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SOCIAL CONTRACT THEORY AND THE PUBLIC'S HEALTH: A VITAL CHALLENGE
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“A government of the people, by the people, for the people shall not perish from the earth.” (Abraham Lincoln, Gettysburg Address 1863, Bliss Copy)

INTRODUCTION

Social contract theory describes trade-offs people face between freely pursuing their own self-interests and becoming members of a society (Hobbes, 1651). Granting authority to a civil society through its government should provide for systematic and consistent enforcement of societal norms, which in turn, should provide benefits to individuals. As such, individual members of society can experience greater cooperation with others in that society and protection from random acts of individuals. At the same time, citizens forfeit some of their own unregulated freedoms as they grant legitimacy to the socially constructed entities designed to protect them (Allen, 1999). In the United States, social contract theory has been used to justify programs to protect and advance the health, safety, and welfare of its citizens (*Barnes v. Glen Theatre*, 501 US 560, 1991, Legarre 2007). For instance, limits on smoking among individuals were developed to protect other members of society from health related risks of second-hand smoke. Individuals socially construct the entities that create these rules, and then imbue them

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with the power to legitimately enforce the rules. The Declaration of Independence is one example, which promised its citizens “life, liberty and the pursuit of happiness” (Declaration of Independence; Anastaplo 1991, Calabrisi 2015). This edict serves as the cornerstone of the American public health system.

The development of a society can also accentuate inequality among its members (Rousseau, 1762). For instance, individuals who were once freely independent are now compared against other societal members. One potential role of government, then, could be to reduce inequity among the population, and to protect those who are less advantaged. In the United States, the government has become responsible for developing a vast and complex regulatory system to meet, among other things, basic human needs related to food, water, shelter, and heat. Various governmental laws and regulations have established institutions in which to house or assist ill, disabled, and dying populations; developed vaccines and other medicines to prevent the spread of communicable disease; placed restrictions on dangerous and risky behavior; dedicated significant and public resources to research; and develop interventions for mitigating chronic diseases. Federal, state and local governments, as the conduits for society, have enacted public health laws and regulations implemented through public health departments, public hospitals and clinics, and other institutions (Hodge, pg. 6, Gostin 2008).

Most recently, social contract theory has been invoked to justify a social commitment to the provision of individualized health care services. Under this social contract, citizens give up their ability to opt-out of insurance coverage, in exchange for improved access to care. Healthcare costs are distributed across the population, so that individuals cannot be denied service when their healthcare needs become very costly, as well as to provide expanded health insurance coverage to previously uninsured individuals. (Patient Protection and Affordable Care

Act, P.L. 111-148 (2010)). In addition, governmental initiatives have served to develop and support the healthcare workforce, training a range of healthcare professionals including physicians, nurses, physician assistants, medical technicians, and other health care providers, as well as more contemporary jobs such as community health workers and patient navigators.

These occupations are integral to the government's objective to protect the health and safety of a sizable and growing aging population (Kumar 2013, O'Byrne 2009). In fact, according to the United States Department of Labor, Bureau of Labor Statistics, occupations and industries related to healthcare are projected to add the most new jobs of any sector between 2012 and 2022, totaling 5 million of the 15.6 million total new jobs (BLS 2013).

Finally, it is worth noting that public and private workplaces are increasingly being implicated as key players in civil society's protection of its individuals. About half of Americans (53.9%) are covered by employer-sponsored health insurance (Smith & Medalia, 2014; Janicki, 2013). And, employer contributions seem to have an impact on employee behaviors, influencing the degree to which sick employees continue to work (even when sick or injured) to maintain their employer sponsored health insurance coverage (Bradley, Neumark, & Barkowski, 2013). This alone raises interesting issues involving social contract theory, since these organizations are not necessarily legitimated by society to provide for the well-being of its citizens. Also confusing is the role of these entities compared to citizens. Private corporations now have the same rights as individual citizens, despite the fact that they typically control far more resources. Yet, employees spend a large portion of their time in the workplace, making it an intriguing partner or context for addressing the health needs of the population. For instance, the workplace could be a site for implementing governmental interventions designed to enhance worker

wellness. Employers could contribute to the social contract by investing in training around healthy eating or designing the job to enhance opportunities for exercise.

The role of the social contract among social entities, like employers and individuals, for improving society's health and wellness is even more challenging in the healthcare industry, where organizations are responsible for protecting the wellness of citizens in their communities, as well as of their employees. Their workers (e.g., nurses, community health workers, allied professionals) provide health care to the larger population (BLS 2013) but the quality of care they are able to provide is dependent on their own well-being. This juxtaposition of the role of individuals in the workplace versus their role as caregivers in society sets up a complex tension, exacerbated by variables such as income and geography. Healthcare employers are challenged by their conflicting responsibilities between providing high quality, but not too costly care to the community, and providing living wages and manageable work arrangements for their employees. As a result, the private and public workplace is an integral and important component of the larger civil society influencing health both for its employees and the community at large.

