The Obamacare: Pushing back the Limit of Possibilities in the U.S. Welfare System

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INTRODUCTION

On March 21st 2010, President Barack Obama welcomed the vote of the Health Care Reform by the members of the House of Representatives, with the following declaration:

> Tonight, at a time when the pundits said it was no longer possible, we rose above the weight of our politics. We pushed back on the undue influence of special interests. We didn't give in to mistrust or to cynicism or to fear. Instead, we proved that we are still a people capable of doing big things and tackling our biggest challenges.

Through this presidential discourse that praises America's preference for "big things" and "biggest challenges" in the face of "special interest", "mistrust", "cynicism" or "fear", one realizes how much the vote of this reform is important for the administration of President Obama who had placed health at the centre of his electoral campaigns in 2008 and 2012, and for the American population in whole given the relief that it is supposed to bring in the health system. As a social law, the new legislation brings, for sure, one major missing component to the American welfare system. But the issue of health remains a disputed question in America given the controversy it has raised among political leadership and the subsequent amendments it has gone through during the voting process. And even though the decision of the Supreme Court about the constitutionality of the law on June 28th 2012 legally implies a stop of the controversy, questions still remain in the mind of the researcher: What makes the reform of health system so important an issue in American society? Does it really change anything in the American health situation today after so many amendments? To what extend can the Obamacare, as they call it, represent an example to emulate in terms of policy making, for the people in developing countries like Côte d'Ivoire[i]? In order to provide efficient answers to these questions, and for better understanding of the complex U.S. health system, we'll have to go through the great moments of implementation of what can be called the *American welfare policy* which became popular during the New Deal (1930s) and the Great Society (1960s). An examination of some specific cultural, economic and social circumstances that act, according to experts, as backlashes to social programs in America will also be undertaken with the final objective to show the ongoing reform as one landmark event that extends the limits of possibilities.

I/ A HARD WON LEGISLATION

It is certainly not too much to qualify the vote, on March 21st 2010, in the U.S. House of Representatives as "historic". Like most of the major legislations which have been passed before, that vote which institutes President Obama's proposal for Health Care into law has triggered passions between the two leading political parties as well as among individual members of the American society. In the course of this work, we'll analyze in detail the reasons for the controversy over this question which, undoubtedly, amount from simple political rivalry between Republicans and

Democrats given the presidential campaign (2008; 2012), to more historical or ideological considerations about the scope of health itself in the context of the U.S. social policy making[ii]. For the time being, let's assess theoretical elements on conceptualizing the notion of social solidarity in which the question of health takes a great part.

a- Conceptualizing social solidarity : theories and context of health policy

In the United States of America, like in most developed countries, the question of health is, sure, one issue of national interest. It is part of the whole agenda generally known as Public/social Welfare. According to social scientists, the development of public welfare is closely related to the evolution of modern industrial societies. The objective of welfare programs, according to sociologist Asa Briggs is to make organized power to modify the play of market forces in at least three directions: (1) "by guaranteeing individuals and families a minimum income irrespective of the market value of their property"; (2) "by narrowing the instant of insecurity by enabling individuals and families to meet certain social contingencies"; (3) "by ensuring that all citizens without distinction of status or class are offered the best standards available in relation to a certain agreed range of social services"[iii].

From the stand point of the theory known as *theory of historic development*, the implementation of systems of social welfare is a natural process in the course of evolution of human societies toward economic and democratic refinement. Working in a structure-functionalist pattern, this theory considers the notion of public welfare as an important tool in the development of nations toward a welfare state which generally concerns sectors as various as legal safety, allowances for the poor and the retired, and assistance of war victims, etc. For Harold Wilensky and Charles Lebeaux who conduct an elaborate analysis on welfare in industrial societies, one of the main consequences of urbanization and the growing capacity of industrial societies to generate resources and modern types of social organization has been the destruction of old systems of family, community and feudal solidarity. Those traditional forms of social link have, thus, been replaced by the ones created in modern nations in the form of welfare programs[iv]. A more recent analysis developed by Peter Flora shows that social insurances in late 19th century have been created both as a response to negative effects of socio-economic development of traditional societies and to rising organized actions of workers[v]. Next to this theory of historic development is the *political class struggle approach* which insists on the pressure of corporate groups on organized power for implementing social policies based on solidarity. According to Costa Esping-Anderson, who is adept of this theory, the introduction of systems of social insurances is motivated by the intention of governments to collaborate with workers and, in doing so, avoid possible trouble in society[vi].

