

The Day After Trinity

Just as Nuclear Threats Continue to Influence Foreign Policy, the Ghosts of Past Efforts to Improve the U.S. Health System Still Trouble Us



BY EMILY FRIEDMAN

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On July 16, 1945, the first atomic bomb was detonated near Los Alamos, N.M. The explosion was code-named “Trinity” by the project’s lead physicist, J. Robert Oppenheimer. He later said that the name, ironically, was inspired by the poetry of John Donne, a 17th century Anglican priest and author of the famous sonnet, “Death Be Not Proud.” Within weeks of the explosion, Hiroshima and Nagasaki were devastated. Today, the legacy of Trinity still haunts humankind, as we worry about which nations have the capacity to produce these weapons and what they might do with them.

It is not much of a stretch to see the parallels to what is generally being referred to these days as health care “reform.” (Personally, I don’t like the term; it seems to imply that the health care system has committed some criminal act, as in *reform* school.) Whatever we call it, the idea is to control costs, achieve access and coverage for most or all Americans, and reconfigure the provider and insurance sectors. Beyond that, there is little agreement. Proposals run the gamut from “keep things pretty much as they are and give tax credits to the uninsured” to “let’s have a government-controlled single-payer system,” as many other countries do.

What are the parallels with the nuclear threat? For one thing, we’ve been kicking this particular ball around for decades, with limited results. There have been successes — Medicare, Medicaid, the State Children’s Health Insurance Program, a few state initiatives — and there have been failures, including the Clinton health plan. We produce studies, hold conferences, publish articles. But the number of uninsured continues to grow, as has membership in the club of nuclear nations. Furthermore, just as the nuclear threat still influences foreign policy, the ghosts of previous

efforts to improve our health system haunt us. We do not seem to have learned the lessons of the atomic age any more than we have learned much from previous attempts to bring rationality, and justice to health care. So although there is great hope right now, there is also great anxiety about what “reform” will bring. Policymakers are busily formulating “reform” proposals, jockeying for power goes on, lobbies prepare their assault. Yet, most of those involved in the effort are too busy furthering their agendas to ask the most difficult and controversial questions.

Who Should Have Coverage?

Everyone talks about “universal” coverage, which conveniently ignores the huge national debate over immigration. (One in 10 U.S. residents was born outside the country.) Does anyone really think that Congress would approve subsidizing premiums for low-income undocumented residents? What if their children are citizens, but they aren’t? Should there be a waiting period before *legal* immigrants are eligible for government assistance, as is often the case now? What if undocumented residents can pay for coverage? Should we let them? Or should we only punish those who are poor?

Either the undocumented population should be treated like everyone else when it comes to coverage, or the program will not be universal, and should not be described as such.

Another debate focuses on behaviors that affect health. Indeed, in late May, the Senate Finance Committee, in its proposals for funding “reform,” included what it coyly described as “lifestyle related revenue raisers,” including higher taxes on alcohol and an excise tax on “sugar-sweetened beverages.” (Interestingly, it did not mention tobacco, possibly because it is already taxed so heavily.) Specifically, the proposal reads, “The tax would apply to beverages sweetened with sugar, high-fructose corn syrup, or other similar sweeteners. The tax would not apply to beverages sweetened with non-caloric sweeteners.”

Some employers reward employees who engage in approved health-promoting behaviors; others punish workers who don't. Society condemns smokers, obese people, non-exercisers, and other groups. Why should we not do the same when it comes to universal coverage, especially if government subsidies are involved?

We should not do so because, in the first place, it would be hypocritical. If we are going to condemn behaviors that negatively affect health, we should condemn all of them, not just those that are engaged in largely by lower-income, less-educated people. Let's go after skiing and bungee jumping; let's punish bulimics and anorexics; let's end the dangerous practices of working too hard and not sleeping enough. And let's come down hard on *all* alcoholics, not just those who are arrested for public drunkenness while the more fortunate recover in expensive dry-out farms in Napa Valley. Alcoholism is a disease, it would seem, only if you have enough money.

As a colleague of mine says, "If they really want to ban dangerous behaviors, they should prohibit driving."

Besides the inequalities involved, the fact is that we hardly know everything about why some people get sick and others don't. Winston Churchill, who drank and smoked heavily, worked way too hard, was overweight, and suffered from depression, nevertheless lived to the age of 90. Two friends of mine, both optimum-weight, non-smoking vegetarians, died young of colon cancer. Most smokers do not get lung cancer.

