The Affordable Care Act: What Does Healthcare Reform Say About Us?

Andrew J Fichter
First the process, then the product.

PROCESS

In case a healing amnesic balm has started to erase your memory of 2009, let me remind you that the process by which we arrived at the enactment of the Patient Protection and Affordable Care Act ("Affordable Care Act") was painful. Every fissure in our society was exposed, and each seemed to widen. The political center became dangerous ground. No distortion of fact was out of bounds in the service of what disparate groups hastily perceived as their self-interest. Remember death panels? We were told that our healthcare system was the best in the world, and that it was the worst among developed nations (37th in the world, in a 2000 World Health Organization assessment); we were variously warned that our elderly would lose Medicare, and that government would take over healthcare for the rest of us; we were shamed by the statistic that 46 million people in the richest nation on earth had no insurance, and infuriated upon learning that the uninsured, illegal aliens among them, received expensive care at our cost in our emergency rooms. Demagogues rose up to manipulate our irrational fears and basest motives to their political advantage.
And I think we can be proud of all that.

Democracy in action, right? But seriously, there is a reason for pride somewhere in that mess. We undertook healthcare reform in circumstances very different from those that engendered the world’s other two major strategies for healthcare delivery, and the difference says a lot about who we are as a nation. The other two arrangements are the Bismarck model, which was adopted by the German government in the late nineteenth century in an effort to forestall the rise of socialism, and the Beveridge model, which was adopted in Great Britain in the wake of World War II. We, however, undertook healthcare reform in the absence of any war or political upheaval of the magnitude that provoked change in those other countries.

To be sure, there were indicia of system failure and economic hardship aplenty in the U.S in 2009. You could argue that we were forced to reform in response to the unnerving inflation of healthcare costs; but truth be told, we could have deferred reform for another generation. In certain respects our system worked, or at least its flaws were concealed. We could have continued insuring only those who did not need much care, dropping the coverage of a limited number of individuals from time to time when their care became expensive. We could have gone on in collective self-denial, because those whom we neglected were a politically powerless minority (the more powerless because they were by definition either unemployed or preoccupied by illness, or both). Any voices sounding on their behalf could easily have been drowned out by powerful lobbies and demagogues. It is to our credit that we finally listened to our better angels instead — or at least that we abandoned the devil we knew for we know not what.

By way of contrast, Germany adopted what is known as the Bismarck model for health insurance coverage largely as a counter-measure to the very real possibility of massive social upheaval in the 1880s. Seeing labor organizations winning the hearts and minds of the Industrial Revolution’s emerging labor class by providing healthcare benefits through unions, Chancellor Bismarck moved to implement a plan that made coverage universal through capitalist institutions. As a result of this social safety net, the German workforce became further obligated to capitalism and to the status quo and less interested in socialist revolution. This arrangement survives in Germany and a number of other countries to the present day. German employers and employees each contribute a percentage of wages to nonprofit insurance funds which provide coverage for most of the population. For individuals covered in these funds, the cost of coverage is determined in relation to income rather than risk level. Minimum service levels for the insurance are established by government regulation. Eighty-five percent of the population is covered in this way, and the remainder is covered through private insurance. Insurance coverage is mandatory, so coverage is effectively universal. The arrangement resembles that upon which we are embarking in the U.S., except that we will use a wider variety of coverage arrangements and continue to leave 15 million people uncovered.

Great Britain’s national health plan resulted from that country’s experience during and after World War II. The government had already begun assuming the task of providing care on a national scale before the war ended, as soldiers were mobilized, families disrupted, and plans were made to displace whole urban populations to more secure locations. Hundreds of hospitals were built or expanded as part of the national Emergency Medical Service. Meanwhile, the war precipitated the degradation or reallocation of the existing healthcare infrastructure. As the war came to an end, the National Health System was not only an evident necessity but also to a large extent fait accompli.

The arrival of healthcare reform in our country was not leveraged by circumstance as it was in Germany and Great Britain. We did what we did, when we did it, as much by choice as necessity, and therein lies an argument for our national courage of conviction. That being said, we should own the implications of the fact that the process took decades to unfold. Congressional attempts to incorporate health insurance into the Social Security System began in 1943 with the Wagner–Murray–Dingell bill. This and two subsequent attempts in 1945 were headed off by both employer and labor groups, which enjoyed the power that came with controlling this important benefit. These two groups were soon joined by private insurers, whose growth our employer-based system necessitated. As a nation we settled into “welfare capitalism” and accepted its talking points as doctrine: private benefits were deemed superior to public ones; welfare arrangements perpetuated unhealthy dependencies. Left behind were (a) the concept...
that healthcare was a universal human right, or at least a governmental responsibility, and (b) the millions of people the employer-based model did not reach. And in the meantime, the cost of healthcare rose dramatically.