Whether we are in a *structure-functionalist perspective* or in a *political class struggle* one, welfare policies appear as necessary part for coherent functioning of modern societies. In European countries, Germany was the pioneer in implementing welfare programs as early as 1883 under Bismarck Administration. Financed by employers and workers alike, those early programs comprised health and accident insurances for low-wage workers. Later, other European nations like England and France followed, first under the threat of popular revolts in the 1930s, second and chiefly in order to meet big poverty problems caused by the two World Wars.

b- History of health policy in the U.S. welfare system

In the U.S.A. the conditions for developing welfare policies have been different. For one thing, America has experienced a rapid industrial evolution, and for another, unlike European countries, the U.S.A. benefitted from the two World Wars which were wagged distance away from the continent. The combined effects of these two situations were economic prosperity, which in fact, didn't encourage large initiative for solidarity. And particularly in everything that concerns health, public initiative has been limited. Different reasons account for this. Among these we have first, the good financial conditions mentioned above; second, institutional/constitutional restrictions which, as we'll see later, attribute major social responsibilities to federated states and counties rather than to the federal authorities; and third, the liberal orientation of the U.S. economy.

To say that liberal ideology determines the health system in the United States of America means that as a field of activity, health takes a mercantile value just as any other article of the market place. As such, it is only the market which must act as regulator in everything that concerns the health system, just as it is the market which regulates the other fields of economic activities. As R. Hofstadter accurately observed American democracy is a "cupid", not a "fraternal democracy"[vii]. The predominance of liberal ideology in the U.S. health system has resulted in the emergence of a whole business industry with various branches. Among these we have insurance companies, pharmaceutical laboratories, private hospitals, etc. Each of these feeds and develops on the health system as they take part in its growth. A real wall of lobby, these private health corporations have always been an obstacle to public interference in the health branch of social welfare. Consequently, the activities related to health remain predominantly on the private control. This does not mean that no public action has ever been taken at all. On the contrary with the rapid industrial and economic activities, a lot of difficulties soon came to the surface: low-wage workers went through economic troubles and could hardly save enough money for their old-age; severe yellow fever epidemic struck New Orleans in 1879, etc. And one realized that only the market could not regulate everything for the best, and that public initiative embodied in federal authority was needed in the sector of health. Efforts started, in fact, as early as the mid-nineteenth century, more precisely after the serious social crisis caused by the civil war in the mid-nineteenth century. But those efforts were limited in scope and dimension. For example, the Massachusetts State was the first to set up a real State Board of Health in 1869. This was followed by many other initiatives like the New York City Health Department which got set up in 1908. The actions of these early local health institutions were various: inspecting tenements, anti-smallpox and TB vaccination campaigns, building of hospitals, etc. At the federal level, it was only in 1953 that the government created a Department of Health and Education. Though modest, these early local and federal health institutions played a significant role in the field of sanitation but they were constantly exposed to the assaults of organized associations and the hostile actions of the conservative public opinion which did not give large occasion for such public initiatives to prosper. In addition to the lobbying actions from private health associations, we have to count with the constitutional restrictions and the ideological suspicion against socialism as well. Indeed, according to the U.S. Constitution, the responsibility for health as well as different aspects of public welfare (legal security, allowances for the poor, etc.) falls on local administrations and counties. Historically this constitutional close inspired by the notion of Separation of Power coupled with the suspicion against Communism have acted as backlash against effective public action in the

field of health. Thus near the rare local and federal initiatives, innumerable other attempts to set up health policies resulted in failure. For example, in the corporate sector, between 1913 and 1916, sections of conservative members of the American Medical Association (A M A) helped by a coalition of unionists, businessmen and insurance companies rejected all the proposals made by the American Association for Labor Legislation (A. A. L. L.) which was trying to get a vote of a legislation on health insurance. The American Federation of Labor (A. F. L.) opposed the Bill arguing that it went too far in its prerogatives and constituted a strong menace to the worker's freedom[viii]. The World War I and the effect of a continuing anti-socialist/communist propaganda of the period contributed to this rejection. And it was not until the 1960s that effective federal initiatives began to be taken in the form of the two landmark programs: *Medicare* and *Medicaid*. These two programs, which were set up in 1965, came as corrective measures to one key social legislation passed three decades earlier: the Social Security Act of the New Deal era, taken (in August 1935) as a response to the great demand for federal action against poverty problems in depression times. The objectives of Medicaid and Medicare were, in fact, to provide federal assistance and insurance to the poor and the retired[ix]. Reputed as two of the key social measures of the Great Society of the 1960s, these programs were also limited in scope and, in spite of their good intentions, still left innumerable American citizens uninsured. In the 1990s during the presidency of Bill Clinton, the president who was aware of the urgent need for action in the matter of health pushed a plan for health reform to Congress but failed for almost the same reasons as mentioned above.