Are there correlations between certain behaviors and poor health? Of course. But there is almost always more than one factor at work, and that includes genetics. Discriminatory public policy will inevitably lead to a situation in which half the population is disfavored.

Beyond all that, the sad fact is that illness and injury are difficult and unpleasant; it isn't like people are getting away with something scot-free. As anyone who has had experience with the disease will tell you, AIDS is more than punishment enough for unthinking behavior. And we are *all* guilty, at one time or another, of actions that might cost the taxpayers a little extra.

Further, in this age of "healthy communities," it is important to remember that health status is affected by social factors, many of which are beyond the power of the individual to counter. These include poverty, poor and unsafe housing, violence (domestic, street, etc.), firearms, insuffi-



A sign at the Trinity test site, Alamogordo, N.M.

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cient language skills and illiteracy, low educational levels, bad schools, occupational dangers such as pesticides, bad diet, racism, fear and despair. If the "reformers" are serious about improving health status, they will need to widen their current laser-like focus on the formal health care system and its problems. Comparative effectiveness research on treatments for low back pain will not protect the little girls who get caught regularly in gang cross-fire on the streets of Chicago.

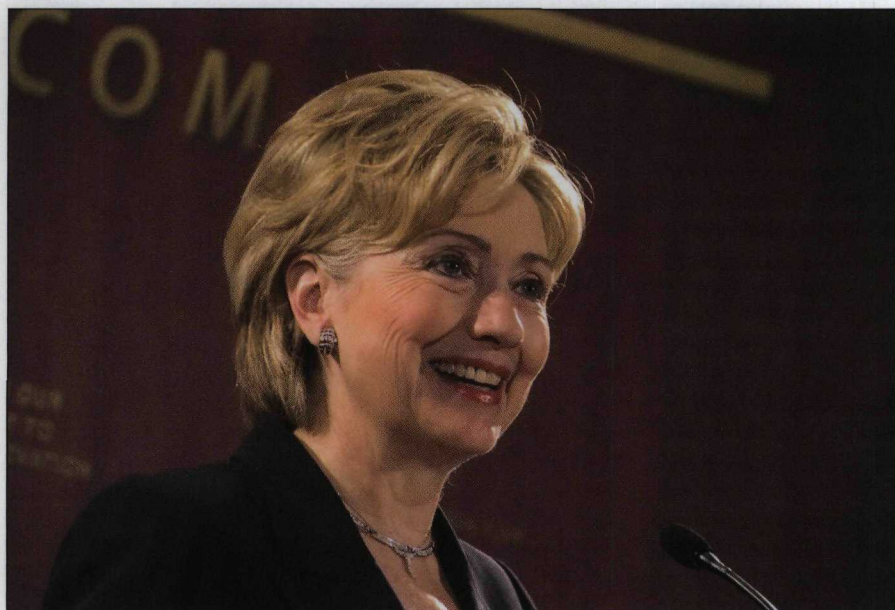
THE ETHICS OF INSURANCE

At least at this point in what promises to be a long and tangled process, there is enthusiasm for an individual mandate; that is, a federal requirement that everyone must obtain health insurance. This was a feature of Hillary Clinton's presidential campaign agenda and is also a key component of the Massachusetts state health care program.

Even America's Health Insurance Plans, the lobby for the health insurance industry, has endorsed the concept, albeit for selfish reasons. The most obvious one is that, as a lobbyist once said of the state of Hawaii's requirement that employers cover most workers, "It's always nice when the government forces people to purchase your product." The less obvious reason for the lobby's endorsement is that, if a mandate is



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Hillary Clinton campaigned for a federal mandate requiring everyone to obtain health insurance during the 2008 presidential campaign.

enacted, employment-based coverage will likely disappear, thus turning the entire nation into a market in which we are all on our own and the insurers can cherry-pick the good risks to their hearts' content. No group-coverage protections here.

But the lobby has stated that if an individual mandate is approved, its members will stop discriminating against people based on health status or gender. One is tempted to say, "Gee, isn't that swell of them?" But be wary. It's a hollow promise. The lobby's position is a smokescreen for the real agenda: They want to prevent establishment of a public, government-run health plan that would compete with the private plans, an idea that has a lot of support. A public plan would be a real threat to the health insurance industry; it would have lower expenses (no shareholders who want dividends, less administrative overhead, no required reserves) and thus could charge less. Opponents of the idea argue that this would amount to unfair competition — and they're right. Proponents of the public plan claim that it could be configured in such a way as to allow a level playing field, although that would be difficult and would likely result in all kinds of complex and artificial restrictions. Besides, public-plan enthusiasts aren't exactly showing their hand, either. Many of them support this option because they see it as a huge step toward a single-payer system.

