resource, it is no longer available for another individual’s use. The non-excludability of a common good entails that once the good is provided it is impossible to exclude others from partaking in it. Once these stipulations are met, everyone living within the community has access to the provided good; however they must compete for use over the resource. A general example of a rival, non-excludable common good is the edible fish stock in a local pond; although no one in the community can be excluded from fishing in the pond, the number of fish that can be caught are finite. Additionally, common goods can be further divided into two categories; either voluntary or non-voluntary. A voluntary good is one that an individual can choose to partake in, if she wishes, for example public transportation. These common goods are accessible to all within a community and everyone has an equal opportunity to enjoy the benefits provided by the good, however not everyone is forced to participate in receiving the benefits. Due to the fact that no two people can occupy the same bus seat at a given time, it is therefore possible to regulate the use of voluntary public goods and when this happens they then become a ‘club good’. A community might want to restrict access to voluntary public goods in order to ensure that those who are using the good are responsible for the cost of upkeep. For example, one might be required to purchase a ticket to utilize the services of public transportation. On the other hand, non-voluntary public goods are ones that community members have no choice in consuming. Once this kind of good is provided, the benefit is conferred to the whole community and no one has the choice to opt-out of its use. An example of non-voluntary goods is herd immunity, which is an additional level of immunity to a communicable disease that everyone within a population receives once a statistically significant

portion of the population has been vaccinated, whether or not they themselves have gotten a vaccination. Once a community has invested resources to immunize its citizens from diseases like measles or mumps, it is impossible to exclude certain members of the society from partaking in the communal benefit (i.e. reduced risk of contracting that particular illness due to insulation).

Under the ACA, individual healthcare has indisputably become a common good. The health insurance mandate, along with the reduction in insurance premiums and increased accessibility, has made access to individual healthcare a non-excludable and non-voluntary good which all citizens must participate in to some degree. By requiring that all citizens purchase health insurance either through a private company or a state-run exchange program, unless one wants to pay a heavy penalty in the form of a fine, the new law has made it close to impossible for individuals to forgo (at least some level of) participation in the new system. The new healthcare system will also be a rival good. First, citizens seeking health insurance will have several different options available to them, depending on their socioeconomic status. Most individuals will have the option to choose between private or government insurance programs. A majority of citizens will be offered insurance through their employer, others will have to purchase their insurance plans out of pocket, and those who are without work or do not make enough to afford a plan on their own will be eligible for government subsidies. Additionally, the insurance companies will offer several different options for coverage plans, thus creating healthy competition in the market within the private and public spheres. But, most importantly, the subsequent healthcare that the insurance provides is a rival good. Once a particular healthcare resource is provided to one individual, for example a heart transplant, the resource (the healthy heart) is no longer available for another person's use. Unfortunately, the accessibility to healthcare for all citizens, without additional costs to others as new individuals join health

insurance plan, will directly depend on the health of the individuals involved in the scheme. Depending on the health of the group (the public health), changes may have to be made to individual lifestyles so as not to burden others with unnecessary healthcare costs and to reduce the waste healthcare resources that could be better used in other areas.

Public Health is a Public ‘Good’. Public health (which is the summation of each individual’s state of health within a community) is a good in itself; no rational person would choose to be sick if they could help it, because being a healthy citizen not only allows the individual opportunities to better pursue their own projects and desires without physical constraints, but also contributes to a more productive society as a whole. According to Aristotle, human flourishing (or Eudaimonia) consists in engaging in rational activity in accord with virtue, over a whole life. Aristotle acknowledges that several things are needed before a person can reach a state of human flourishing, one of which is basic physical health. (Aristotle and Irwin, 1985) Having a baseline level of health is instrumental in allowing one to engage in the kinds of activities that will bring further happiness. Participating in community activity or engaging with other people, is the only way to exercise both rationality and virtue, according to Aristotle’s view. When individuals are able to achieve at least a threshold level of good health, the thought is, they are more likely to be able to further their levels happiness if they so choose. Good health is simply the meeting of a threshold requirement such that the agent is not constrained by ailments or symptoms that interfere with their ongoing projects and desires, within reason (i.e. natural talents and attributes allowing).

First, studies have shown that children and adolescents are best able to learn and thrive in school when they have good health. (Behrman et al., 1996) (Briggs et al., 2003) (Raaijmaker, 2013) It is difficult to perform well in school and other areas of academia if students are not

receiving the right kinds of nutrition, do not get enough physical activity, or have other ailments that prevent them from focusing during class. Furthermore, good physical health is a fairly reliable indicator of good mental health. Various studies indicate that individuals who eat nutritiously, exercising regularly, and avoid overconsumption of alcohol or tobacco tend to have decreased prevalence of depression, anxiety, and other non-genetic mental disorders. (Barnes, et al. 2003) (Folkins, 1981) (Hassmen, et al. 2000) Education and expanding one's intellect by engaging in rational activity is an important component Aristotle's conception of being able to live a "good life". Secondly, having a healthy population improves the productivity of the workforce and decreases the amount of sick days taken. (Bodenhimer, et al. 2009) (Hirth, et al. 2003) (Stewart, et al. 2003) Healthy employees are able to produce more, which in turn increases both the individual's wealth and the nation's gross domestic product (GDP). Having wealth, while not a good in itself according to Aristotle, is certainly a means to engaging in other sorts of pleasurable, virtuous, or rational activities. (Aristotle and Irwin, 1985) And lastly, another benefit to having an overall healthy population is that more citizens are able to participate within the community. Whether it be volunteering for community sponsored programs or participating in government, citizens of good health are better able to be contributing members of society when compared to their counterparts of poor health because they have more time and energy to devote to fostering local community. Aristotle believes that engaging in community activities with others is the way to achieve Eudaimonia, especially when it is done with friends. Interacting with family members and friends in a meaningful way that fosters friendship and love is an important aspect to living a good life. (Aristotle and Irwin, 1985) Therefore, a baseline level of good health is indeed a 'good' because it is nearly impossible to pursue other life goals and projects without good health.

