Special Section: Unheard Voices:
Religious Perspectives on Access to Healthcare

Health Reform in America: The Mystery of the Missing Moral Momentum

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Examining health policy and its recent reform misadventures in the United States from a moral viewpoint is painful. That the nation devotes 14% of its Gross Domestic Product to health services—sometimes of doubtful clinical efficacy and value for money—and yet lets more than 40 million citizens go without health coverage strikes critics, both foreign and domestic, as a disgrace explicable only by ethical deficiencies distinctive to the American value system. There is certainly merit in this critique, which understandably incites fire and brimstone about the urgent moral imperative of getting the nation on the path of righteousness at last.

Too seldom recognized, however, is that debates about universal coverage (and health reform more broadly) in the United States are in important part about ethics, although, to be sure, these arguments are shaped and framed by culture, institutions, and interests in ways that reformers often deplore. Persuading a stubborn society to change its ways in health affairs is necessary (and perhaps sufficient) to win reform, but reformers might fare better by listening respectfully to the "other side" and inviting doubting Thomases—including the befogged middle class—to a dialogue, not a sermon. The mystery of the missing moral momentum for health reform must be explored before it can be solved.

The United States is an intensely moralistic society whose political disagreements are often suffused with concern for the right and the good. Health policy, which evokes deeply felt conflicts about values and interests, is a leading case in point. In the American context, however, moral argument often works politically against interventionist public policy, redistribution, cross-subsidies, and social solidarity, and in defense of entrenched inequities. Unless reformers learn to penetrate this context conceptually and politically, affordable universal coverage may remain chimerical. Three ingredients are key to encouraging a change in health policy: culture, structure, and strategy.

Culture

Culture connotes a powerful and durable—albeit not immutable—set of normative values and attitudes. American cultural patterns differ from those in other comparable nations in several ways that influence social policy.

Social Pluralism

American society is highly diverse in its class, race, ethnic, religious, and regional composition. These divisions inhibit social solidarity, discourage con-

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sensus about the rights of citizens beyond the basics of human and civil rights, and complicate the political case for universal programs. Furthermore, these social splits cut across one another. 'Working-class solidarity,' for example, is traditionally weak in the United States partly because the working class is fragmented by race, ethnicity, religion, and region. Cross-cutting cleavages fuel group suspicions and antagonisms that invidiously distinguish a deserving "us" from an undeserving "them," and discourage redistributive public programs.

Economic Individualism

In the United States the virtues of weakly fettered markets are widely admired. When government intervenes to tax, regulate, and spend it supposedly erodes incentives to work, save, and invest, and thus depresses general economic well-being. Public social welfare programs reward those who elect not to work, save, and invest, and thereby ruin social character. This reasoning, discernible in adulterated form since the founding of the nation, found its purest formulation in the 19th century doctrine of Social Darwinism. Although these hard-nosed views were challenged and dispelled by Progressivism, the New Deal, and the Great Society, they are regularly revised and resubmitted to the populace, and often meet with approval. Ronald Reagan's success in putting social welfare spending on the defensive is a recent example. Slow growth in wages tends to heighten the appeal of economic individualism while casting a moral pall on the cross-subsidies that "progressive" social measures require.

Religious Moralism

The United States famously separates church and state. But, as De Tocqueville and others have observed, this formal divorce leaves religious forces freer to act on government precisely because they are not in or of it. In American politics, religious sentiment tends to concentrate on moralizing individual behavior, not reforming broad social policy. The religious right views government as a threat to the autonomy of family and community, a usurper that wrongheadedly contrives to poke its nose where it does not belong (alleged "rationing" in the Clinton plan is an example) but that declines to intervene where it should (by outlawing abortion, for instance). Moreover, when the religious moralizers wear out their welcome (as may be happening now) their declining influence does not reflect insufficient zeal for new public measures applicable to the have-nots but rather excessive zeal for regulating the personal behavior of the middle class.

Political Idealism

The United States is unique in its conviction that small government is integral to the genius of its political system. That government is best which governs least. Obviously, over the past half century the nation has departed repeatedly—and cumulatively—from this minimalist path. Americans are principled but also pragmatic. Nonetheless, this political philosophy hangs in the air, awaiting exploitation—not only by Ronald Reagan but also by contemporary "New Democrats," as in Bill Clinton's declaration that "the era of big government is over." Such cultural precepts color the social definition of the rights govern-

ment should guarantee. By and large, these rights are civil and formal-legal; the notion of 'rights' to some output of social policy is alien and, when pressed, controversial. Americans apparently cannot swallow a federal entitlement to welfare assistance, and although citizens who have health insurance often act as if it gives them a right to any and all medical treatments, they have never formally recognized a right to coverage. The right to a free public education, which supposedly validates the equality of opportunity that legitimates unequal outcomes down the road of life, would seem to be the exception that proves the rule.

