Health Care Reform — Why So Much Talk and So Little Action?

Victor R. Fuchs, Ph.D.

As promised during his campaign, and under pressure from many quarters, President-elect Barack Obama may seek badly needed changes in the way the United States finances and delivers health care. Responding to public interest and perceived need, several previous presidents have attempted to enact some kind of national health insurance: Harry Truman in the 1940s, Richard Nixon in the 1970s, and most recently Bill Clinton in the 1990s. These attempts went nowhere. In pursuing comprehensive health care reform, President-elect Obama should be aware of four major reasons why, in the past, we heard so much talk and saw so little action.

First, many organizations and individuals prefer the status quo. This category includes health insurance companies; manufacturers of drugs, medical devices, and medical equipment; companies that employ mostly young, healthy workers and therefore have lower health care costs than they would if required to help subsidize care for the poor and the sick; high-income employees, whose health insurance is heavily subsidized through a tax exemption for the portion of their compensation spent on health insurance; business leaders and others who are ideologically opposed to a larger role of government; highly paid physicians in some surgical and medical specialties; and workers who mistakenly believe that their employment-based insurance is a gift from their employer rather than an offset to their potential take-home pay. These individuals and organizations do not account for a majority of voters, but they probably have disproportionate influence on public policy, especially when their task is simply to block change.

Second, as Niccoló Machiavelli presciently wrote in 1513, "There is nothing more difficult to manage, more dubious to accomplish, nor more doubtful of success . . . than to initiate a new order of things. The reformer has enemies in all those who profit from the old order and only lukewarm defenders in all those who would profit from the new order." This keenly observed dynamic, known as the "Law of Reform," suggests that a determined and concentrated minority fighting to preserve the status quo has a considerable advantage over a more diffuse majority who favor reform but have varying degrees of willingness to fight for a promised but uncertain benefit.

Third, our country's political system renders Machiavelli's Law of Reform particularly relevant in the United States, where many potential "choke points" offer opportunities to stifle change. The problem starts in the primary elections in so-called safe congressional districts, where special-interest money can exert a great deal of influence because of low voter turnout. The fact that Congress has two houses increases the difficulty of passing complex legislation, especially when several committees may claim jurisdiction over portions of a bill. Also, a supermajority of 60% may be needed to force a vote in the filibuster-prone Senate.

Fourth, reformers have failed to unite behind a single approach. Disagreement among reformers has been a major obstacle to substantial reform since early in the last century. According to historian Daniel Hirshfield, "Some saw health insurance primarily as an educational and public health measure, while others argued that it was an economic device to precipitate a needed reorganization of medical practice. . . . Some saw it as a device to save money for all concerned, while others felt sure that it would increase expenditures significantly."[1] These differences in objectives persist to this day.

Currently, many health care reformers favor an approach based on comprehensive mandates and generous subsidies. This approach would leave in place employment-based insurance and income-tested insurance, such as Medicaid, attempting to shore up these systems rather than replace them with a more unified method of financing care. Other reformers favor "Medicare for all," an approach that is often referred to as "single payer." Still others want to combine the single-payer approach with choice and competition through a system of universal vouchers for enrollment in competing health plans that take responsibility for the care and costs of their enrollees. These approaches, and others that have been proposed, vary in their objectives and in the methods they would use to achieve those objectives. Differences among approaches are not easily reconciled, because they reflect differences in values and

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analyses. Even if a substantial majority of the public and legislators favors some kind of reform, we will continue to witness much talk and little action unless they can unite behind a single approach.

This type of review of the obstacles to health care reform is of more than theoretical or historical interest. It could help the Obama administration find a successful path to reform. Consider the groups that seem to prefer the status quo. They may not be as unified as they first appear. Some individuals and organizations might realize that they could benefit from changes in the health care system. For example, some of the large health care insurers or managers, such as Anthem, UnitedHealth, and Aetna, would flourish in a system where relatively few competing health plans are equipped to assume responsibility for large numbers of enrollees in return for risk-adjusted capitation payments. Reformers need to try to secure their support or, at a minimum, to blunt their opposition. Similarly, though some physicians would probably see their income fall under comprehensive reform, others might see an increase, and all would probably prefer a system in which no one is uninsured. Even in the pharmaceutical industry, where opposition to reform is traditionally strong, some firms are beginning to embrace a goal of high-value innovation; such companies would move to the head of the industry under a well-designed new system.

Under the best of circumstances, however, a major Obama reform initiative will still face strong defenders of the status quo. Machiavelli's Law of Reform highlights the importance of galvanizing those who favor reform into a more vigorous, aggressive source of political pressure. The success of Obama's campaign team in involving millions of supporters through the Internet points the way toward such an outcome. The U.S. political system will still have its numerous choke points, but skill and determination on the part of leaders in the executive and legislative branches may prevail, especially if high unemployment, a financial squeeze on Medicaid, an influenza pandemic, or some other crisis increases the political dangers for legislators who oppose reform.

One argument against comprehensive reform that is sure to surface is that it is not politically feasible. That may well be true, for the reasons mentioned above. But U.S. history is studded with major policy changes that were not politically feasible — until they were. Examples include the emancipation of slaves, the creation of a strong and independent central bank, the establishment of Social Security, the fluctuation of foreign exchange rates, and most recently, more than $1 trillion devoted to bailing out large financial institutions. Six months ago, a bailout of this nature and size was not even close to being politically feasible. Comprehensive health care reform must happen, if for no other reason than to avert a national fiscal crisis. The big questions are when it will happen and what form it will take.

In my judgment, it is far more important to get the right answer to the question of "what" than "when." It would be a shame to let short-term political feasibility dominate the discussion. Political leaders who aspire to greatness first decide what needs to be done and then set about making it politically feasible. If the current health care reform initiative is limited to questions of coverage, without serious attention to cost control and coordination of care, the "crisis" in health care will continue to plague us for years to come.

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1. Hirshfield DS. The lost reform: the campaign for compulsory health insurance in the United States from 1932-1943. Cambridge, MA: Harvard University Press, 1970.

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The Fast-Food Fund

Perri Klass, M.D.

At the end of our clinic meeting, one of the doctors announced that she was taking up a collection. Not the usual someone's-getting-married, someone's-having-a-baby, someone's-leaving collection; this one was for the family of a child with many serious medical problems, who had died in the hospital a day or two earlier. Most of the clinic's doctors and nurses had known the child and the family, always coming in with questions and concerns, with that long problem list, with that complicated and ever-changing set of medications. The collection was to help the family

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