Some may argue that having minimally decent health is not important to living a “good life”. It is true that the United States is far from being a homogenous population; with citizens of different race, class, gender, and level of personal health. There are many examples of individuals who have accomplished a great deal, despite extremely poor physical health. Stephen Hawking, the notable theoretical physicist, is probably the best current day example of an individual who has greatly contributed to the world despite being paralyzed by neuromuscular dystrophy. However, for every story of someone overcoming physical obstacles to achieve greatness, there are hundreds of other individuals who are deprived of being able to do even the most basic activities due to illness. According the U.S. Department of Health and Human Services’ Office on Disability, over 14 million adults currently receive disability compensations every month due to the inability to work because of a medical condition. If an individual cannot work due to a medical ailment, they are likely also unable to enjoy participating in other activities. On the converse, there are also a lot of healthy individuals who do not flourish in an Aristotelian sense, or contribute to society in any robust manner, because they make the choice to indulge in immediate pleasures by partaking in activities like sitting at home alone and playing video games all day. But, it must be noted that the difference between the avid gamer and the disabled individual is that if the gamer’s desires were to change she would be able to pursue other (more virtuous and rational) activities without substantial constraints, unlike the individual with a medical disability who physically cannot due to their maladies.

The Duty of Fair Play and Health Insurance. When an individual joins a cooperative scheme she is implicitly agreeing to equally shoulder the burdens of the system with the other participating members. If she enters into the cooperative agreement with no intention of sharing

in the burdens, but still partakes in the benefits conferred through cooperation, she is doing so in bad faith. Thus, the duty of fair play dictates that social obligations are owed to fellow members of a cooperative scheme, and not directly to a third party facilitator. In response to receiving benefits, such as social programs, the members of the society are not only morally obligated to obey the rules of the cooperative scheme but are also socially obligated to fellow citizens participating in the scheme to contribute to the upkeep of the benefits they are being offered (for example, by paying taxes). Klosko argues that by accepting the package of benefits, obligation is generated. (Klosko, 1987) Obligations are generated under the duty of fair play by the acceptance of presumptively beneficial goods, i.e. public goods and common goods, which are essential benefits that everyone is supposed to want, such as affordable access to healthcare. (Klosko, 1987)

Now the question remains, whether universal healthcare falls under the fair play category of obligation. Good health and access to healthcare is something all rational agents are presumed to want. When purchasing health insurance, one is protecting oneself against the risk of incurring medical expenses upon falling ill. By combining one's risks with those of other individuals, healthcare costs are spread out among all people within the insurance pool at any given point in time. Purchasing insurance is a lot like gambling because not everyone will get sick at the same time, sometimes one will "lose" a small amount of money by purchasing health insurance when one is having a particularly healthy year, and other times the individual will "win" by avoiding having to pay the full price of an expensive medical procedure.

For example, suppose there are a hundred people at risk of getting a heart attack, but on average only one out of a hundred people will have a heart attack in any given year. Now suppose that the cost for coronary bypass surgery is \$5000. Without an insurance plan, each of

the hundred people at risk would have to prudentially save \$5000 every year, in case they are the individual who needs the coronary bypass. At the end of the year ninety-nine people would have an extra \$5000 in their savings account, and one person will have spent \$5000. But if the hundred people were to get together and spread out their risks, each individual would only be required to pay \$50 to the insurance pool every year, instead of one lump sum of \$5000. Each individual would in effect be saving \$4950 every year, because now they can reallocate that money to use for other expenditures. Most people would rather risk losing \$50, than face the possibility of having to pay \$5000 for surgery out of pocket (or worse, go bankrupt, if they have not planned ahead accordingly).

In the case of entering a cooperative insurance scheme, none of the insurance plan members are the individual who must pay the full \$5000 if they have a heart attack, the majority of their cost will be covered by the money in the insurance pool. By betting a little money in the present, members of the insurance pool think that the odds are good that they will need to dip into the pot in the future. However, each member in the insurance pool must do her part and pay the \$50, regardless of whether or not she is feeling particularly lucky (healthy), otherwise the system collapses. If there are fewer people paying in than there are taking out then there will not be enough money to cover everyone's future healthcare costs.

Thus, health insurance is a kind of cooperative scheme. Citizens accept the package of healthcare benefits when purchasing insurance; the act of purchasing a particular insurance plan is a form of acceptance because the individual is knowingly, willingly, and actively seeking to take advantage of the goods and services provided by a particular healthcare coverage plan. Furthermore, the healthcare benefits will only be provided if each individual equally shares in the benefits and burdens of the system, which is now facilitated by either private insurance

companies or state-run exchanges, depending on which insurance plan is chosen. Even though health insurance exchanges are now facilitated by third parties, it is each individual's responsibility to pay into the cooperative scheme so that it can be maintained; and therefore health insurance falls under the duty of fair play and health insurance participants are both socially and morally obligated to each other in the form of reciprocity.