Structure

Cultural obstacles to the quest for affordable universal healthcare coverage in the United States are compounded by governmental structures and institutional arrangements.

Separation of Powers

The structural separation of the American executive, legislative, and judicial branches of government carries a heavy cost in the health sphere, namely, the absence of reliable mechanisms to resolve conflicts among the proponents for change. This cost is all the greater given the intense opposition to health reform that its proponents predictably face. Windows of opportunity for major health policy innovations always open onto a lush panorama of proposals offered by the President, members of the House and the Senate, or influential private groups. Usually neither the President, nor the major political parties, nor committee leadership can integrate and harmonize them. In the early 1970s employer mandates vied with comprehensive publicly funded coverage, catastrophic benefits, kiddie care, and other proposals, and movement toward universal coverage stalled. Twenty years later history repeated itself as the drive for fundamental reform spawned the Clinton plan, a single-payer system, mandates for individual coverage, medical savings accounts, and other proposals. Leadership without means of assuring followership does not get far.

Federalism

The United States is not the only nation that divides health policy functions between central and subnational governments. Germany, Canada, Australia, and Switzerland, for example, successfully reconcile affordable universal health coverage with sizable state or provincial roles. Federalism complicates the search for universal programs in the United States, however, precisely because the states are lionized for their diversity. The states, so the argument goes, are not only closer to the people than the central government, they are also natural "laboratories of democracy." The wise policy course, then, encourages the states to experiment, evaluates the results, promotes dissemination of successful strategies among states, and perhaps—in due course—extracts innovations worthy of national adoption.

This image of state leadership has its appeals, but it can also serve as a principled excuse to defer hard national policy choices into an indefinite future. Such procrastination would matter less if the states were well equipped to

blaze their various trails toward affordable universal health coverage. In fact, states face the same deep-rooted political obstacles that encumber national policy reform and have the further difficulties of interstate competition for business, tax base, and jobs, which complicate regulation and redistribution on behalf of the disadvantaged.

Interests

The structure of the interests that health reform implicates is doubtless unique to the United States. About 85% of the population gets health coverage from employers, Medicare, or Medicaid. To be sure, these citizens are displeased by high costs and waste in the system. The practical expression of this irritation, however, is an unwillingness to bear higher taxes or premiums to cross-subsidize the uncovered 15% of the population, given that "enough" money is already in the system and the uninsured are protected by safety net facilities. This reasoning is by no means amoral; on the contrary, the American public has a tenaciously moralistic view of the cost problem, which it attributes to profiteering by greedy physicians, hospitals, insurers, and drug companies and which it would fix by applying the scourge of price controls to the money changers in the medical temple.

Meanwhile, organized medicine denies the legitimacy of direct negotiations between itself and government over fees, and prefers clinical micromanagement to budgetary regulation. Managed care is a lesser evil than government rules—or so has run the prevailing professional opinion. The small business community obdurately denies that government may properly require its members to confer healthcare benefits on workers and disclaims all social responsibility for coverage, airily asserting that workers need jobs more than health coverage. The big business community remains so fixated on "too much government" that it shuns reforms (such as the Clinton plan) that might serve its economic interests. Until a minor renaissance in 1996, organized labor had lost both political influence and ardor for national health insurance. In debates on the Clinton plan it was a peripheral player that mobilized mainly to defend tax and other advantages its members valued in the status quo. The elderly "got theirs" and are happy to see the uninsured gain coverage—so long as Medicare is held harmless in the process.

The uninsured themselves—mainly lower-wage workers (and dependents) in small firms—are neither organized nor vocal and are dispersed all across the country and the economy. They often pay taxes to help support relatively broad benefits for Medicaid clients who may not be much worse off than themselves—a poignant moral dilemma that is also a potent recipe for social conflict. At the same time, some of the uninsured do not want health insurance if they must pay for part of it themselves, and one can see why. Juggling recurring costs—housing, food, transportation, utilities, and plenty more—with low wages, they tend to be unimpressed by even deeply discounted rates on health coverage. Young, healthy wage earners may therefore decline to insure against unlikely risks, take their chances, visit the emergency room if illness strikes, and worry about settling the bill later. Even if employers agree to cover all or most of the premium, workers may still prefer the wage increases that might be traded off for health coverage. The political expression of these motley interests and

incentives makes it tortuous indeed to craft a tripartite scheme that enlists families, employers, and government in financing universal coverage.

