

EDITORIALS



Health of the Nation — Coverage for All Americans

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In this year's Shattuck Lecture, we break with long-standing precedent. After 117 Shattuck Lectures delivered since 1890, the lecture this year took the form of a seminar with 13 panelists and a moderator discussing the topic "Health of the Nation — Coverage for All Americans." The panelists included physicians, academics, and leaders from business, the insurance industry, and politics. In this important election year, with health care as one of the principal campaign issues before the nation, we wanted to present the perspectives of a number of experts representing many parts of the health care community and different political persuasions, not just those of a single person. Since 47 million Americans lack health insurance and many others have inadequate coverage, we wanted to explore how the presidential candidates propose to provide health care for all Americans while controlling costs and maintaining quality.

The seminar was videotaped and is posted on our Web site at www.nejm.org.¹ Excerpts of the Shattuck Lecture are also published in this issue of the *Journal*.² One of the panelists, Jonathan Oberlander, has written a Perspective article entitled "The Partisan Divide — The McCain and Obama Plans for U.S. Health Care Reform,"³ in which he outlines the health plans of the expected presidential candidates of the two major political parties. This article, which complements the videotaped seminar and provides background about the candidates' plans, is also in this issue of the *Journal*.

The health plan of Senator John McCain (R-AZ) is based on market forces and the purchase of health insurance by individuals. To offset part of the cost of that insurance, Senator McCain proposes a refundable tax credit (\$2,500 for individ-

uals and \$5,000 for families), which would be available to everyone regardless of whether they pay taxes. The tax credit for individuals and families, however, comes at the expense of the existing tax exclusion for businesses that currently provide health insurance for their employees. Under the McCain plan, the employer tax advantage would be canceled, leaving in doubt whether most businesses would continue to provide a health insurance benefit for their employees. Although a "guaranteed access plan" would also be developed to help uninsured Americans find coverage, it seems unlikely that, even with optimistic predictions, all Americans would be covered under the McCain plan.

In contrast, the plan of Senator Barack Obama (D-IL) is based on an employer mandate to provide health coverage for employees; if employers do not, they would be required to pay a tax ("play or pay"). Small businesses, however, would be exempt. Senator Obama also plans to develop new public and private insurance tools that give small businesses and persons not covered in the workplace a choice of options to purchase insurance on their own. The Obama plan also calls for substantial regulation of the insurance market, including the requirement that persons cannot be denied coverage because of preexisting medical conditions. In contrast to the McCain plan, the Obama plan is more likely to provide coverage for most, if not all, Americans, but how effectively it would control costs is less certain. Senator Obama claims that his plan will save families \$2,500 per year on health coverage, but this figure appears to be based on debatable assumptions. In general, the Obama plan calls for a larger immediate investment in health care than the McCain plan.

What are the prospects that either proposal

will result in meaningful reform of the U.S. health care system? One of the Shattuck Lecture panelists, Charles Baker, voiced skepticism, calling the candidates' plans "political bromide" that serves only to show the voters that they have plans and arguing that these plans are not certain to bring needed changes to a health care system in crisis. In his Perspective article, Oberlander notes that "the McCain and Obama health plans are best viewed as sketches rather than finished portraits."

The last time that legislation successfully produced a seismic shift in the U.S. health care system was in 1965, when the Medicare bill was signed into law by President Lyndon Johnson. Since then, change has been incremental and has failed to keep pace with the mounting problems confronting American health care. In 1994, a major health care reform bill produced under the aegis of President Bill Clinton and Hillary Clinton was essentially dead on arrival in Congress.

There is some reason to be pessimistic that we will see meaningful health care reform in the next administration. Given the divergent views of the two major parties on health care, it is uncertain that — unless the new President's party has substantial majorities in both branches of Congress — a health care bill will achieve sufficient political consensus for passage. Much, too, will depend on presidential leadership.

We believe, however, that it would be a mistake to rely on government alone to solve the crisis. Meaningful health care reform will require a concerted effort by all the major stakeholders in our health care system, as represented by the panelists in the Shattuck Lecture. As was pointed out by panelist Reed Tuckson, reform will also require a willingness to compromise. We offer a challenge to these stakeholders: create together a system that

will provide high-quality, affordable health care for all Americans during the next administration. The time is right for reform. The opportunity is here, and the need is clear.

It is especially important that the academic medical community heed this challenge and address the complex policy and economic research questions that surround access to health care as well as its cost and quality. The perspective of academic medicine will be critical. Without input from the experts in health policy, economics, and health care delivery who make up the academic medical community, no reform will be successful. The leaders of academic medicine have been nearly unanimous in supporting broadened access to care, but they must recognize that such access can be sustainable only if we address the costs of care in earnest. This will require providers to show leadership in reducing inefficiency in health care.

In the weeks leading up to November 4, we will be publishing a series of articles, interviews, and symposiums on the future of American health care and its place in the presidential election. When the next administration has been chosen, we will continue our commitment to publishing the work of the academic medical community in high-quality articles focused on improving the health of the nation and providing coverage for all Americans.

No potential conflict of interest relevant to this article was reported.

1. Baker CD, Caplan A, Davis K, et al. Shattuck Lecture: Health of the nation — coverage for all Americans. May 10, 2008. (Video available at www.nejm.org.)
 2. *Idem*. Shattuck Lecture: Health of the nation — coverage for all Americans. *N Engl J Med* 2008;359:777-80.
 3. Oberlander J. The partisan divide — the McCain and Obama plans for U.S. health care reform. *N Engl J Med* 2008;359:781-4.
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Pharmacogenomics and Drug Toxicity

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In the United States alone, it is estimated that adverse drug reactions affect nearly 2 million patients and kill about 100,000 people each year.¹ Adverse drug reactions are often classified into two groups. The first group can be explained by the mode of action of the therapeutic drug. Ex-

amples of adverse drug reactions in this group include hypoglycemia induced by diabetic drugs, leukopenia induced by cytotoxic anticancer drugs, and bleeding induced by warfarin, an oral anti-coagulant. The phenotypes of the second group are not explained by the mode of action of the