This paper will provide a brief discussion of social contract theory and outline the state of public health and public health care within that framework. Next, it will describe how the workplace in general and the healthcare workplace in particular serve as societal drivers for the provision of health and health care. Finally, it will apply social contract theories to societal expectations related to the police power, and give some innovative examples of how the government can better meet its obligations under its public health-related social contract.

SOCIAL CONTRACT THEORY

Traditional and contemporary social contract theories provide a lens by which to evaluate how our society meets the basic needs of its people. The bedrock concept of the “common good” and civil society’s obligations to protect it has been legitimized through the philosophical works of Thomas Hobbes, John Locke, Jean-Jacques Rousseau, and John Rawls, among others. Under social contract theory, individuals give up personal freedoms to grant social entities, including governments, the authority to provide for a common good. This could include opportunities for better coordination, cooperation, or efficiency among citizens, by protecting against arbitrary acts from random, unconnected individuals; or opportunities to enhance equity among citizens and reduce asymmetries, by emphasizing social welfare and placing constraints on powerful leaders (Rousseau, 1762).

Contemporary social contract theory scaffolds traditional theory by parsing out motives and objectives of individuals *vis a vis* governments. Thus, “subjectivists” look to each person’s individual interests as a justification for political action (Gauthier 1986, Hill 1995). For instance, Gauthier uses the example of the two farmers whose fields will be ready for harvesting at different times. According to modern interpretations of social contract theory, the second farmer may be hesitant to help the first farmer harvest her crop, out of concern that the first farmer will not reciprocate this action when the second farmer is ready to harvest at a later point in time. The first farmer would be in an advantageous position, and would be personally better off, at that moment, not helping the other farmer to harvest his crop, thus keeping supply lower (Uzan-Milofsky 2009). Comparably, even though limiting hazardous plant emissions might be beneficial for society, it is costly for individual organizations to invest resources to control emissions. For this reason, governments are granted power by their citizens to regulate actions that promote the well-being of society as a whole, while possibly inconveniencing certain

individuals. So, the government may incentivize farmers to jointly increase productivity, or limit or control hazardous plant emissions. Two other modern social contract theories examine how citizens consider the needs of others. First, Rawlsian theory looks to the common, shared interests of individuals to justify political action (Rawls 1971, Hill 1995). Here, it is the joint interests of citizens in the larger society that ignite action. For instance, the citizens' need for healthcare access, and healthcare entities' increasing costs, drove the government's healthcare intervention. Second, another theory presents the idea that individuals in society might willingly give up their own benefits for the good of others (Nagel 1970, Scanlon 1981, Hill 1995). For example, some individuals would pay income taxes to fund entitlement programs that make others better off. These modern theorists seem to define the exercise of the authority based on a collective of individuals in a preexisting and changing environment. (Verschoor 2015).

Social contract theory does not itself represent a formal contract among a society and its citizens, nor does it formally grant power to a governmental entity. Instead, it is a socially constructed understanding between the citizens, who willingly forego certain rights in order to reap the benefits of a civil society, and that society. However, in regulating and enforcing the informal contract between a group of citizens and their society, governments do tend to enact laws and develop contracts to formalize the rights and responsibilities of members. In this section, we highlight some of the laws and contracts that have been developed to reinforce the norms and expectations underlying an efficient society.

The Legal Context underlying the Social Contract

In the eyes of the law, “a contract is a promise or a set of promises for the breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a

duty.” (*Restatement of Contracts*, sec. 1). And, “the formation of a contract requires a bargain in which there is a manifestation of mutual assent to the exchange and a consideration” (*Restatement of Contracts*, Section 17). The social contract is not legally binding, instead it represents the perceptions of its citizens. However, without some formal understanding, it can be difficult for citizens to fully understand their rights and responsibilities and those of society, including the responsibility of the government to protect its people, and the people’s responsibility to comply with governmental rules for implementing such protections. Accordingly, “a major part of the agreement is that citizens give up their position as the ultimate law, reposing that power in a representative government that is itself subject to law.” (Mitchell 2006).