II/ THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA: March 23, 2010): ONE STEP UP THE LIMIT OF POSSIBILITIES.

a- A federal health insurance at last

The name given to the health care bill passed by Congress on March 21st, 2010 is the *Patient Protection and Affordable Care Act* (PPACA). Informally referred to as "Obamacare" after the name of President Barack Obama its main initiator, this law is, together with the Health Care and Education Reconciliation Act, considered as "the most significant regulatory overhaul of the U.S. health care system since the passage of Medicare and Medicaid"[x]. At the moment President Obama decided to use the reform of the health system as one of his principle electoral projects, the issue of health was considered as more than serious among worrying problems in the U.S. during the past 226-year search for a better life in America, to paraphrase one statement of President Lyndon B. Johnson during the launching of the *War on Poverty* in 1965[xi]. The address President Obama made to welcome the passage of his proposal on that 21st of March, 2010 obviously said much about the seriousness of the question of health in the United States. Pundits, he said, report it was no longer possible to continue that way. Alarming reports from experts, indeed, ceaselessly appear from everywhere in the world. According to 2009 data from the World Health Organization (WHO), the United States devote more than 16 percent of their Gross Domestic Product (GDP), and about $ 7,400 per habitant to health expenses, which is considerable enough compared to other developed countries like France where such expenses amount only a little more than 11 percent of the G. D .P. In spite of this rise in health expenses, the sanitary situation seems lukewarm. According to the same 2009 WHO records, the United States come 37th in the ranking of the countries that offer the best medical services. And an estimated 36 million Americans are reported to have no health insurance[xii].

These different records show how precarious the situation is at the level of social welfare in the United States which is reputed as the champion of the developed nations. And yet, until the passage of the Patient Protection and Affordable Care Act, on March 2010, not any effective nationwide health policy has ever been successfully implemented[xiii]. Hence, in pushing his reform project to the American legislator, President Obama wanted to cope with serious shortcomings in the field of the health care. The main objective of the voted legislation is to create a nationwide insurance system that is supposed to extend insurance coverage to more than 30 million Americans who are reported to have no health insurance. To achieve this goal, specific provisions –composed of nine (9) titles– have been put into place with different terms of effectiveness (starting from the day of enactment to the year 2020). For the purpose of simplicity, we shall describe some of the most important ones. First insurance companies are required, according to the G*uaranteed issue*—also known as *employer mandate*—to offer the same premium to all applicants of the same age and geographical location without regard to gender or most pre-existing conditions (excluding tabacco use)[xiv]. In return, all uninsured individual, according to the term of *individual mandate*, is required to purchase and comply with an approved private insurance policy or pay a penalty. Other important requirement and not the least, is the *shared responsibility*, which incites firms employing 50 or more people but not offering health insurance to pay for such insurance coverage thanks to tax credits grants. These provisions as well as others like the *expansion of Medicaid eligibility*, and the *Health insurance exchanges* are as many requirements that have been designed with the aim of decreasing the number of uninsured Americans and reducing the overall costs of health care. But this official discourse is ceaselessly denounced by opponents of the legislation notably members of the Republican party who affirm on the contrary that the reform will inevitably increase federal deficit. In a book entitled Why Obamacare is Wrong for America (2011), co-authored by Grace-Marie Turner; James C. Capretta; Thomas P. Miller and Robert E. Mofft, the discourse is almost defiant to Obamacare. As Grace Turner and al. write, "Obamacare is looming disaster for patients, for our economy and for the future of health care in America"[xv]. And in spite of the assurances given by the presidential team concerning provisions for funding the reform and those designed to avoid deficit, opponents remain skeptical about the legislation and promise to repeal it as soon as power turns to Republicans.

b- A crippled health system?