In any case, a public plan wouldn't destroy pri-

vate insurers. Private plans have been competing with traditional Medicare for years, and they have made significant inroads. Interestingly, though, despite massive efforts by the Bush administration to give private Medicare plans an advantage in the market, most Medicare beneficiaries remained with the public side of the program. The Medicare experience teaches us that public and private plans can compete without one side or the other being ruined.

Furthermore, a public option could work to private insurers' benefit because of a dirty little secret: They make most of their money by avoiding or overcharging people who are sick and women, who live longer and use more health care. Life insurers do that

too. It is how the game is played. And the insurers' promise that they would stop doing this if a mandate is approved is hogwash. So they'll price everyone the same (within age groups), as was once the case. Great. But there are many other ways to discriminate. I remember an older friend of mine, who lived in a retirement community, telling me about all the free meals that were offered to her and her neighbors by private Medicare plans that had invited them to listen to their pitches. The interesting feature was that these meals were invariably served on the second floors of buildings that lacked elevators.

In the case of health insurance, it's easy. Just avoid marketing in certain areas. Pay for confidential information about applicants' health status. Mislead applicants about what they are signing up for, and then refuse to pay their claims. (A huge scandal regarding this practice recently made news in California.) If an applicant appears to be pregnant or ill, tell her that she would be better off with the public plan. All these approaches have been used in the past, and it is difficult to prevent them through government oversight, especially before the fact.

Another proposal is to use Medicaid as a platform for universal coverage. This could make for problems. The first is that this program often underpays providers, sometimes egregiously. Second, the majority of its beneficiaries are low-income Americans, and they are disproportionately non-white. That combination has led many physicians (and some hospitals) to refuse to care



for Medicaid patients, sometimes with dire results. One such case was that of Deamonte Driver, a 12-year old Maryland boy whose family had been on and off Medicaid. He had a toothache, but his mother could not find a dentist willing to treat him. The tooth became abscessed; the infection spread to his brain and killed him in February 2007.

As is true of other forms of discrimination, preventing bias against Medicaid beneficiaries is difficult, which does not bode well for that population, or for efforts to use Medicaid to cover the uninsured. Karen Davis, Ph.D., president of the Commonwealth Fund, told me in 1977 that one of the worst health policy mistakes ever made was to divide the poor and vulnerable who qualify for Medicaid from the more “socially acceptable” (and universally covered) Medicare population. It is not an error that should be repeated.

One of the many lessons of Medicaid is that access is different from coverage. One can have no coverage and still have access to care in some form, whether in an emergency department or through the charity of providers. But one can also have coverage, especially Medicaid, and no access, in which case the coverage is meaningless, no matter how much policymakers may congratulate themselves on their generosity.

ACCESS TO WHAT?

Whatever the vehicle that is eventually chosen to broaden coverage, perhaps the prickliest question will then arise: What services, exactly, will be included? The free-for-all that will break out immediately will require some difficult decisions.

For one thing, every health care profession known (and some that will suddenly appear) will want its services covered, preferably directly (as opposed to payment coming through hospitals or other entities). Naturopaths, homeopaths, acupressurists and many others will seek to feed at the trough. Turf wars will become still more intense as various professions and specialties seek control of lucrative technologies and therapies.

All this is already taking place, but if we insure the 50 million or so people who currently lack coverage, the amount of money involved will raise the stakes considerably. Furthermore, any new program — or new source of funding — represents an opportunity for those providers who have been previously excluded to get their noses into the tent.

The problem is that politics can often trump

both science and common sense in such situations, and effective lobbying and campaign contributions could easily lead to all kinds of things being covered — purely cosmetic surgery, quartz crystals, Laetrile — that should not be subsidized by taxpayers or anyone else. It has happened before. And that is not even to mention the fact that clever coding and unscrupulous providers can characterize a treatment as necessary when it isn't, or simply describe a treatment that is not covered as being something that is.

Then there's the increasing connection among quality, outcomes and payment. Comparative-effectiveness research has gained a great deal of political support and a lot of federal funding, and its findings will affect payment policy. Payers are refusing to reimburse providers for medical events that should never happen. Better outcomes and adherence to quality standards are yielding higher reimbursement. This is all to the good.

