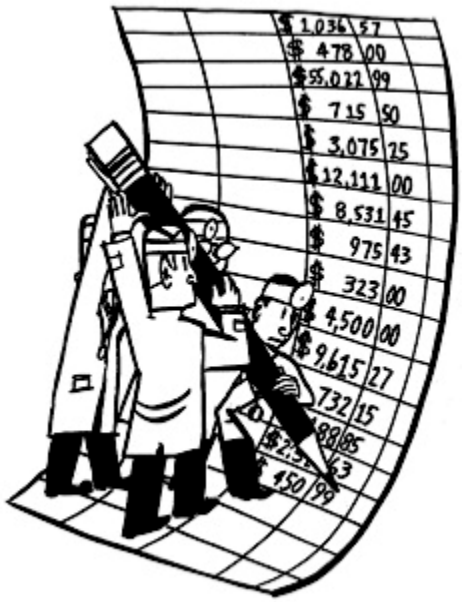
THE NEW YORKER

COMMENT

NOW WHAT?

by Atul Gawande

APRIL 5, 2010



On July 30, 1965, President Lyndon Johnson signed Medicare into law. In public memory, what ensued was the smooth establishment of a popular program, but in fact Medicare faced a year of nearly crippling rearguard attacks. The American Medical Association had waged war to try to stop the program, and doctors weren't about to abandon the fight against "socialized medicine" simply because it had passed into law. The Ohio Medical Association, with ten thousand physician members, declared that it would boycott Medicare, and a nationwide movement began. Race proved an even more explosive issue. Many hospitals, especially in the South, were segregated, and the law required them to integrate in order to receive Medicare dollars. Alabama's Governor George Wallace was among those who encouraged resistance; just two months before coverage was to begin, half the hospitals in a dozen Southern states had still refused to meet Medicare certification.

Either boycott could have destroyed the program. Hundreds of thousands of elderly and black patients would have found their hospitals and doctors' offices closed to them. But, as David Blumenthal and James A. Morone recount in "The Heart of Power," their riveting history of health-care politics, Johnson recognized the threat and outmaneuvered his opponents. With the doctors, he cajoled and compromised, giving the A.M.A. a seat on an advisory council that oversaw the rules and regulations, and working with it on a series of thirty "improving" amendments to the legislation. With hospitals, however, the President brooked no compromise. He convened a battle council of top advisers; set Vice-President Hubert Humphrey phoning mayors to pressure resistant hospitals; and deployed hundreds of inspectors to make sure that participating hospitals integrated their wards. There was fury and acrimony. In the final weeks before Medicare's start, though, the hospitals decided to abandon segregation rather

than lose federal dollars. Only then was Medicare possible.

The health-reform bill that President Obama signed into law last week—the unmemorably named Patient Protection and Affordable Care Act—could prove as momentous as Medicare. Yet, because most of its provisions phase in more slowly than Medicare did, they are even more vulnerable to attack. The context, of course, is different. As Robert Blendon, of the Harvard School of Public Health, points out, the war against health reform in 2010 has not been an interest-group battle. The A.M.A. endorsed the legislation; hospital associations were supportive. Once the public option was dropped, most insurers favored the bill. The medical world will wage no civil resistance. This time, the threat comes from party politics. Conservatives are casting the November midterm elections as a vote on repealing the health-reform law. If they regain power, they are unlikely to repeal the whole thing. (No one is going to force children with preëxisting conditions back off their parents' health plans.) Instead, they will try to strip out the critical but less straightforwardly appealing elements of reform—the requirement that larger employers provide health benefits and that uncovered individuals buy at least a basic policy; the subsidies to make sure that they can afford those policies; the significant new taxes on household incomes over two hundred and fifty thousand dollars—and thereby gut coverage for the uninsured.

Opponents may also exploit the administrative difficulties of creating state insurance exchanges. The states have four years to prepare, and creating an exchange is, in theory, no more complicated than what states do in providing health-benefit options to public employees. Massachusetts, which has achieved near-universal coverage this way, had its exchange working in six months. Still, with fourteen state attorneys general already suing to stop parts of the reform, some states may refuse to coöperate, forcing a showdown.

The major engine of opposition, however, remains the insistence that health-care reform is unaffordable. The best way to protect reform, in turn, is to prove the skeptics wrong. In 1965, health care consumed just six per cent of U.S. economic output; today, the figure is eighteen per cent. Nearly all the gains that wage earners made over the past three decades have gone to paying for health care. Its costs are curtailing all other investments in the economy, and, if they continue to rise as they have been doing—twice as fast as inflation—the reform's subsidies, not to mention America's prosperity, will indeed prove unsustainable.

But the reform package emerged with a clear recognition of what is driving costs up: a system that pays for the quantity of care rather than the value of it. This can't continue. Recently, clinicians at Children's Hospital Boston adopted a more systematic approach for managing inner-city children who suffer severe asthma attacks, by introducing a bundle of preventive measures. Insurance would cover just one: prescribing an inhaler. The hospital agreed to pay for the rest, which included nurses who would visit parents after discharge and make sure that they had their child's medicine, knew how to administer it, and had a follow-up appointment with a pediatrician; home inspections for mold and pests; and vacuum cleaners for families without one (which is cheaper than medication). After a year, the hospital readmission rate for these patients dropped by more than eighty per cent, and costs plunged. But an empty hospital bed is a revenue loss, and asthma is Children's Hospital's leading source of admissions. Under the current system, this sensible program could threaten to bankrupt it. So far, neither the government nor the insurance companies have figured out a solution.

The most interesting, under-discussed, and potentially revolutionary aspect of the law is that it doesn't pretend to have the answers. Instead, through a new Center for Medicare and Medicaid Innovation, it offers to free communities and local health systems from existing payment rules, and let them experiment with ways to deliver better care at lower costs. In large part, it entrusts the task of devising cost-saving health-care innovation to communities like Boise and Boston and Buffalo, rather than to the drug and device companies and the public and private insurers that have failed to do so. This is the way costs will come down—or not.

That's the one truly scary thing about health reform: far from being a government takeover, it counts on local communities and clinicians for success. We are the ones to determine whether costs are controlled and health care improves—which is to say, whether reform survives and resistance is defeated. The voting is over, and the country has many other issues that clamor for attention. But, as L.B.J. would have recognized, the battle for health-care reform has only begun. ♦

ILLUSTRATION: TOM BACHTELL