Another way that governments can enforce the rights and responsibilities of their citizens is through the concept of the police power. Traditionally, the police power has been used to justify the government’s legislative authority to “promote public health, public safety, and public morality”. (Legarre pg 787, citing *Mugler v. Kansas*, 123 US 623, 661 (1887)). Notably, the police powers are conferred through the United States Constitution and its sister state constitutions, which set forth the rules by which government governs. If the government acts beyond its constitutional limits of protecting the public health, safety and welfare, the government’s actions may be found unconstitutional and, therefore, unenforceable (Legarre, pg. 788). Thus, for instance, when the government goes beyond its authority to protect its citizens by unlawful detainment (Urbanoya 1988; *Mapp v. Ohio*, 367 U.S. 643, 660 (1961)); “stop and frisk” (Clark 2015; *Floyd v. City of New York*, 283 F.R.D. 153, 159, 178 (S.D.N.Y. 2012); repression of speech (Jackson 2015; *Chaplinsky v. New Hampshire*, 315 U.S. 568 (1942).); taking of property (Meltz 2007; *United States v. Carmack*, 329 U.S. 230, 241-42 (1946)), or

denial of due process (Cella, 2015, *Matthews v. Eldridge*, 424 U.S. 319, (1976)), the citizens can formally confront the violation of their social contract.

Throughout our constitutional history, the extent of governmental policy has changes depending on the given political and social climate and context (Molander 1994). Thus, as it relates to the First Amendment, for instance, the Court's decisions have consistently reflected "Lockean liberal individualism" during peaceful times, and "Machiavellian civic republicanism" during times of conflict (Molander 1994, pg. 598). This changing environment is often analogized to a swinging pendulum (Scott 2009, Rahdert 1993), swinging between individual rights and government intervention. For instance, while the government, through its police power may require a child to provide proof of immunizations before attending school, an exception is carved out in some jurisdictions (including Illinois, see, 105 ILCS 5/27-8.1(8)) for those that have religious or moral objection to such immunizations. The CDC actually has a website dedicated to parents who choose not to vaccinate their children (<http://www.cdc.gov/vaccines/hcp/patient-ed/conversations/downloads/not-vacc-risks-bw-office.pdf>).

Arguably, parents who choose not to vaccinate are potentially breaching the social contract, despite the existence of some formalized regulations policing these behaviors. Without widespread immunization, diseases that are virtually eradicated or at the least highly manageable, place people, particularly children, at risk. The dire nature of this conundrum is illustrated by the Vermont Commissioner of Public Health's plea for people to re-think the importance of vaccinations. Around the time of the recent Disneyland measles outbreak, the commissioner put out a call for people to vaccinate their children. In the document he implored:

“Given that most of the current patients [in the Disneyland outbreak] are unvaccinated the outbreak is a result of parents choosing not to vaccinate their children... There is no controversy. Giving vaccines, like the MMR vaccine that protects against measles, mumps and rubella, is the most important action parents can take to protect their children from illness or death... Given our society’s value of individual rights, it is important to understand that with those rights come responsibilities. Vaccinating our children is part of the social contract.”

http://healthvermont.gov/news/2015/021115_vaccines_work_chen_oped.aspx

Another example relates to the recent Ebola outbreak. During the crisis, the CDC issued health travel warnings, and the State Department required passengers traveling from virus-originating countries to enter the United States through one of five airports with “enhanced screening” (<http://travel.state.gov/content/passports/english/go/Ebola.html>). This unprecedented quarantine restriction demonstrates how quickly the pendulum can swing. Generally, in order for a quarantine to be valid, it must be a proportionate and appropriate response to the threat (Rothstein, pg. 254). It also must be designed to present the “least infringement” possible. For the public to respond in a positive manner, and to uphold its duty to comply with this part of the social contract, the governmental response must be appropriate (Rothstein, pg. 268). If not, the people could perceive the government to have breached the social contract.

Thus, social contract theory provides a framework for assessing the relationship between governmental policies and societal well-being, including the public health and health care needs of its people. The government exercises its duty to protect its people from health-related threats. At the same time, the government’s exercise of its authority must be reasonable and rational, and within the confines of constitutionality. Individuals must also act responsibly, both as discreet

members of the society, and within the context of the greater community. Ultimately, both parties to this “contract”—the government and the people—must act responsibly and with an eye towards their respective duties.

In addition to describing the responsibilities of individuals (at a micro level) and public health institutions (at a macro level) in a society, social contract theory has also been used to describe the social obligations of workplaces to their constituents, namely communities, individuals and employees. Workplaces derive value from investing in their communities. For instance, research on corporate social responsibility highlights how the provision of service and outreach can improve the workplace’s image among its diverse stakeholders.