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But the question must be asked: Should there even be access to poor care? Should newly enfranchised patients (or any patients) be put at risk by shoddy providers, even if they are the only ones available? Which would be worse, having access to little or no care, or having access to lousy care? How serious are we about making quality a core part of the “reform” mix, and what will we do about providers who don't measure up? And if care from underperforming physicians or hospitals or clinics is not covered, what will happen to their patients? Will they be welcome elsewhere — if they can get there?

Speaking of access: Has anyone noticed that, as usual, the issue of long-term care is largely off the table? Howard Gleckman, a senior research associate at The Urban Institute, wrote in the January-February 2009 issue of *Health Progress* that long-term care financing has to be part of the reform mix;¹ I don't think anyone was listening.

FIGHTING OVER THE SPOILS

It won't only be providers who are fighting over the spoils; deciding who gets what will involve

visceral questions of how to divide up a pie that will, in one way or another, be limited. For if increases in the cost of care are not constrained, nothing we come up with will work for long. It is nearly impossible for government or insurers or employers or anyone else to continue to pay for something whose cost doubles every few years. There will have to be limits. So no matter how “reform” comes out, the frightening cry of “rationing!” will soon be heard in the land.

To anyone who is still dreaming of a single-payer system with one tier of care for all, wake up. Forget it. No nation has achieved that — not Canada, not Great Britain. There is always a safety valve; there are always tiers.

The fact that all nations ration health care in some way will be irrelevant. The fact that the United States rations health care in a particularly vicious way will be ignored. As James Tallon Jr., president of the United Hospital Fund of New York, has observed, it's not politically palatable to ask Americans to give up something they consider to be a right in order to help out someone they don't know. I would add that if the beneficiaries are strikingly unlike the unwilling benefactors, it is even more unpalatable.

For the creepiest fact involved in the ethics of American health care is that we are not all equal in the eyes of the law or anywhere else. This society prefers the young to the old, and *greatly* prefers the young to the very elderly. As for the rich, they are, as Ernest Hemingway famously said, different from the rest of us: They get more, because they can buy more. And they can get away with a lot.

The gross disparities in health status and access to care between whites and everyone else offer awful evidence of the legacy and continuing presence of racism and other forms of bigotry, whether conscious or not. We may have elected an African-American president, but African-American women still die in childbirth three times as often as white women.

In other words, in our society, there is a huge gap between the “powers that be” and beings with no power, and I don't think health care “reform” will change that. We can only try to mute its impact.

And that will be difficult, because it isn't just

that we don't *have* a classless society; we don't want one. The heck with the Bill of Rights; we need someone to feel superior to. We tolerate tiers of care because we *like* them. Most of us don't go to bed at night fretting about the uninsured poor, as long as we ourselves have coverage. As ethicist Ann Neale, Ph.D., wrote in *Health Progress*, “We are part of a culture that glibly assures pollsters that ‘everyone should have access to health care regardless of ability to pay’ — and then lives with a scandalously different reality”²

So, to anyone who is still dreaming of a single-payer system with one tier of care for all, wake up. Forget it. No nation has achieved that — not Canada, not Great Britain. There is always a safety valve; there are always tiers. You get different care depending on who you are, and that is not going to change. The best we will be able to do, I think, is heed the words of Arthur Hess, former commissioner of the Social Security Administration, who told me *32 years ago*, “I'm afraid that we are heading back to two-track medicine. That might be all right, as long as the second track still means high-quality health care.”³

In his brilliant article on rationing and resource allocation in health care,⁴ James Childress tells the true story of a overcrowded lifeboat floating around in the frigid North Atlantic, and how the crew decided who would stay in the boat and live, and who would be thrown overboard to certain death. Childress quotes philosopher Edgar Kahn, who believed that no one should have been thrown overboard; rather, he thought, they all should have stayed in the boat and died together, because in such circumstances, “no one can save himself by killing another.” He was correct, morally. But we do it all the time.

We will never all be in the same health care boat, but perhaps, given the opportunity before us, we can at least commit to trying to protect each other's lives.

In one of his landmark essays, Daniel Callahan, Ph.D., wrote that there just might be enough effective health care to go around, if we could all curb our appetites a little and rein in our seemingly insatiable desire for all the care we can possibly corral.⁵ He argues that this is the only acceptable solution in a civilized society, and that it is not, in his words, “an impossible ideal.” I agree. More important, it is probably the only way that we can bring sanity and justice to health care in a manner that will last.

In 1965, 20 years after the Trinity explosion,



“If you do not **hope**, you will not find what is **beyond** your hopes.”