In the case of universal healthcare, citizens are now asked to purchase health insurance under the ACA. There may be concerns that because of the health insurance mandate, it no longer falls under the category of fair play since the duty of fair play stipulates that citizens must willingly accept the package of healthcare benefits. However this is not necessarily the case. There is a provision in the ACA, where citizens can "opt-out" of the health insurance option by paying a fee in the form of a tax at the end of the fiscal year. Thus, those who do not choose to purchase health insurance are therefore not obligated in the same way as someone who actively seeks to acquire an insurance plan. Although it may be prudent for everyone to accept this particular package of benefits being offered, not everyone is forced to participate in the insurance plans. Thus, the obligations derived from the duty of fair play are only applicable to those who purchase a health insurance plan. This is not a new obligation to individuals who have previously held health insurance policies. However, with the ACA mandate coming into effect, the scale on which these obligations occur has increased dramatically and concerns relating to these fair play obligations should be at the forefront of universal healthcare discourse because misuse and abuse of the universal healthcare system is imminent; especially if citizens do not understand that they are incurring these fair play obligations by joining the universal healthcare scheme.

The New Health Insurance Policy Problem. Until recently, many people who have high risks for (or are currently plagued by) chronic illnesses were either forced to pay higher insurance premiums or are denied coverage altogether. With the new ACA laws coming into effect, insurance companies will be required to take on more “high risk” individuals while simultaneously charging everyone less. Some worry that this may eventually lead to an unsustainable insurance plan because more money and healthcare resources will be taken out then put back in. By allowing higher-risk individuals to enter into an insurance pool the premiums, in theory, should go up for everyone participating in the cooperative scheme because now, the 100 people comprising the new insurance pool are at a higher risk for having heart attack; however the ACA creates a price cap for health insurance by fixing certain healthcare prices. Government subsidies are being made available for those who still cannot afford to purchase insurance on their own, however they are not intended to directly address this problem of unsustainability. The inability to pay for one’s own health insurance can either be due to current medical conditions that do not allow one to qualify for the lowest level of coverage because the condition requires medical assistance that is not covered by the basic plan, or the inability to pay is due to general poverty; only the latter of which makes one eligible for federal subsidies.

Suppose the annual average of heart attacks has now doubled so that two out of a hundred people are projected to need surgery in any given year. In a normal market, this will raise insurance premiums to \$100 per person, so that each of the two individuals can receive the \$5000 coronary bypass surgery, totaling the insurance pay-out to \$10,000 annually. These prices can escalate quickly, if five people per year have heart attacks the insurance premium will be raised to \$250 per person; and if one quarter of the individuals in the insurance pool is expected

to have a heart attack in a given year each individual will have to pay \$1,250 to keep the cooperative scheme viable. This is still all well and good because each individual is still not required to save the full \$5000 to pay for coronary bypass surgery out of pocket if they happen to be the one that has a heart attack that year. However, the more expensive the premiums get, the more it might seem reasonable for someone to opt out of the program and just pay for their surgery out of pocket once the time comes, rather than pay the yearly premium.

However, the Affordable Care Act has an additional component, in that it is offering “affordable” coverage to everyone via regulations and subsidies by the government. For example, let’s assume that the government “caps” the insurance rates for the individual at the original \$50 per person through subsidies. Plus those who are at higher risk are now part of the pool and have doubled the average of individuals who will have a heart attack in any given year. Now the insurance pool is only taking in \$5000 total from each individual, but paying out \$10,000 annually for both of the heart attack victims. In order to prevent the insurance scheme from running a \$5000 deficit that compounds each year, something must be done. Thus the government will either have to contribute an additional \$5000 to the insurance pool by paying for low-income individuals to sign up for healthcare coverage, or convince the healthy (who are not at risk for heart attacks at all) to also purchase insurance that covers procedures they do not need. However, the subsidy strategy will only work if the additional individuals do not also increase the amount taken out of the pool. Unfortunately, people of lower socioeconomic status tend to have the highest rates of health problems due to their inadequate living conditions, the subsequent lifestyles, and their previous inability to access healthcare. Furthermore, the government subsidies have to come from somewhere, namely other taxpayers, who are already

buying their own insurance for full price. Thus it will fall to the healthy to reduce the overall cost of health insurance to everyone.

To illustrate this issue more clearly, recall that in the beginning 100 people who were at risk for having a heart attack came together to pool their risks so that each individual did not have to save an extra \$5000 in case they needed a coronary bypass, because on average only one of them would have a heart attack in any given year. Instead each individual ended up paying only \$50 a year for receiving full medical coverage. Now with the ACA, individuals who are at higher risk of having a heart attack comprise the pool and (let's suppose for ease of math) have doubled the average number of individuals who will have a heart attack that requires coronary bypass surgery in any given year. Additionally, the government fixes the rates of the insurance scheme so that the consumer cost remains at \$50 per person. Thus if the insurance pool was only comprised of the hundred individuals at risk for a heart attack it would only be taking in \$5000 total. But, now the insurance pool consists of the 100 individuals who are at risk for a heart attack (two of which will have a heart attack that year) and another 100 individuals who are not at risk of a heart attack; they then all pay \$50 per person for the health insurance which increases the total to the required \$10,000. By requiring healthy individuals to also participate in the insurance scheme, healthy individuals are now paying for a medical procedure they will never require. To go back to the original analogy, healthy individuals are gambling on a game that is not fair and in which they will always be paying more than their share. Therefore, the only options to preserve a universal healthcare system will be: 1) to enroll enough healthy individuals and charge them equally for insurance premiums that cover medical procedures they will never need to offset the rising medical costs of others, 2) to charge more in taxes to directly subsidize the state-run insurance providers, or 3) to convince the public that their individual health matters

significantly and convince the public that they are responsible for the controllable aspects of their health, in attempts to reduce the number of individuals who have heart attacks altogether. It does not seem just to ask citizens who are healthy to pay more for another's poor lifestyle choices, nor does it seem fair to charge taxpayers even more to further subsidize state insurance exchanges beyond the point of providing a social net to those of lower socioeconomic status. Thus convincing the public to change lifestyle habits that have been scientifically proven to contribute to chronic diseases seems like the best alternative to preserve a universal healthcare system.