THE PUBLIC HEALTH LANDSCAPE

Government has regulated factors influencing basic human survival for centuries. For instance, the discipline of public health is often said to have originated when John Snow, a well-respected epidemiologist linked a cholera outbreak in London to one single source of polluted water (Gostin 2008, pg. 19). And, since the inception of the U.S. government, the political and legal system has been fixated on the responsibility to protect citizens from health-related injury, the spread of disease, and death. For example, laws relating to quarantine, vaccine and controlling contagion go as far back as the original colonists (Hodge 1998, Rothstein, pg. 230).

The Centers for Disease Control and Prevention in “celebrating a century of success” described the “Ten great public health achievements in the United States, 1900-1999” as follows: vaccinations; safer workplaces; safer and healthier foods; motor vehicle safety; control of infectious diseases, decline on deaths from coronary heart disease and stroke; family planning; recognition of tobacco use as a health hazard; healthier mothers and babies; and fluoridation of

drinking water. <http://www.cdc.gov/about/history/tengpha.htm> . One wonders, then, why our society appears to be lagging in so many of these areas. If the social contract is designed to promote the greater good, why are our infant mortality rates, teen pregnancy rates, tobacco usage, accident rates, etc., still so high, particularly as compared to other Westernized countries? Our current infant mortality rate is around 6 per every thousand births, and the rate among some aspects of the country, especially rural areas with large minority populations, is even higher. In some cases, the rates in these areas more closely resemble rates in developing countries than in the US. Other Western countries are much lower.

www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm. Similarly, the teenage live birth rate is 26.5 per 1000 in the population, making it the highest among Westernized countries. www.cdc.gov/teenpregnancy/about/index.htm And, according to the CDC, 18 out of 100 (or 42 million) adults still smoke tobacco, accounting for 480,000 deaths per year. www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm. These summary data demonstrate that, at least in these three key indicator areas, our public health system does not appear to be meeting its obligations to protect its citizens or reduce inequity under the social contract.

Yet, our government couches the discussion with the assumption that progress has been made since “public health [in these areas] is credited with adding 25 years to the life expectancy of people living in the United States in [the 20th] Century” (CDC, 2013). While admirable and indeed a demonstration of great progress, unhealthy outcomes like infant mortality, teenage pregnancy and smoking are rampant, and in many sectors of our society, continuing to grow. More urgently, many of these factors are higher in disparate communities, making health disparities a high societal priority. The National Institutes of Minority Health and Health

Disparities, “envisions an America in which all populations will have an equal opportunity to live long, healthy and productive lives”. <http://www.nimhd.nih.gov/about/visionMission.html>

In 2010, the United States Department of Health Human Services announced its Healthy People 2020 Initiative, the goals of which are to: “attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve the health of all groups; create social and physical environments that promote good health for all; and, promote quality of life, healthy development, and healthy behaviors across all life stages” (www.healthypeople.gov). Embedded in the website are detailed data sets, which upon cursory exploration, once again seem to belie the underlying notion that our public health social contract is working. According to the Healthy People 2020 Leading Health Indicators Program Update in March 2014, 4 indicators have met or exceeded targets; 10 indicators are improving; 8 indicators show little change; and 3 indicators are getting worse (Healthy People 2020 2014). One interesting example that tells an important story is that, while adult cigarette smoking is decreasing (and, thus, categorized as “improving”), adolescent tobacco use is “getting worse”. (HP2020 2014). While progress in key public health-related areas gives rise to hope and optimism, “nudging” our government agencies and administrators and people to better recognize and appreciate the balance between the government’s promise and duty to protect, and the people’s promise and duty to make good choices is essential to a high-functioning society. (Thaler & Sunstein 2008, Sunstein 2010).

To expand on an issue discussed earlier, while vaccines are called out as one of the top public health priorities in Healthy People 2020, our immunization rates are still low, and there is a perception among a growing segment of the population to disregard the research and not immunize. The result? As previously discussed, an outbreak of measles which started at, of all

places, Disneyland. (New York Times, January 21, 2015). Again, where is the systemic breakdown? According to the World Health Organization, immunizations work—deterring up to 3 million deaths from diphtheria, tetanus, pertussis, and measles (WHO, Global Health Data, 2014). At the same time, many recommended vaccination rates do not meet the Healthy People 2020 goals (Bobo, 2014). Curiously, the CDC has a fact sheet on what would happen if we stopped vaccinations. <http://www.cdc.gov/vaccines/vac-gen/whatifstop.htm> . In this case, it appears our government is trying desperately to maintain vaccination rates. Yet, the public seems confused about its duty to immunize. Maybe it is time for our society to say “enough is enough” (Ropeck 2011).