The Patient Protection and Affordable Care Act is described by all as the most significant regulatory overhaul of the U.S. health care system since the passage of Medicare and Medicaid in 1965, which means, normally, that in terms of coverage the new legislation provides far larger possibilities than the legislations passed before. Is this really true? If this is the case, is the type of coverage with regard to the responsibility shared by the beneficiaries in accordance with the one that was originally proposed by President Obama? Eventually how can this legislation be a model to emulate as element of policy making for developing countries like Côte d'Ivoire where there is no public health coverage? These are the questions which are going to guide our analysis in the last part of this work.

To consider the Obamacare as the most significant regulatory overhaul of the U.S. healthcare system is to assume that it offers larger possibilities. In terms of efficiency it is certainly too pretentious to make any appreciation given the earliness of its enactment. But in terms of coverage,

one may be optimistic. Indeed, except for the Medicare and Medicaid, which were the most recent nationwide social reform of the sort, estimates from public and private agencies say for the first time that the new law will guarantee health coverage to more than 32 million Americans who didn't have insurance coverage or couldn't afford it in the past. This, in absolute, seems to be efficient because the number of potential beneficiaries persons gives to the legislation a more national dimension than what existed before. Unfortunately some of its provisions, specifically those which went through litigation, limit its impact in a way that a considerable number of American people still remain uncovered. Indeed, shortly after the passage of the law on March 21, 2010, opponents turned to the Supreme Court to challenge its constitutionality. The Court upheld the individual mandate, but restricted one major portion of the law: the expansion of Medicaid. The ruling gives States some flexibility not to expand their Medicaid programs without paying penalties. This flexibility added to other characteristics of the legislation, like the fact that it relies on *private*-insurance instead of *public*, leaves an estimated 5% Americans (that's 23 million of them) still uninsured. This fact, fundamentally changes the nature and definitely the quality of President Obama's proposal. Moreover, given the high uncertainty concerning projections issued by the Congressional Budget Office (cut in the government's budget deficit, benefits from tax increase, etc.), and given the fact that not all aspects of the legislation are fully implemented (for example, the number of new agencies, boards, commissions and government offices necessary to handle the new legislation nationwide is likely to outnumber the 124 initially announced), projections are likely to overlap initial estimates. In these conditions is it not wiser to be prudent rather than too much optimistic? One cannot linger much longer in the controversy; what is sure, the reform is underway and whether it goes well or not, it sure is going to make a significant change in the way the American sees the health system of his country. Numerous other countries are observing what is going on in America from a distance. A lot of African countries are among these, and are seemingly asking when their turn comes to achieve this stage of social welfare. In Côte d'Ivoire, as in most African societies, no such a system exists, and the health situation is more than problematic if one reports to statistics provided by the World Health Organization for the decades 1990-2010: 400 women death in childbirth out of 100 thousand; more than 2000 HIV prevalence out of 100 thousand and hardly 45% of them have access to medical treatment; and high rate of TB infection (more than 139 out 100 thousand), etc. It is clear that without a nationwide mobilization involving authorities into a determined health politics oriented toward universal coverage like America's PPACA, future perspectives are likely to be lukewarm.

Conclusion

The Patient Protection and Affordable Care Act or Obamacare as 2008 presidential election candidate Mitt Romney coined the new legislation on the U.S. health care is, undoubtedly, an important achievement in the history of U.S. legislation. Not simply because it comes as a fulfillment of a political promise but significantly because as a legislation that institutes the presidential project (for health care) into law, it appears like an achievement of the *ultimate component of the US welfare puzzle*. It is the achievement of the component that missed to put the U.S. welfare legislation –which brought the Social Security Act of 1935— if not to European standard, at least to World Health Organization's norms. It is the norm that guaranties the citizen of every country health coverage without risking financial ruin[xvi]. Unsurprisingly many of the opponents to the law regard it

as a bad legislation for America because as Grace and Al. write, Obamacare "is leaving a comet tail of broken promises as it steamrolls its way through our economy and into our lives". (p.46) Grace-Marie Turner's statement undoubtedly echoes part or the major American cultural, economic or ideological views that have justified Americans' historical hostility to social reforms, and particularly to the health issue which obviously points to what is essential in the American's life: individual liberty, liberal-oriented economy, etc. Parts of the legislation have been in application for a few years now and some of the revisions, notably the recent decision by the department of treasury to postpone to one year the penalty to companies for non compliance with the "employer mandate", illustrate the complexity in dealing with reforms in a highly sophisticated, market-oriented American society. For us, whether or not PPACA is good for America, it remains a living evidence of Americans' capacity to push forth the limits of possibilities for them, and thus strengthens the promises of better life.