The Current Health Problem: Poor Lifestyle Epidemic. The most prevalent types of illnesses seen in the United States are very costly to both the individual and society. In most cases these diseases are manageable or treatable, but not curable. To date there are five chronic medical conditions that amount to over 75% of total medical expenditures in the United States: heart disease, cancer, diabetes, stroke, and arthritis (CDC, 2013). Chronic illness means that individuals can live a (relatively) full life with the disease, as long as proper medical care is routinely provided. For example, people who develop type II diabetes later in life (in one's 50's and 60's) can expect to live, on average 15-20 years after diagnosis, with proper management. Additionally, half of all adults in the United States have at least one of these five chronic conditions. (CDC, 2013). These top five chronic illnesses have been scientifically studied and shown to be exacerbated by certain lifestyle choices, and thus could be prevented in a vast majority of cases by making changes in one's personal habits. The top behaviors associated with these five chronic medical conditions in descending order are tobacco use, lack of physical activity, poor diet, and excessive alcohol consumption (CDC, 2013). Tobacco use is not only known to cause cancer, but also increases risks of heart disease and stroke. Lack of physical activity coupled with poor diet is the leading cause of obesity. One in every three adults and one

out of every five children in the United States are obese (CDC, 2013). Obesity is one of the leading causes of type II diabetes, heart disease, stroke, and arthritis. Lastly, excessive alcohol consumption has been linked to heart disease, cancer, and type II diabetes. Even though this information is widely accessible (and for the most part common knowledge) due to public health campaigns, most of the United States' citizens continue to engage in these behaviors without moderation. (Bodenheimer, et al. 2009) Furthermore, individuals with a chronic illness are expected to accrue medical expenses that are five times greater than their healthy counterpart (CDC, 2013).

On the other hand, there are many illnesses that the individual's lifestyle does not influence. Having a genetic disease is out of the individual's ability to control, because one cannot control the content of their own genetic code. The majority of genetic diseases are not discovered until after puberty, once the full array of phenotypic gene expression has taken effect. Certainly these individuals should not be held to the same degree of responsibility for their bad health, as someone whose actions and poor lifestyle choices directly lead to their illness, just because they lost the genetic lottery. Questions may arise however, to what extent an individual may be required to undergo genetic testing. Although medical science has the ability to screen for genetic diseases, advances in gene therapy are far from being able to robustly alter the DNA sequences of individuals. It might be the case that individuals should be required to get tested for genetic diseases with high percentages of penetrance that are easily managed or cured. This is already done with newborn infant genetic screening, and it might be wise to follow suit with the adult population. Currently in the U.S. all newborn infants are federally required to be tested for 21 different genetic disorders; these genetic disorders can lead to serious medical conditions if not treated in a timely fashion. But, if caught early the child's risk for physical and intellectual

disabilities is greatly diminished. There are similar genetic conditions that appear in adulthood. Worries about being discriminated against by being denied healthcare coverage is no longer an issue with the ACA now in place, because it is now unlawful for insurance companies to deny access or charge higher premiums to individuals with pre-existing conditions. A hereditary disease is probably the most “pre-existing” disease one can have, since the individual with the genetic illness will have had it since conception. This raises a secondary concern that under the fair play obligations, expecting parents will have a duty to perform prenatal genetic screening and abort any fetus with a diagnosed genetic disease. However, this slippery slope argument for eugenics does not hold. There are many other arguments and principles that can be appealed to in the biomedical ethics literature about both abortion and eugenics, any one of which may supersede fair play obligations if it can be shown that the fetus is a moral person (or potential person) and has a right to life, or appeals are made to women’s reproductive rights, or arguments in favor of pluralism and genetic diversity are made. There is also extensive literature in the area of bioethics specifically addressing the acceptable and objectionable uses for pre-implantation genetic diagnosis and in vitro fertilization. But, for the sake of brevity of this paper, I will only mention these in passing because the issues are outside the scope of my argument.

Although hereditary diseases are unavoidable (at least for now), lifestyle induced illness is preventable. The growing trend of sedentary lifestyles coupled with poor diet and increasing rates of individuals who abuse both tobacco and alcohol are exacerbating the prevalence of individuals with overall poor health. Individuals probably believe their health is theirs alone and does not affect other people. However, with the universal healthcare system, this is not necessarily the case. “The cost of sloth, gluttony, alcoholic overuse, reckless driving, sexual intemperance, and smoking is now a national, not an individual, responsibility.” (Winkler, 38)

The new health insurance schemes makes it impossible for providers to either charge more or deny coverage to those who choose lifestyles that lead to poor health.