In addition to these traditional public health indicators, our government has developed a multifaceted and broad-based approach to addressing environmental issues. In terms of the social contract and public trust, the United States Supreme Court has established a very low threshold for individuals or groups to have “standing” to challenge defendants in environmental cases. In order to file a lawsuit, the standing doctrine typically requires plaintiffs to have a personal interest and have suffered some direct injury. In environmental cases, however, individuals and groups have standing to challenge damage to the environment more generally. (Warshaw 2011, *Duke Power v. Caroline Environmental Study Group*, 438 U.S. 59 (1978)). Thus, under the social contract, individuals and groups can challenge private or governmental decisions that threaten human health and the environment. And, importantly, environmental laws “are intended for the protection of the environment, not for the protection of persons deemed responsible for the consequences of having polluted the environment.” (*North Shore Gas Co. v. EPA*, 930 F.2d 1239, 1243 (1991); Warshaw 2011, pg. 310).

The National Environmental Policy Act, enacted in 1969 created the roadmap for subsequent passage of the Clean Water Act, Clean Air Act, among others. (Ferester 1992, Langberg 2014). Throughout their history, these important laws have provided excellent examples of government regulation of private rights for the betterment of the public good. And, utilizing a system of formal governmental and informal self-controls has proven effective (Umemoto 2006, Bennett 1999). An example of how controversial these issues can become relates to water resource management. Our country's water resources are dwindling at alarming rates, and we continue to widely ignore human impact on climate change. (Parks, 2010), (Rykka, 2013). With regard to our water system, the scheme of laws, rules and regulations at the local, regional, state and federal levels regulating water quality, water resource management, storm water management, recreational use of waterways, riparian rights, among others has had a tremendous impact. (Clean Water Act, 33 U.S.C. §1251 et seq. (1972)). According to the United States Environmental Protection Agency, "The Clean Water Act (CWA) establishes the basic structure for regulating discharges of pollutants into the waters of the United States and regulating quality standards for surface waters." <http://www2.epa.gov/laws-regulations/summary-clean-water-act> . Because of achievements under the CWA, once "dead" waterways, have actually re-emerged as "fishable and swimmable". <http://www.pbs.org/now/science/cleanwater.html> (Abel 1997). The impact of the Clean Water Act serves as an example of how the social contract has met expectations. (Abel 1997, MacDonald 2003). Yet, at the same time, with regard to water resource management, this year for the first time, California has rationed its water, and other states may not be far behind. (Executive Order B-29-15, signed by Governor Brown, April 1, 2015),

http://www.nytimes.com/2015/04/02/us/california-imposes-first-ever-water-restrictions-to-deal-with-drought.html?_r=0 .

Similarly, with regard to climate change, great progress has been made through Kyoto and other treaties. However, our Union of Concerned Scientists and many others continue to raise the alarm of how quickly and dramatically our oceans are rising and our land mass is changing. According to the Union of Concerned Scientists, “global warming is already having significant and harmful effects on our communities, our health, and our climate. Sea level rise is accelerating. The number of large wildfires is growing. Dangerous heat waves are becoming more common. Extreme storm events are increasing in many areas. More severe droughts are occurring in others. We must take immediate action to address global warming or these consequences will continue to intensify, grow ever more costly, and increasingly affect the entire planet—including you, your community, and your family.”

http://www.ucsusa.org/global_warming#.VZrjETvbKAI .

At the same time, the “climate change deniers” continue to put out their rally cry that the science is nonsense. According to Greenpeace, the Koch Brothers have spent at least \$79,048,951 on groups denying climate change science since 1997.

<http://www.greenpeace.org/usa/en/campaigns/global-warming-and-energy/polluterwatch/koch-industries/> . Even high level policymakers are engaged in this trickery. A recent article in the Los Angeles Times called out chairman of the House Committee on Science, Space, and Technology, Rep. Lamar Smith (R-Texas) as one of the “most eminent and influential climate change deniers in Congress” <http://www.latimes.com/business/hiltzik/la-fi-mh-a-congressional-climate-change-deniers-20150506-column.html#page=1> . Arguably climate change “deniers”

breach the social contract by condemning overwhelming scientific evidence supporting the concept of humans impacting climate change.

With regard to the people's obligation towards climate change, Lacasse recently found that many Americans do not rate climate change as important compared to other political issues. (Lacasse 2015) Thus, "78% of Democrats compared with 53% of Republicans believe that climate change is occurring, and 72% of Democrats worry about climate change compared with only 38% of Republicans" (Lacasse, pg. 755-56.) This obvious disconnect between individuals and communities is a stark example of how perceptions impact the social contract. Why don't the majority of people believe our scientists? Clearly, our well-designed system of checks and balances does not appear to be working in the case of climate change, even as our government continues to negotiate laws, policies and treaties on climate change.