ST. CLEMENT OF
ALEXANDRIA



Oppenheimer was asked about then-President Lyndon Johnson's proposal that the United States and the Soviet Union begin negotiations to prevent further proliferation of nuclear weapons. Oppenheimer replied, "It's 20 years too late. It should have been done the day after Trinity."⁶

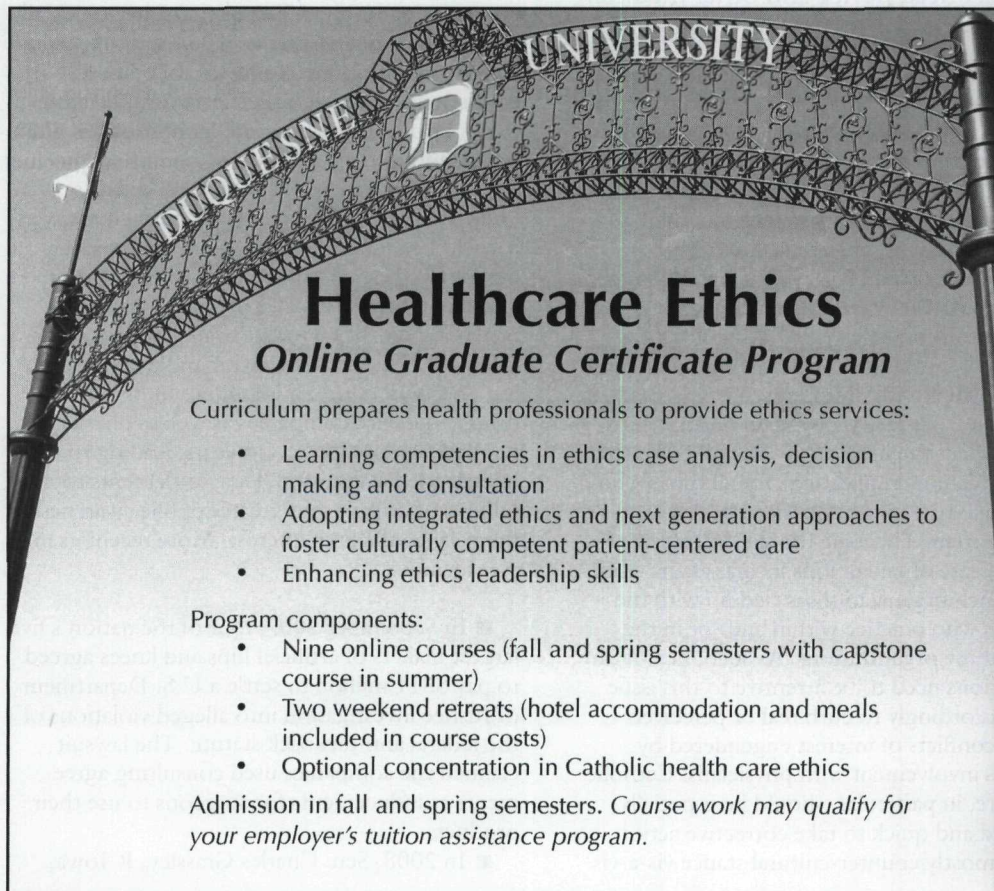
In hindsight, the United States should have begun the process of straightening out its health care system in 1977, when groundbreaking federal research reported that there were 26 million uninsured Americans. That was health care's Trinity. We should have started asking the hard questions then. Let us hope that we will do so now, and that it is not too late. ■



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NOTES

1. Howard Gleckman, "Long-term Care Financing Reform: The Time is Now," *Health Progress* 90, no. 1 (January-February 2009): 47-51.
2. Ann Neale, "Who Really Wants Health Care Justice?" *Health Progress* 88, no. 1 (January-February 2007): 42.
3. Emily Friedman, "Medicaid: Uncertain Harvest" *Hospitals* 51 (Nov. 1, 1977). Also reprinted in *The Problems and Promises of Medicaid*, American Hospital Association, 1977.
4. James Childress, "Who Shall Live When Not All Can Live?" *Soundings* 53 (Winter 1970): 339-355.
5. Daniel Callahan, *Modernizing Mortality: Medical Progress and the Good Society*, Hastings Center Report (January-February 1990), 28-32.
6. *The Day After Trinity: J. Robert Oppenheimer and the Atomic Bomb*, VHS, directed by John Else (1981; Santa Monica, Calif.: Pyramid Home Video).



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