



Health Care for All?

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In the summer of 1793, as Prussian and Hapsburg armies closed in on Paris, French leaders issued an unprecedented decree, ordering all unmarried men 18 to 25 years of age to take up arms,

married men to make arms, women to sew tents and uniforms, and old men to “excite the courage of the warriors” and “preach the hatred of kings.” France thereby transformed warfare from the business of professionals to the work of a whole nation.¹

Historian and legal scholar Philip Bobbitt suggests that we owe our national social-insurance systems to this reinvention of war.¹ In exchange for widespread sacrifice, citizens began looking to the state to secure their welfare. Over the next century and a half, advances in firepower and mobility made mass participation more vital — and wartime sacrifice more horrific. Bismarck gets

credit for forging a compact to ensure that citizens called on to risk everything had their needs met in return. After sending a vast conscript army to take Paris in 1870, he moved to secure the welfare of German citizens by creating the first national system of social insurance and medical coverage. World War I brought a new level of ferocity — and global progress toward national health insurance.

World War II marked both the apotheosis of this social compact and its endgame. The advent of nuclear weapons changed the nature of conflict between countries that have them — barring madness, war between nuclear states

is unlikely to engage whole societies in the same way. For a generation or more after the war, an ethos of reciprocal sacrifice and social obligation lingered in the United States. This ethos helped to create Medicare and Medicaid, enacted in 1965 over opposition from an array of interests. Robert Putnam’s *Bowling Alone* documents the high plateau of public engagement achieved by the World War II generation and the steady decline in civic concern and social connectedness among Americans born later.²

The kind of sacrifice made in World War II is now difficult to imagine. Warfare has again become a craft practiced by comparatively small numbers of highly trained professionals. No longer do most Americans expect to be called on to make the ultimate sacrifice for their country, and no longer do they look to government

to provide for their well-being in exchange for their readiness to do so. The failure of our political process to produce universal health care coverage underscores this fact. Our evolving public morality seems to be turning us away from the concept of health care as a right, toward treatment of health as a private matter.³

Yet there is, in our politics, a hint of something new on the old subject of extending coverage to everyone. The premise of personal responsibility for health is evolving toward an obligation to acquire coverage and to attend to wellness more generally. The idea surfaced politically in the early 1990s, in a proposal by the late Republican Senator John Chafee of Rhode Island. He urged an individual mandate to obtain coverage, accompanied by subsidies for the less well-off. Although Chafee's plan went nowhere, his lead staff member on health went to the New America Foundation, which made the individual mandate the centerpiece of its plan for U.S. health care.⁴

Some criticize the mandate as a political distraction. The real challenge, they say, is to make coverage affordable to people who don't have it. But over the past few years, the idea has spread. It is the moral premise for the pioneering effort to achieve universal coverage in Massachusetts and for California Governor Arnold Schwarzenegger's plan for health care reform. Democratic presidential candidate John Edwards has embraced it, and Republican Mitt Romney points to the Massachusetts plan (which, as governor, he signed into law) as proof of his presidential mettle.

That health care payers are

unhappy about the use of cross-subsidies to cover care for the uninsured is part of the reason for the growing interest in the

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individual mandate. But the larger story, I suspect, is the resonance between the mandate and the moral calculus of the diminished state: We no longer expect the state to call on our children en masse to face fusillades of hot lead — or ask government to reciprocate with 20th-century-style public generosity. The trend instead is toward an ethic that calls on us to take care of ourselves.

Other expressions of this ethic include high-deductible coverage,⁵ financial rewards for regular workouts and weight control, and penalties (such as premium surcharges) for failure to comply with treatment. The federal role in furthering these initiatives has been minimal; they are spreading by swarm logic. Employee-benefits managers, consultants, state legislators, and local offi-

cial are experimenting, swapping ideas, and encouraging each other.

If the United States is to come close to universal coverage, personal responsibility will need to play a larger role than it did in the mid-20th-century welfare state. Is there room for a new compact between citizen and state along these lines? Resurgent interest in universal coverage — among state legislators, business leaders, and presidential candidates — suggests that there is.