<http://www.epa.gov/climatechange/>

Without question, the public health challenges facing our government, and others across the globe, are tremendous. While we continue to face historical issues like deterring the spread of contagious diseases, the complexity of our new global community requires us to act with great care as we engage in our contracted-for obligations. In addition, more recent developments relating to the environment and climate change provide us even greater opportunities to negotiate the terms of a new social contract.

THE HEALTHCARE LANDSCAPE

The Patient Protection and Affordable Care Act (P.L. 11-148 (2010)) created reforms on how individuals obtain healthcare, and how employers provide healthcare. These significant changes, while giving rise to considerable political unrest, have provided health care to an

additional 16 Million Americans. <https://www.whitehouse.gov/healthreform/blog> . This is only the most recent attempt at developing government policy to enforce citizens' rights to health and well-being as part of the social contract. In 1944, President Franklin Delano Roosevelt enumerated a "second bill of rights" which included "a right to adequate medical care and the opportunity to achieve and enjoy good health". (Smith and Gallena 2014). Through the earlier passage of the Social Security Act in 1935, Roosevelt created a foundation for the establishment of government-provided health care. And, in 1965, the Social Security Act Amendments of 1965 established Medicare—"a hospital insurance program for the aged". From Roosevelt's "New Deal" to Lyndon Johnson's "Great Society", a clear path of government-supported health care was established. The progeny of these efforts was the recently enacted Patient Protection and Affordable Care Act.

The Patient Protection and Affordable Care Act (P.L 111-148 (2010) is a monumental piece of legislation. Without a doubt, it has modified the social contract between the government and the people as it relates to the provision of health care. According to the United States Supreme Court in its recent decision, *King v. Burrell* (___ U.S. ___, June 25, 2015), "the Patient Protection and Affordable Care Act grew out of a long history of failed health insurance reform". (*King*, pg 2). In describing the Act, the Court noted that the Act adopted four key reforms from previous state-wide efforts: 1) guaranteeing coverage and community ratings; 2) requiring individuals to maintain insurance or be penalized; 3) making health insurance more affordable; and 4) creating insurance exchanges (*King*, slip op., pg. 4-5). In upholding portions of the Act in their controversial decision, the Court stated, "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter." (*King*, Slip Op. pg. 21).

The Impact Of Health Care Organizations

Through this monumental legislative change, the Affordable Care Act highlights society's responsibility to address the needs of an aging and unhealthy population, and to satisfy its promise to provide health care to its citizens. While monumental, the Act has also had incremental effects on discreet stakeholders. For instance, one interesting consequence of the Affordable Care Act relates to how it has changed the way healthcare organizations operate. In the healthcare domain, healthcare organizations are key players in civil society's protection of public health. Healthcare organizations treat the health needs of the communities in which they operate, and are reimbursed for the care their employees provide. As the reimbursement becomes value-based, organizations are having to change their processes to better track patients in the system to help them manage their health.

Health care organizations are also encouraged to increase the health services and outreach they provide to the community, to manage chronic diseases, and to reduce readmissions into the hospital. In fact, there has been movement away from reimbursements around the treatment of disease and toward the promotion of wellness. Employees in a variety of health care organizations (e.g., hospitals, nursing homes, federally qualified health centers (FQHCs), home health agencies) provide care to members of the community as part of their jobs. Sometimes this entails direct health care within the organization, but it can also include outreach and education to members of the community. Increasingly, these employees, as agents of the organization, deliver health care in the community—e.g., in community clinics or patients' homes—as opposed to in hospitals or institutional settings. As a result, healthcare systems have been developing new organizational forms and partnerships to address their social obligations for the public's health.

At the same time, health care organizations consider two primary trade-offs when fulfilling the social contract in their communities. First, healthcare entities deciding how best to deliver health care must consider the trade-off between their obligations to provide effective health care (to the community) and to allocate their limited resources judiciously (and sustain the organization). Second, they must trade-off between the needs of their patients and those of their employees.

Trade-off between the needs of the community and organizational considerations. For many healthcare organizations, there is a constant tension between providing high quality care to as many people as possible and providing care that is as inexpensive and as efficient as possible. Health care spending in the United States is still high compared to other developed nations, but overall spending has slowed over the last five years. The old adage “no margin, no mission” puts pressure on hospital administrators to ensure that their organizations reduce costs and maintain enough resources to continue to provide services into the future. At the same time, they must consider their responsibility to provide care to all citizens in their communities, including those who are uninsured. To facilitate this responsibility, federal and state governments have traditionally provided reimbursements to hospitals that provide uncompensated care, called charity care. However, reimbursements for charity care are not always enough to cover the costs of providing services.