The Tragedy of the Commons. With this issue in mind, the universal healthcare system in the U.S. faces a collective action problem, otherwise known as “the tragedy of the commons”. According to Olson, “if the members of a large group rationally seek to maximize their personal welfare, they will not act to advance their common or group objectives”. (Olson, 1965) This means that most rational agents will attempt to take as many benefits from a common good as possible, without contributing to the common good’s sustainability. The tragedy of the commons happens mainly in large groups when it is both advantageous for all members of a group to act collectively to secure a common good, while at the same time no one single member of the group has a noticeable effect on the outcome of the common good’s security. To illustrate this point more clearly, imagine that a local fishing hole is a common good (as defined previously). The amount of fish in the pond that can be caught and consumed are rivalrous in the sense that no two fishermen can catch and eat the same fish. The fishing hole is also non-excludable because no fisherman can stop another from fishing in the pond. Each fisherman also knows that if too many fish are caught in a given year, there will not be enough during spawning season and repopulate the fishing hole. If the fishing hole is over fished, none of the fishermen will be able use the common pond to sustain their livelihood. Therefore the fishermen community has a joint interest in regulating the amount of fishing done in the pond; however, each fisherman also wants to be able to catch as many fish as possible and so no single fisherman is therefore willing to self regulate his fishing practices. If the rest of the fishermen do not agree to self-regulate it is not in the interest of the single fisherman to forgo catching as many fish as possible because she should prudentially catch extra fish to stockpile for when the population

collapses; but it is also irrational for the single fisherman to regulating her fishing even if the rest of the fishermen self regulate because her catching a few extra fish will not cause the fish stocks to collapse and she will have a comparative advantage. Herein lays the tragedy of the commons, and the way to resolve this problem is for the fishermen to reach some kind of agreement in which they all share equal responsibility for the fish pond's sustainability. This can be done one of three ways: 1) privatization of the common good, 2) disincentivize those who take more than their allotted share, or 3) having a third party create and enforce regulation policies. The same scenario holds true for access to healthcare once individuals fall ill. Healthcare insurance is not only a common good but also a cooperative scheme, therefore the theory of fair play allows for individuals buying healthcare to trust that everyone else shares equally in the burdens of sustaining the common good (i.e. paying one's share and changing personal health practices to reduce risks of falling ill).

A problem with notions of fair play arises from a concern about whether or not an obligation to cooperate is generated only when the cooperative scheme is small enough so that any participant's failure to play by the rules might spoil the system of benefits. Worries about the free-rider problem have left questions about the legitimacy of the fair play principle; if it is the case that the cooperative scheme is large enough for some people to receive all of the benefits without taking on equal burdens of the system, then perhaps reciprocation and the equal sharing of benefits and burdens may not be the ultimate grounding for generating this social and moral obligation. "Free-rider" is a term used to distinguish someone who does not pay for a good which they consume. In certain cases it seems unfair for an individual to take advantage of a common good without contributing to the sustainability of the scarce resources. By not contributing to the sustainability of the affordable healthcare that one realizes (or ought to

realize) is worth paying for, they are knowingly placing the burden of funding the universal healthcare system onto others who both understand its importance and are already contributing their fair share. In the specific case of universal healthcare, free-riders will be detrimental to the sustainability of the system because in the end, health conscious individuals end up paying more than they ought, in order to provide healthcare to others (the free-riders). This seems counterintuitive because individuals who are less of a health risk should be required to pay lower premiums since they will not be taking as much out of the insurance pool. However, the new ACA law is counting on the fact that healthy individuals will be required to also purchase insurance at the same rates as the unhealthy, otherwise the government will have to further subsidize the healthcare system from elsewhere (tax revenue).

There have been worries however, because for some healthy young adults who barely break the poverty line and therefore do not qualify for subsidies; are being expected to pay up to 115% more for health insurance than they would have had to prior to the ACA's implementation. (Commissioner of Insurance Report, 2013) Conversely, persons with a chronic illness are expected to accrue up to five times more in medical expenditures than those who do not. (CDC, 2013) This in turn means that the healthy are paying more and receiving significantly less. Thus in the specific case of universal healthcare, the free-rider is someone who does not take reasonable precautions to protect their own health and in turn draws more from the insurance pool than is otherwise necessary. There are some fairly simple precautions that the individual can take to prevent illness and reduce overall medical expenditures, which I argue, everyone is obligated to do when entering into the new ACA insurance exchanges. Being up to date on vaccinations, going to routine check-ups, eating a balanced diet, engaging moderately in regular physical activity, as well as attempting to cut back on tobacco and alcohol consumption are all

steps that one can take to avoid future illness. By taking a few simple steps to cut down one's risk for getting a chronic illness or easily preventable communicable disease, the individual is "doing their part" in keeping healthcare costs down for everybody participating within the system and not unduly burdening their fellow participants. By being careless about personal health individuals knowingly pass on the burden of their healthcare costs onto other individuals, namely the healthy, as well as harm themselves in the process.

Identifying the Free-riders Among Those with Risky Lifestyles. Due to the ACA citizens are specifically obligated to take the necessary precautions to maintain a baseline standard of personal health by making good lifestyle choices. Many individuals in the United States will need to readjust their current attitudes towards their personal health and strive to make their overall health a priority in order to keep the universal healthcare scheme viable. There is no question among the scientific and medical community about whether or not certain everyday lifestyle choices lead to increased risk for medical problems (lack of exercise, poor diet, overuse of tobacco or alcohol, and failure to receive routine physicals). Thus, there needs to be a way to delineate between those who are being prudent with respect to personal health and fulfilling fair play obligation and those who are not by taking undue risk with respect to their health.