The new compact is likely to start with an enhanced sense of individual obligation — to eat sensibly, exercise regularly, avoid smoking, and otherwise care for ourselves. It may include an obligation to buy insurance. Government, in exchange, can offer some protection against the threat of economic and social change that will disrupt people's coverage by destabilizing employment and family relationships. Not only can the state provide subsidies to enable poorer citizens to buy insurance; it can, at low cost, combine people's purchasing power and clear away obstacles to competition, empowering markets to extend coverage to tens of millions who now go without it. Government can also fashion incentives to foster evidence-based practice, health promotion, the elimination of racial disparities in care, and the reduction of medical errors.

The ideas on health care reform that are being taken seriously in state capitals and in the 2008 presidential campaign are variations on this theme. No plausible presidential candidate is urging a European-style program of generous public insurance for all. Like the Massachusetts plan,

the proposals from John Edwards and Senator Barack Obama (D-IL) patch together existing public programs, employment-based coverage, insurance market reforms, and new public subsidies. Their proposals have the potential to achieve near-universal coverage and to improve the quality of care. Senator Hillary Clinton (D-NY) is expected to offer a similar package.

These ideas will disappoint proponents of more sweeping reform aimed at achieving uniformly generous coverage for all. But this strategy responds to the anxieties of working Americans, who accept that they must, in the main, depend on themselves. It supplies a safety net when self-reliance falters because of large economic and social forces. And it shields the poor from the degrading, life-endangering consequences of going without

basic care because they cannot pay for it. It calls on all of us, though, to take greater personal responsibility for our health, by caring for our bodies and buying insurance. And it permits some stratification of medical care on the basis of wealth (though it softens this inequity by promoting evidence-based practice for all).

In the wake of September 11, 2001, and again after Hurricane Katrina, many Americans hoped to restore a spirit of shared sacrifice and mutual support. More able leaders might have brought us closer. But barring a catastrophe much more severe than that of 9/11, a return to a World War II ethos isn't likely. What is possible is a new reciprocity of personal and public commitment, tailored to American self-reliance and the uncertainties of a global economy. This arrangement stands a decent chance of

delivering near-universal coverage. Success could cement a new understanding of government's role — not as a guarantor of easy living irrespective of striving but as an insurer of basic decency when self-reliance fails.

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1. Bobbitt P. *The shield of Achilles: war, peace, and the course of history*. New York: Knopf, 2002.
2. Putnam RD. *Bowling alone: the collapse and revival of American community*. New York: Simon & Schuster, 2000.
3. Epstein RA. *Mortal peril: our inalienable right to health care?* Reading, MA: Addison-Wesley, 1997.
4. Calabrese M, Rubiner L. *Universal coverage, universal responsibility: a roadmap to make coverage affordable for all Americans*. Working paper no. 1. Washington, DC: New America Foundation, 2004.
5. Bloche MG. Consumer-directed health care. *N Engl J Med* 2006;355:1756-9.

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Eulogy for a Quality Measure

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On May 8, 2007, one of the best-known quality measures in health care was put to rest. The percentage of patients with acute myocardial infarction who receive a prescription for beta-blockers within 7 days of hospital discharge has been used to evaluate U.S. managed care plans since 1996. This measure will no longer be reported by the National Committee for Quality Assurance (NCQA) because it is simply no longer needed — a development that offers encouragement and important lessons.

The data in the graph show

why the NCQA Committee on Performance Measurement voted unanimously to retire the beta-blocker measure. A decade ago, only two thirds of U.S. patients who survived acute myocardial infarction received beta-blockers; today, nearly all do. As the curve representing the 10th percentile crept above 90%, the NCQA found little variation among health plans. At least when it comes to this intervention, the U.S. health care system has become reliable.

This story is hardly one of overnight success: the NCQA's action came 25 years and 6 weeks after

the publication of the Beta-Blocker Heart Attack Trial (BHAT).¹ This randomized trial sponsored by the National Heart, Lung, and Blood Institute was stopped 9 months early because, after a 2-year follow-up period, mortality in the group of patients receiving propranolol was 7.2%, as compared with 9.8% in the placebo group. Subsequent data suggest that the relative reduction in mortality might be as high as 40% and that these benefits apply even to patients with relative contraindications to treatment with beta-blockers, such as chronic ob-