The Affordable Care Act has expanded insurance coverage to millions of Americans, increasing the demand for healthcare services, and also improving reimbursements for providing services. The ACA includes incentives for healthcare entities that coordinate care, promote patient health, and can minimize readmission rates from inadequate or improper care. The focus on health care, as opposed to the treatment of disease, has changed organizational structures and

processes to better manage patient needs. It has also affected the types of staff that healthcare systems employ. For instance, to manage their community's health, many organizations have begun to hire front line staff, including care coordinators, navigators, home health aides or even community health workers (BLS, 2015). These employees work directly with a broad range of patients to help them track and manage the daily aspects of their care, including scheduling appointments and tracking medication. In long-term care facilities, front-line care workers additionally assist their clients with activities of daily living, including healthy tasks that the clients cannot complete on their own.

Trade-off between employees and patients. In this way, many healthcare organizations fulfill their social contract to provide healthcare services to a growing insured population by expanding their front-line workforce. However, this raises issues about the trade-off that occurs within the organization between the needs of the employees and the needs of the patients. The ACA emphasizes high quality patient care, but the front-line employees providing the bulk of the direct care to patients receive low wages and few direct incentives for doing so. In fact, the feminized nature of the work and the emphasis on direct care may be associated with the lower wages paid to these employees (England, Budig, & Folbre, 2002). The work that they do is physically and emotionally demanding, and low wages and few resources (e.g., time; income) make it difficult for these employees to cope with the demands. Instead, front-line employees experience conflicts between work and family demands. For instance, low wages can force employees to trade-off between healthy behaviors, which may be more costly, and unhealthy ones, which fit into their schedules or budgets. Instead of cooking a healthy meal at home, busy schedules could lead employees to become more dependent on fast food, which tends to have fewer nutritional benefits. While employees are advised to stay home or rest when they are sick

or injured, many employees may continue to work in order to maintain their hours or health insurance benefits (Bradley, et al., 2013).

Similarly, while some healthcare organizations may facilitate health and wellness training in other organizations, their own employees may not have access to such training programs. In summary, healthcare organizations also experience tension between the health needs of the patients in their communities and their social obligation to their employees' well-being. The passage of the Affordable Care Act has confounded this tension, and redefined the terms of the social healthcare contract.

The focus on employee health serves a practical purpose to society beyond simply fulfilling the social contract. First, replacing employees in health care is a costly process, since open positions require new applicants to be recruited, selected, and socialized into the organization. Turnover and absence reduce the consistency of care available to patients and can increase opportunities for accidents and/or injury. In health care especially, patients and employees develop relationships that can improve the delivery of care, as the employees learn about the patients and understand how best to treat the patients' concerns and illnesses. The quality of the human resources practices for employees in the organization can affect the quality of care available to members of the community (Eaton, 2000). Since the employees are responsible for providing direct care to patients, factors that inhibit the employees from doing a good job can result in poorer care for patients. Front-line employees who do not receive basic support from their organizations, including wages and benefits, must find other ways of supporting themselves. For instance, having to work multiple jobs or shifts to earn more money leaves less time to spend on family or community caregiving responsibilities, including looking after children or volunteering in the community (Taylor, Repetti, & Seeman, 1997). These extra

responsibilities can also erode their ability to provide high quality care to patients in their health care organizations. For instance, Rogers, Hwang, Scott, Aiken, and Dinges (2004) found that nurses who worked shifts longer than twelve hours, worked overtime, or worked more than 40 hours per week had a significantly higher risk of making an error. Working multiple jobs can lead to fatigue or exhaustion at work, increasing the risk of injury.

The Health Social Contract And The Workplace

Generally, workplaces are expanding their roles as potential targets for healthy interventions for employees. They can provide positive benefits to employees (e.g., money, pride, positive self-image). Since employees are located in their workplaces, and often spend a large portion of their time there, the workplace could be an ideal avenue for intervening to improve their health and well-being. In many cases, it involves employee benefits around health. For instance, employers could give their front-line workers additional resources to improve their health (e.g., time to use organizational fitness amenities, incentives for reducing harmful behaviors, or information to help employees to make healthier decisions).