There are a few reasons why individuals do not prioritize healthy lifestyles. First, some individuals may truly want to make the healthy choice but due to a lack of resources within a family or community, their options are severely limited. Socioeconomic status can be a significant external constraint on lifestyle choice. There are individuals who live at and below the poverty line who are unable to allocate their time or financial resources to healthy living. These citizens are unable to prioritize their personal health, not because of under-motivation or

lack of appreciation for health information, but due to the inability to choose otherwise as a result of their limited material resources. These cases call for changes in other areas of social justice so that these individuals have the means to change certain aspects of their lifestyle. Although individuals in this category live riskier lifestyles, they are not intentionally being free-riders because they cannot choose otherwise.

Secondly, some individuals are truly misinformed when it comes to the implications of certain lifestyle choices leading to poor health. There are many individuals with mistaken beliefs about what is healthy and what is not. This does not mean that the individual does not wish to be healthy, but rather lacks the appropriate knowledge for healthy decision making. This individual may in fact be making an effort to live a healthy lifestyle but due to false beliefs, consistently makes bad decisions regarding certain aspects of their health. Unfortunately there are some sources of misinformation about what is healthy and what is not. For example, a recent high fructose corn syrup commercial's slogan is "sugar's sugar, your body can't tell the difference". Even if perhaps one cannot taste the difference between sweeteners (although I argue this is not the case for sugar specifically), the human body's biochemistry can certainly tell the differences (a fructose dimer is much more detrimental to one's health when compared to glucose molecule). Someone without training in biochemistry who watches this commercial may believe that foods with high fructose corn syrup is on par with foods containing cane sugar, and therefore make poor health decisions. Fortunately, all that would be required for these types of individuals is to provide them with the correct information. Although these individuals are currently increasing their risk for chronic illness, they are not being free-riders because their poor lifestyle choices are not due to a direct failing in their deliberative process.

Another possible scenario is in the case of addiction. Two of the four lifestyle triggers for chronic illness are caused by documented addictive substances, tobacco and alcohol. It could very well be the case that a particular person wishes to be healthy however lacks the will power, due to an addiction. An alcoholic, for example may understand all of the relevant facts about how drinking too much can cause a wide variety of physical ailments including (but not limited to) heart disease, cancer, and type II diabetes and therefore genuinely wishes to stop. (CDC, 2013) However, due to the addiction the individual lacks the ability to do so. By making it a priority to offer assistance when it comes to substance abuse (whether it be medical interventions, psychotherapy, or rehabilitation facilities), an individual can have the opportunity to regain their autonomy and thus cease the behavior associated with adverse health risks.

A fourth consideration is that some individuals place an inappropriate weight on the “inconvenience” of being healthy. They understand the risks of falling ill and have all of the relevant facts, but think that it is over burdensome to make healthy choices; and thus do not even make an attempt to be healthy. But, those who claim they do not care about the health implications of living unhealthy lifestyles will probably feel differently when they find themselves ailed with health complications like heart disease, cancer, diabetes, stroke, and arthritis. Once these individuals suffer from an illness associated with being unhealthy choices, they will probably wish they would have placed a higher weight of importance on a healthy lifestyle. They will be regretful at the very least due to the physical discomfort and perhaps due to the new limitations they face when participating in the meaningful projects and activities they enjoy. Once these individuals get sick with a chronic condition and begin consuming medical resources they become free-riders on the healthcare system because although they understood the

risks of falling ill associated with their lifestyle choices, they failed to fulfill their obligations by sharing equally in the burdens of the cooperative system.

Furthermore, some individuals under appreciate the probabilities of contracting a chronic illness due to certain lifestyle choices. For example, many habitual smokers acknowledge that they are aware of the studies linking tobacco use and the high probability of getting cancer—approximately a 70% chance (CDC, 2012); however the vast majority of smokers mistakenly believe that they will be part of the lucky minority (30%) who do not get cancer, which is unreasonable for every smoker to believe. There is a lot of readily available information about the implications of certain lifestyle choices on personal health in the public sphere. However some individuals have a hard time appreciating the seriousness or severity of the chances; and thus, they continue the practices regardless of their knowledge because they are hedging their bets that they will not get sick. Again, these individuals should be charged as free-riders because of their impudent and irrational calculations about future events, despite having the relevant knowledge, because they forgo their obligation to help reduce overall healthcare costs of the universal system.

Lastly, there are some individuals who simply do not care about their health. Whether it is through willful ignorance or stubborn irrationality, some individuals cannot be convinced to take their personal health seriously. Some of these individuals will choose to opt-out of the universal healthcare system, and will not partake in the benefits of health insurance. However others will buy health insurance and although the relevant information about maintaining good health is accessible, these individuals will knowingly choose to partake in the benefits of the universal healthcare system without any regards to contributing to its ongoing sustainability.

Thus, those who buy health insurance but do not take their personal health seriously are free-riding on the system.

The first way to solve collective action problems is to privatize the common good. However, this would simply be reverting back to the healthcare system that was in place before the ACA was brought into affect. Another way to solve the problem of free-riding is to employ state sanctioned regulations and intervention. Collective actions problems have been successfully resolved by the state in the past. For example in the fishing problem illustrated above, the Department of Natural Resources (DNR) sells fishing licenses which permit individuals to use the pond in tandem with placing regulations on how many fish and what size fish a given individual can catch in a season. Selling fishing licenses is much like selling insurance plans, those who consume the common good contribute to its sustainability through a monetary tax. However, this has been shown to not be enough. Thus further government intervention is needed to ensure the common good remains viable. The first way for a third party to solve a collective action problem is by de-incentivizing free-riding by punishing the free-riders when they are caught taking more than their share of the common good. A second way is to enforce additional polices that mitigate the free-riding problem further.