Strategy

What do these cultural and structural patterns imply for strategies to achieve affordable universal coverage? One line of argument—pessimistic, but perfectly reasonable—interprets them to suggest that "strategy" can do little or nothing to realize the ends in question. Reformers too often assume that some internal (il)logic at work beneath the deeply flawed healthcare system will sustain inevitable progress as the American people gradually come to see the light. Perhaps, however, affordable universal coverage is achievable only as an accidental, incidental byproduct of large political shifts that have little directly to do with healthcare. The Great Depression brought Franklin D. Roosevelt to power and gave him the ideological support in Congress to launch the New Deal. Social turmoil in the early 1960s (not to mention John F. Kennedy's assassination) ushered in Lyndon B. Johnson and the Great Society programs (including, of course, Medicare and Medicaid). If 20th century American political history displays less than ten years of significant concentrated policy activism then one is reduced to "hoping" that some serendipitous combination of economic stress, foreign problems, or domestic scandals will pave the electoral path toward legislative-executive enthusiasm for big, bold, new domestic federal programs. If, by chance, universal health coverage then stood at the top of the executive and legislative agendas, then it might, by chance, pass. There is, however, no chartable strategic route through this sea of political contingencies.

An alternative to this frustrating line of argument holds that a coalition in support of affordable universal coverage could be built on its merits but that reformers have gone about it badly. Those who cling to this comforting conjecture need first to diagnose what went wrong in the past. In such an inquiry, lessons from the ill-fated Clinton plan may be useful.

First, reformers should avoid facile assumptions about what the public wants and will accept. As a guide to the formulation and marketing of the Clinton plan opinion polls proved to be treacherous, because they were poorly constructed, naively interpreted, or both. Overwhelming support for "fundamental" or "complete" overhaul of the system left the impression that the public recoiled in disgust from the system as a whole and clamored for a comprehensive reorganization. Most people, however, seem rarely to think deeply about "the system"; rather, they identify disagreeable bits and pieces of it and want to see these fixed while others are left alone. They also grow impatient with and intimidated by wonkish exegeses of tradeoffs they had not contemplated. In retrospect the "fundamental change" the public sought in health reform in 1992–94 was portable health insurance coverage, belatedly delivered (in some measure) by the Kassebaum–Kennedy legislation of 1996. Those who are convinced that affordable universal coverage is a moral imperative should not proceed as if those who wish to think twice about it are ethically challenged. Successful reform demands sensitive reflection on the subtle connotations of political discourse about proposed changes, and then a careful construction and communication of innovations in terms that make sense to the middle class.

Second, reformers should be stubbornly self-critical about their grasp of the dynamics of group politics. In happy contrast to past forays on behalf of

universal coverage (when interest groups could and did stop initiatives in their tracks), the early 1990s seemed to bring exhilarating news. This time it seemed clear that the old veto groups could not block reform if they wanted to (given the overwhelming force of public sentiment for a new system), and that they would not even want to try (given their collective and mutual despair over the growth and shifting of costs). Economic interests finally aligned with moral imperatives.

This, alas, proved not to be so. After the Clinton plan went public, almost every major interest group either opposed it wholly or in pertinent part ("We favor reform, but not this kind") or sat silently on the sidelines and monitored its dismemberment. Public relations pronouncements in favor of reform plus abstract economic propositions asserting why organizations ought rationally to welcome change are not a substitute for intense coalition building and bargaining. Business, payer, provider, and other groups are often deaf to the social appeals of health reform and support change only so long as its costs fall anywhere but on them. Demonizing these "special interests" is a losing game precisely because the "special" positions they promote resonate widely in a nation that is reluctant to acknowledge government as a force for good. Unless health reform is concretely connected to the values and interests of a critical number of these groups they will continue to spook an ambivalent public.

Third, reformers should be skeptical that the merits of analytic policy proposals can be easily and effectively translated into political support. For example, Clinton planners "knew" that their innovative proposed health alliances would be user-friendly cooperatives run by employers and consumers who would thereby win long-sought countervailing power against payers and providers. Logic and good intentions did not, however, prevent critics of these innovations from persuading the public and Congress that alliances amounted to "another layer of government bureaucracy" that would mercilessly force consumers into managed care plans. Workable reform models require the precious but elusive aura of legitimacy, a resource that derives less from theoretical acumen than from a plausible marriage between policy innovation and public sensibilities.

These lessons boil down to correcting a massive disjunction between policy currents inside the beltway (and in some state capitols) and what people across the country think, fear, and want from healthcare reform. Reformers should begin anew by listening, learning, debating, and mobilizing at the proverbial grass roots, within community organizations and religious congregations that might mediate the translation of policy complexities into political consensus.