A separate line of research has examined the employer's responsibility for ensuring a safe environment for employees at the workplace. Safety climate is a construct that measures employee perceptions of safety in their organizations (Zohar, 1980). It has been associated with safer behaviors in the workplace (Zohar & Luria, 2005). In this case, organizations could work to increase the importance of safety in their organizations. The primary drivers of safety climate tend to be perceptions that the supervisors value safety and that safety is important to the employees' jobs (Seo, Torabi, Blair, & Ellis, 2004). Finally, organizations could invest in

better/more training for their employees around safety and health. Organizations could become important sites for developing, testing, and implementing interventions for increasing health promotion activities and improving safety in the workplace. The result could include partnerships between private and public workplaces as a part of the larger civil society influencing health both for its employees and the community at large.

We do not suggest that workplaces are necessarily motivated to improve or responsible for addressing the health needs of citizens in society. In fact, many of the organizational improvements in safety and work design came about through the work of unions and other social groups. However, the point is that one area for advancing a focus on health and well-being as part of the social contract might be a partnership with workplaces or enhanced regulations for ensuring that employers are protecting their workers' health.

THE FUTURE OF THE HEALTH AND HEALTH CARE SOCIAL CONTRACT

Understanding social contract theory is critical as we consider how civil society should protect the public's health, both individually and as a population. Further, a systems theory approach can be used to integrate the broader theoretical underpinnings as applied to the health care system, health behavior, as well as communicable and chronic disease prevention and intervention. (Varghese 2012). Understanding how individuals and organizations are interconnected becomes a key evaluative inquiry. (Varghese, pg. 306). Using contemporary models such as "governability" can promote efficient and effective utilization of scarce government resources (Kooiman 2003). Thus, evaluating process and outcomes of health interventions can provide additional measurements to determine how our governmental systems are meeting its benefit of the bargain under the social contract.

Further, when exploring the application of the social contract to the public's health and health care, it is appropriate to focus on public values. These values "help galvanize citizen allegiance, especially in a democracy". (Beck Jorgensen 2006, Hefner 1998, Bozeman, pg 62). Public health is considered a particular policy domain (Feeney & Bozeman, Bozeman pg 63). Clearly, the government's protection of the public health and the provision of health care are a long-term public value. The concept that to government will protect its people is at the core of social contract theory and is static in nature. (Stiglitz 2012, Bozeman pg 65).

At the same time, it is worth considering the role of various entities in contributing to the health and well-being of society. Individuals give up unlimited freedoms to maintain a safe, ordered society. In return, they empower government to provide for the health, safety, and well-being of societal members. In a similar way, employers give up unlimited profit to obtain protection and support from the government to advance their missions. Healthcare organizations, in particular, benefit from federal reimbursements designed to enable them to provide care to all citizens, including those who are uninsured. At the same time, they have a responsibility to their communities to provide that care, and also to provide a safe workplace for their employees.

Looking forward, the ACA raises important questions about the role of employers in contributing to the social contract around advancing society's health and wellness. Are employers potential partners for increasing the health and wellness of employed populations? The majority of Americans are insured through their employers. Providing health and wellness programs to employees in organizations makes it easier to recruit and target individuals for wellness programs. However, do organizational leaders perceive that they are partners in

upholding the social contract, and improving the health and wellness of their employees? Or, are they incentivized by other considerations?

What is the future of social contract theory as it relates to public health and health care, and what policy recommendations may serve as a catalyst for conversation? What are the implications of the changing healthcare and public health environment based on monumental policy changes such as the Affordable Care Act? Is there a new expectation of health care as a right to citizens rather than a privilege? Is there a higher burden for providing services--healthcare systems, healthcare professionals, and/or employers who pay higher rates for their employees' insurance? What are the impacts of the changing environment on individual responsibility? These questions highlight the significance of using social contract theory as a lens to understanding the role of civil society to protect the health and safety of its population.

CONCLUSION

Protecting the public's health and providing healthcare to the public are two key functions of our American Political System. Historically, our governmental structures at the local, state and federal levels have developed an infrastructure to address the public health needs of our society. At the same time, over the past century, our government has been building the foundation of a complex health care system to provide necessary and sufficient healthcare services to its people. And, our private sector, through the work place, provides an extra layer of infrastructure through which to improve individual health and cover employee's health care needs. The obligations and duties of the government, its citizens, and the private sector can be analyzed using contract theory. Thus, all parties promise to perform certain actions by which to provide benefit to the other. Government promises to enact laws to protect the health, safety and

welfare of its people. The people promise to abide by the laws passed. And the private sector promises to act maternally and paternally to provide for its workers. As such, this complex system provides an excellent example of applied social contract theory. Whether traditional or contemporary, understanding how government interacts with its communities gives insight into how well our government is serving the health and healthcare needs of its citizens, and what people can do to be more healthy. As a society, we can all gain from the benefit of the bargain as it relates to the public's health and health care.

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