The Winkler Solution. Instead of merely reacting to the current health problem in the United States by offering affordable insurance to all, taking action to prevent such high frequencies of lifestyle induced chronic illness will go a long way in making it possible to provide healthcare access to everyone. This can be done in two ways; penalizing or incentivizing. Thus the prevailing question is whether or not in this particular case, paternalistic actions by the government namely enforcing the adherence to fair play obligations, is morally justifiable. It might be possible to identify those individuals who choose to life a riskier lifestyle

and “tax” them for doing so by requiring additional extra charges on their insurance premiums. If this were possible, it would preserve the liberty of individuals to act as they please without passing the burden onto the prudent. An interesting example offered by Daniel Winkler illustrates this point:

“A case in point might be a government “fat tax”, which would require the citizens to be weighed and taxed if overweight. The surcharges thus derived would be held in trust, to be refunded with interest if and when the taxpayers brought their weight down. This pressure would, under the circumstances, be a bond imposed by the government upon its citizens... The two single properties of this policy would be its aim of improving the welfare of obese taxpayers, and its presumed unwelcome imposition on personal freedom. (Certain individual taxpayers, of course, might welcome such imposition, but this is not the ordinary response to penalties.) The first property might be called ‘beneficence’ and it is generally a virtue. But the second property becomes ‘paternalism’, and its status as a virtue is very much in doubt.” (Winkler, 37-38)

What this example is intended to illustrate, is that one solution to the free-rider problem is to penalize unhealthy lifestyles through the imposition of a tax. Although a “fat tax” may be going a bit too far, the essence of raising insurance premiums for those who choose to live riskier lifestyles might be warranted. Deterring individuals from tobacco use, living sedentary lifestyles, having poor eating habits, or engaging in excessive alcohol consumption may prove beneficial to the overall cooperative insurance scheme. However, this is not a solution that should be endorsed, because first and foremost it is in direct violation of the central tenant of the ACA- protecting individuals from discrimination against pre-existing conditions (including

chronic illnesses). And secondly, the “fat taxes” do not distinguish between the free-riders who make poor lifestyle choices and those who have unhealthy lifestyles due to circumstances outside their control. The “fat tax” solution is incapable of parsing out individuals who are externally constrained due to lower socioeconomic status, have been blatantly misinformed by third parties, or are addicts who wish to reform but lack willpower to do so from other individuals who place an inappropriate weight on the burdens of being healthy, under appreciate the risks associated with certain actions, or simply do not care about their health in general but purchase health insurance anyways.

The Wright Solution. I propose that the same results (detering free-riding) could be achieved by changing the focus of healthcare in the United States to a proactive system, as opposed to the reactive system in place currently. The majority of healthcare in the United States is currently provided at the tertiary level. Tertiary intervention falls under the category of physicians treating the sick and pharmacists distributing prescription drugs to those who need them. To better promote healthy lifestyles the focus of healthcare will need to switch to prevention. Primary intervention, or public health intervention, refers to the measures taken to avoid an illness or disease before they occur. Such primary measures are taken to protect the public from health risks that afflict the majority of the population. Along with primary intervention, secondary intervention is the screening for an illness or disease before the symptoms begin to occur. This is also referred to as preventive medicine because doctors are trying to “catch” a disease early to prevent the onset of adverse symptoms. By switching the focal point of medicine in the United States to primary and secondary medical intervention of disease, the rates of chronic illness should decrease significantly because it will either be prevented entirely or discovered at an earlier stage when medical treatments are more effective

and less costly. If the government were able to alter some of their policies that currently enable poor lifestyle choices such as tobacco use, inactivity, poor diet, and excessive alcohol consumption, the policies would deter free-riding.

One possibility is to reform other areas of the government that perpetuate poor lifestyles, especially diet. For example, the corn subsidies in the United States allow for the favoring of food additives like high fructose corn syrup and monosodium glutamate (MSG) because these additives are overall cheaper than their natural counterparts, even though they have been shown to not only have no nutritional content but also contribute to certain illnesses. Corn oil, starch, and syrup are all prominent forms of cooking aids in the food service industry that come from corn and which have healthier alternatives, but are being used because they are cheaper due to the subsidies. If the government were to reduce the amount of subsidized corn in order to encourage food distributors to forgo the use of non-natural flavorings, colors, and preservatives then healthier food options would be readily available and comparable in price. Additionally, another measure that could be taken to improve nutrition is to reform the current food assistance programs for the poor; making fresh foods like fruits and vegetables more available to those of lower socio-economic status thus ending food deserts. By changing the current SNAP food assistance program to provide vouchers for fresh fruits, vegetables, and whole grains instead of providing merely high calorie foods that are either high in sugar, fat, or salt; the demand for nutritious foods within a community of lower socio-economic status will bring the healthy foods into the area. Lastly, some states have already enacted legislation to deter individuals from being unhealthy, a good example is Trans-fat Bans. Trans-fat bans are particularly useful pieces of legislation because trans-fats have no nutritional value and have healthier substitutes that are comparable in both price and taste. The hope with banning trans-fat

is to reduce the rate of severe health problems that the food additive is directly linked to, namely heart disease, type II diabetes, and obesity. Recently, there have been talks by the Food and Drug Administration (FDA) to ban all trans-fats across the United States, which I heavily endorse in another paper.