When we took the next giant step toward universal public coverage in 1965 with Medicare and Medicaid, we also scripted our dialogue about healthcare in a way that probably made national coverage less likely in the years that followed. We differentiated between earned and charitable benefits in a manner that stigmatized the latter. Medicare was a contributory entitlement, an earned right, paid for through lifelong wage deductions. Medicare recipients — all Americans over 65 — are called “beneficiaries,” and they are not means-tested for their benefits. Medicaid recipients are called “clients” by the agencies that administer their benefits, which are means-tested and stigmatized accordingly. Thus when the idea of national health insurance was re-floated in the Clinton era, the perception that benefits were either contributory, earned benefits or charitable handouts governed the conversation. It was too easy for reform opponents to marshal public sentiment against welfare healthcare (known without controversy in other countries as the right to healthcare, the provision of which is a government responsibility), so the Clinton health plan adhered to the earned-coverage approach. The employer-based, contributory model was enshrined; the social insurance, “welfare” model was in shambles. As a nation we committed to the employment-based system as the embodiment of a virtue we held fundamental to our national character.

What is self-revelatory in the fact that it took us eight decades to arrive at the Patient Protection and Affordable Care Act? For one thing, we should acknowledge that we are not the bold social innovators we may imagine ourselves to be. For a nation born in revolution, we are impressive in nothing so much as our resistance to change. Where healthcare is concerned, we have moved with truly glacial alacrity. We may be revolutionaries by birth, but we are incrementalists in deed. Moreover, what we have labored so long and hard to bring forth falls short in many respects of anything truly revolutionary. Which brings us to the second part of this piece.

PRODUCT

For all the drama of 2009, healthcare reform was not so much reform as a series of tweaks. There were important tweaks, to be sure. I do not wish to belittle our accomplishment, because there is nothing insignificant about extending coverage to 31 million additional people. But if you consider that we began in 2009 with a national healthcare system based on providing private insurance through employers with government subsidies, supplemented by programs such as Medicaid, Medicare, State Children’s Health Insurance Programs (SCHIPS), and the Veterans’ Administration, but still leaving a significant part of the population uncovered, that is essentially where we ended up in 2010. In 2010 we adjusted the numbers in each category; we did not reform the underlying employer-based structure. If we reformed anything, it was the insurance industry, not healthcare as a whole.
To put our reform achievement in perspective, recall that we assess healthcare systems by examining their three key variables: quality, access, and cost. What we dealt with in 2010 was access. We significantly increased the number of people who can now get access to healthcare on other than an emergency basis. We generally punted on quality and cost, however. The (possibly misnamed) Patient Protection and Affordable Care Act is unimpressive with respect to both patient protection (quality) and affordability of care (cost).

With respect to quality, the Affordable Care Act gives us a number of pilot programs. The Act will encourage experimentation with Accountable Care Organizations, for instance, which should reward providers for achieving cost-effective advances in quality of care. With respect to cost, we seem to have limited ourselves to “bending the curve,” or reducing the rate of cost increases, and this process awaits full implementation of the Act eight or nine years from now. Healthcare economists tell us that one of the most significant cost-control components of the Affordable Care Act will be the excise tax on so-called Cadillac insurance plans. Intended to discourage overuse of healthcare resources by those with extraordinary coverage, this provision is aspirational at best, a correction with respect to incentives. It does nothing directly to limit costs, but rather relies on market theories that have generated as many questions as answers. (Does demand really drive up healthcare costs? To what extent do we seek more healthcare services simply because we can afford them or because insurance is paying, rather than because our doctors tell us they are necessary?) In any event, for better or worse, we have steered well clear of the kind of structural approaches to reducing healthcare costs that other countries use, such as rationing resources or command and control government budgeting.

Putting aside any discussion of its merits, what does the Affordable Care Act tell us about ourselves? That we can move slowly, for one thing. More significantly, that we are ambivalent about undertaking healthcare on a communal level. We never fully embraced the idea that we are all in it together with respect to healthcare — that it is a social obligation for each of us to provide for the others, and a fundamental right of each of us to have basic care as needed. Instead, as we cling to our employment-based, private insurance coverage arrangement, imperfectly supplemented by a variety of government programs and needs-based subsidies, we seem to say “some of us have earned healthcare privileges; we are willing to extend ourselves somewhat to those of you who have not, but not to the extent of jeopardizing what we have garnered to ourselves.” That we differ from Great Britain and Europe in this attitude is perhaps a function of our different national experiences during the 1940s, as some have suggested; but it may run deeper than that.

Taken together, the process of enacting the Affordable Care Act and the Act itself verify an observation about our national character made by Alexis de Tocqueville nearly 200 years ago. We are pulled between what Tocqueville called “social” behavior and “individualism.” For Tocqueville, America distinguished itself from other nations by providing its citizens with “equality of conditions,” or equal access to the circumstances and means for achieving security, prosperity, and general well-being. Somewhat surprisingly to Tocqueville, the effect of this was to nurture radical individualism rather than any sense of community. As Americans experience equal access to their resources, Tocqueville tells us, the “bond of human affections is extended and loosened,” and we drift towards “individualism,” the “habit of always considering [ourselves] in isolation.”

It is not an especially good habit where healthcare is concerned, as everything about managing health on a national scale points to interdependency: the health of each of us affects all of us; the best approach to risk is to spread it widely. Our national habit of considering ourselves in isolation does not serve us well in dealing with these matters. Perhaps the most important legacy of the Affordable Care Act will be to have renewed this discussion. It would be a shame, on the other hand, if the Act left us thinking we have now adequately addressed the problem. That will not have happened until we have fully embraced the idea that in matters of healthcare, each of us has a responsibility to all of us.