A good beginning is recognition that the debate about health reform does not pit the moral and enlightened against the malign and benighted, but rather turns on conflict between competing moral visions, diverging political philosophies. Redistributive issues in health and other arenas are not mere polemical sideshows, and a reflexive ethical urge to transfer resources from haves to have nots goes nowhere when society denies the legitimacy of public roles that other nations readily accept as indispensable to sound policy. American reformers should target and develop cultural supports (admittedly weak and obscure) for public activism; these include a sense of fair play, equality of opportunity, and benevolence toward underdogs. Influence is in important part an exercise in cultural communication, and accrues most readily to those who can modernize cherished cultural symbols and values in ways that prove persuasive to the public. Ronald Reagan performed this role masterfully on behalf of conserva-

tism; those to the left of center have yet to match his success. Religious and ethical reasoning may supply valuable raw materials for a "new" left, newly respectful of a middle class that has turned social skepticism into something approaching a world view.

Some believe that the American value system is basically incorrigible, at least in matters of social policy. A more charitable reading holds that the problem is not values per se but rather the well-honed American habit of inserting myths between observed facts and applied values. The legendary safety net is a case in point. Everyone knows that lack of coverage does not mean lack of care. The seriously sick go to emergency rooms of public or voluntary hospitals and get treated. Why, then, invite the federal government to "fix" for all citizens arrangements that are not truly broken for the uninsured?

The problem with this view is not so much moral obtuseness or factual inaccuracy as mythology about how things work. If people were dying in the street for want of medical care, public opinion would recoil, the media would expose this "national scandal," and policymakers would rush to the rescue. Visible tragedies prick the national conscience. But the uninsured do not die in public view because they cannot get care. Instead, their medical ailments degenerate incrementally over the years, silently awaiting the crisis and the ride to the emergency room that proves that no one goes without. These millions of microcosmic failures to forestall human suffering, avoidable by simple acts of medical management, are invisible tragedies; they happen out of public sight, and therefore out of political mind. If the insured citizenry understood better the subtleties of coverage and access, would its antigovernmental values remain unmoved?

The same troubling mythical interplay between facts and values impoverishes current debates about cost containment in Medicare and Medicaid, constriction in cross-subsidies for "essential community providers" such as public hospitals and clinics, and stretching of the social safety net more generally. Wholesale elimination of these programs and institutions would trigger visible tragedies and, in turn, political redress. The likelier prospect is a more threadbare safety net, obliging public clients and the uninsured to travel farther, wait longer, and (perhaps) get less attentive care. The invisibility of this suffering, however, will feed the myth of the safety net as moral bulwark, which in turn will reinforce the myth that a humane and fair system can do without a larger role for government in financing coverage.

The basic task, then, may be educating the American public about the true costs of nonuniversal coverage. But mass education delivered from on high by moral elites is patronizing—especially in the democratic precincts of public policy—so the first strategic step may be to let "the people" educate the policy experts. If reformers gain deeper insights into public sensibilities they might successfully sustain social conversation about the moral issues that frustrate national health policy. Dialogue takes time and patience and may seem superfluous to reformers who know the answers, but the efforts of both the Clinton administration and a range of foundations to educate the public about the merits of affordable universal coverage make it clear that no one has a clue about how to do so. One cannot hope to change hearts and minds without first exploring what is in them.

Exploration should not depend mainly on polls and focus groups but rather on the engagement of reformers and policymakers in rough-edged democratic

deliberations in the familiar local settings in which communities and congregations seek to discern and discuss their fates. Between policymakers and the public lies a rich range of mediating institutions—among them, fraternal associations, unions, and, crucially, religious organizations—that may help their members to get acquainted with the complexities of social choice and build trust in the intentions and intelligence of those who press for innovation. When government's agenda is vast, information about the consequences of social programs is abundant and conflicting, and policy discourse itself is formidably technocratic, "average" citizens grow confused—eager to do the right thing, uncertain about how to identify and pursue it.

In health reform debates, technical complexity often obscures moral conflict. The best antidote may be the old-fashioned basics: social conversation, moral dialogue, democratic deliberation. If sustained long and well enough in enough communities and congregations, such exchanges might yield coalitions imbued both with moral purpose and a practical sense of how to begin transforming purpose into policy. From community commitment and consensus might come, in time, media attention, legislative respect, and influence with important interest groups. Such patient politics might even gradually rekindle support for affordable universal coverage—and, this time, with the secure popular foundation that was conspicuously absent (in retrospect) from recent national reform contortions. Such musings may reflect an absurdly incautious optimism. Yet, the dynamics of health politics in the United States are sufficiently mysterious to justify a healthy respect for fate and perhaps even a hearty residue of faith.