Another area in desperate need of governmental policy reform is in the area of preventing the spread of communicable diseases. Currently there are no national immunization laws, however the Supreme Court has ruled that states can require citizens to get vaccinations in order to protect public health. (Thompson 194-5) Unfortunately, within the last decade almost all 50 states have amended their mandatory vaccination laws to allow for “philosophical objectors” and the policies requiring immunization have been relaxed. Now, an ever increasing number people are forgoing vaccinations for various reasons every year, which is having ill effects on the population as a whole; diseases that were thought to be in the past (polio, measles, mumps, and chickenpox) have begun a resurgence within the general population because people no longer are acquiring immunity through vaccines. (Orenstein, 20-1) (Omer, 1983) (Thompson, 197-8) By allowing for individuals to forgo routine vaccinations, they are needlessly subjecting themselves to easily avoidable illness, many of which usually require emergency room visits or even hospitalization. Encouraging individuals to take a proactive approach to preventing illness, perhaps by having insurance plans fully cover all vaccine costs like MMR, chicken pox, seasonal flu, tetanus, hepatitis; along with making vaccination exemptions more difficult to obtain, will significantly reduce the rate of communicable diseases within the population and thus contribute to a more sustainable universal health insurance scheme. Another area of communicable disease that must be addressed is the ever increasing rates of sexually transmitted infections (STI’s). Right now chlamydia is at a record high with over 1.5 million cases reported in 2013, according

to the CDC; additionally, the rate of HIV/AIDS infections has been steadily increasing by approximately 50,000 people per year due to both person-to-person and vertical transmission. Although promiscuity is usually blamed for both these statistics, it is actually due to the lack of proper sexual education that informs individuals how to protect themselves against possible infection. (Underhill, et al., 2007) (Santelli, et al., 2006) Studies have shown that abstinence-only sexual education fails to provide youth with the knowledge and resources to arm themselves against infectious diseases (and unplanned pregnancy). (Santelli, et al., 2006) Unfortunately, abstinence-only sexual education programs are widespread and robustly funded by the U.S. President's Emergency Plan for AIDS Relief; even though abstinence only education has proven to be less effective than educational programs that promote safer-sex strategies alongside abstinence. (Underhill, et al., 2007) In order to help sustain the ACA, the United States government should stop federally funding abstinence-only sexual education programs, and replace them with those that promote safer-sex strategies because they have shown to be more effective in preventing the spread of STI's because it will reduce the incidence of avoidable illness.

The last possible penalty-free solution to the potential free-rider problem is to create incentives within the insurance systems to maintain healthy lifestyles and offer routine health screenings. Some private insurance companies already have programs like this in place, and the state-run exchange programs would do well to follow suit. There are already discounts off monthly insurance premiums for having a gym membership and visiting it at least twice a week. Most gyms and health clubs have expert trainers on staff that will work with new members upon joining to teach them how to properly use the equipment and devise a workout routine that will optimize the use of their time to get the member's desired results. Having discounted (or free)

memberships to gyms/ health clubs that provide personalized guidance might be the incentive an individual needs to start exercising on a routine basis. Furthermore, there are many family-friendly gyms (like the YMCA) that provide children's programs so that a parent can exercise alone while the child is being looked after by a third party. Another way to incentivize insurance holders is by encouraging individuals make routine physicals, or yearly "check-ups", a priority; there are many illnesses that if caught in the early stages, will require less aggressive treatment or will even be reversed by taking additional precautions. For example, someone who is diagnosed with high cholesterol can reverse their condition through diet change and moderate exercise, before it turns into full-fledged heart disease. Studies have shown that individuals are more likely to make lifestyle changes when their physicians prescribe specific lifestyle alterations (for example: "engage in moderate exercise for 30-45 minutes three times a day" or "eat more high fiber foods and reduce fat intake") using prescription pads just like they would for a medication, when compared to it only being told to do so verbally. Encouraging individuals to make this a priority by offering incentives (regardless of the check-up outcome) will give general medical practitioners the chance to sit down with their patients and explain the importance of healthy lifestyles before the patient develops an incurable condition. But, this can only happen if individuals, medical professionals, and health insurance providers make primary and secondary medical interventions a priority.

Conclusion. Governments should attempt to provide healthcare to citizens because having good health is instrumentally beneficial. Furthermore, healthcare within a universal healthcare system is a common good, as opposed to its widespread portrayal as a public good. Insurance schemes, which provide healthcare resources, are a cooperative scheme. The theory of fair play stipulates that members of a cooperative scheme are obligated by reciprocity to share in

the burdens associated with receiving the particular benefit, and insurance plans are a cooperative scheme falling under this category. The issue with the Patient Protection and Affordable Care Act (ACA) is that insurance companies and state-run exchanges will be required to take on more “high risk” individuals while simultaneously charging everyone less. Government subsidies alone will not mitigate the problem of unsustainability, so the young and/or healthy will be paying more than their share for universal healthcare. Thus individuals should strive to be more health conscious and take basic preventive measures to preserve their good health, because individual health is no longer merely a personal concern, but rather of national importance. However, poor lifestyle choices are a major factor in the current United States’ chronic illness health problem; and lifestyle induced illness creates a ‘tragedy of the commons’ problem. Free-riders include individuals consuming healthcare resources who placed an inappropriate weight on the inconvenience of being healthy, under-appreciated the probabilities of contracting a chronic illness due to certain lifestyle choices, or did not care about their health, but purchased the insurance anyways. Instead of penalizing everyone through the use of taxes who show the outward signs of free-riding, there instead should be a switching of the focus of healthcare in the United States to a proactive system, as opposed to the current reactive system. By creating policies that promote primary and secondary public health interventions lifestyle-induced illnesses can be more easily avoided. This can be done in two ways, first by changing federal policies that are already in place to better promote good health and secondly by encourage doctors to screen for illness and prescribe lifestyle changes to patients under appropriate circumstances.

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