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http://housedocs.house.gov/energycommerce/ppacacon.pdffile

[i] - The term "Obamacare" was originally coined by opponents, notably Mitt Romney in 2007, as a pejorative term. However by mid-2012 it was an accepted term on all sides. The use of the term in a positive sense was suggested by Democrats. President Obama himself didn't object to the term Obamacare. Because of the number of "Obamacare" search engine queries, the Department of Health and Human Services purchased Google advertisements, triggered by the term, to direct people to the official HHS site. In March 2012, the Obama reelection campaign embraced the term "Obamacare", urging Obama's supporters to post Twitter messages that begin, "I like #Obamacare because..."

[ii] - The question related to the reform of the US health system was at stake in the 2008 presidential campaign between Democrat Barack Obama and Republican Mc Cain, and it came back again in 2012 when Obama was competing for a second term with Republican Mitt Rumney.

[iii] - A. Briggs, "The Welfare State in Historical Perspective" in *European Journal of Sociology*, 2, 1961 p.228.

[iv] - Harold Wilensky, Charles Lebeaux, *Industrial Society and Social Welfare*, New York, Free Press, 1965, quoted by Eveline Thévenard, *Etat et protection sociale aux Etats-Unis*, Paris, Ellipses, 2002 p.16.
[v] - Quoted by P. Flora, A. Heidenheimer, *The Development of Welfare States in Europe and America*, (1998) New Brunswick, Transaction Publishers, 2009, P.29.
[vi] - Costa Esping-Anderson, *The Three Worlds of Welfare Capitalism*, Cambridge UK Polity Press, 1990, p.8.
[vii] - R. Hofstadter, *The American Political Tradition*, New York, Vintage Books, 1989, xxxvii quoted by Eveline Thévenard, Op. cit., p.35
[viii] - For further reading, see Eveline Thévenard, Ibid., pp.67-69; James A. Geschwender, *Class, Race, and Worker insurgency: The League of Revolutionary Black Workers*, Cambridge Univ. Press, USA, 1977, pp.18-30.
[ix] - For further reading on the Medicare and Medicaid programs, see Sar A. Levitan, *Programs in Aid of the Poor: Policy Studies in Employment and Welfare, No 1*, The John Hopkins Univ. Press, Baltimore, 1976 p.130.
[x] - http://housedocs.house.gov/energycommerce/ppacacon.pdffile
[xi] - During his address in Congress in early 1964 when he called for a national war on poverty, President Lyndon B. Johnson referred to his project as a "milestone in our 180-year search for a better life for our people". By the time of the passage of the Health Care Reform in 2010, 46 years have gone by since 1964. This makes the total years in this search to 226. For more details on President Johnson's discourse, see Eveline Thévenard, Ibid., p.123.
[xii] - The data is given by the U.S. Census Bureau in its report of September 2009. See "Obama Urges Congress to Pass Health Care Reform".htm, September, 10, 2009. in http://america.gov/ (October, 5, 2009).
[xiii] - The Medicare and Medicaid were effective because they covered only partial components (the old-age and poor persons) of the population.
[xiv] - This requirement which was initially subject to penalty if not respected by the year 2014, has been modified by presidential decision taken on July 3rd2013. According to the announcement made by the Treasure Department, the deadline for compliance to the employer mandate is postponed to 2015. For more detailed resource, see Kelly Kennedy, "Obamacare fines delayed for employers" in USA Today, July 3-4, 2013 p 2A; Russ Britt, "Administration says it will delay Obamacare penalties for large firms" in http://blogs.marketwatch.com/health-exchange/2013/07/02/administration-says-it-will-delay-obamacare-penalties-for-large-firms/
[xv]- GRACE-Marie Turner & al. *Why Obamacare is Wrong for America*, Broad Side (Harper Collins Pub.), New York, 2011 p.17
[xvi] - as reported in WHO's record referenced: 9789242564440_fre OMS.pdf Adobe Reader p.40