INTRODUCTION
What We Talk About When We Talk About Health Reform

Lindsay F. Wiley

With appreciation to Raymond Carver,[1] this commentary explores the question: what do we talk about when we talk about health reform? The tile of the symposium published in this issue, *Next Steps in Health Reform*, and ASLME's aspiration to continue the *Next Steps* conference on a biannual basis beg another question: are we going to be talking about health reform forever?

When we talk about health, we talk about the United States as an outlier. U.S. health care expenditures per capita are the highest in the world, exceeding those of the second highest spender by more than 30%.[2] In spite of spending about twice as much on health care as other similarly situated countries,[3] the U.S. experiences below-average outcomes by most measures.[4] U.S. life expectancy is lower and growing more slowly than in other comparable countries.[5] Among its economic peers, the U.S. has the highest maternal mortality rate — nearly triple the rate of its closest rival — and the rate is increasing in the U.S. even as it declines in every other wealthy country.[6]

When we talk about health reform, we talk about whether access to health care and healthy living conditions is a right or an individual responsibility. Most other countries have made commitments to respect, protect, and fulfill the health-related needs of their populations through international human rights instruments and national constitutional provisions.[7] In countries with gross domestic product similar to that of the U.S., the right to health is secured in part through universal health care systems highly dependent on public financing[8] closely integrated with public health systems that assure the conditions required for people to be healthy.[9] In the U.S., however, health care remains first and foremost an economic good financed through a fragmentary system of public and private coverage subsidized to varying degrees. Access to high quality clinical care, healthy living conditions, and good health outcomes are among the prizes for doing well financially.

If we solve these problems, if we achieve universal coverage, strengthen the social safety net, and bring U.S. health care costs and outcomes into alignment with those of peer nations, will we be done talking about health reform? Probably not. Britain continues to grapple with the impacts of fiscal austerity on its National Health Service.[10] In a recent op-ed in the *New York Times*, "Why It's So Hard to Reform Canadian Health Care," Danielle Martin lamented:

About This Symposium

This symposium issue is the product of the 2017 Next Steps in Health Reform Conference. American University Washington College of Law launched the Next Steps in Health Reform conference in 2012 with a reprise in 2015. In 2017, in partnership with the American Society of Law, Medicine and Ethics (ASLME) and with support from our co-sponsors, American University School of Public Affairs, American University Kogod Business School, and the University of Toronto Institute for Health Policy, Management and Evaluation, we expanded the event to a three-day conference bringing together speakers and attendees from multiple disciplines, from the academy and practice, and from across the U.S. and Canada.

In 2018, ASLME's Board of Directors voted to continue the conference on a biannual basis, alternating with ASLME's other flagship biannual gathering, the Public Health Law Conference. Plans for Next Steps in Health Reform 2019 are underway. For updates, please visit https://www.wcl.american.edu/impact/initiatives-programs/health/healthreform.

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> More robust dialogue is needed to really tackle… important problems [in the Canadian health care system] — but the long American shadow chills our discussions. Fear of an American-style market-based system inhibits a national conversation about how to expand the breadth of coverage and increase the timeliness of services. Instead of talking about how to make our system better, we're talking about how much worse things are in the United States.[11]

Health reform is an ongoing, iterative process,[12] in this country and in others. There will always be, it seems, more steps needed to sustain health reform in the face of competing interests and priorities.

This is an incredibly dynamic time for the U.S. health care industry. Federal initiatives under the Affordable Care Act have reformed risk-based underwriting, expanded eligibility for publicly financed coverage under Medicaid,[13] made private insurance more accessible via subsidies and direct regulation,[14] and attempted to control costs.[15] The market is rapidly consolidating, at least partly in response to a fundamental shift in how we pay for goods and services that make up more than one-fifth of the U.S. economy.[16] Health care providers and payers are taking on new responsibility for health outcomes.[17]

Like previous transitions, implementation of the Affordable Care Act has prompted policymakers, legal practitioners, judges, health care providers, public health officials, researchers, and scholars to rethink the lenses through which they view the complex relationship between law and health and the role of the public's interest in health care. At the same time, friends and neighbors across the country are talking about our health system, who it serves, who it fails, and how we can do better. A recent *Washington Post* article about two West Virginia bus drivers included this moment:

> When it came to Trump or most national issues, they jousted, like cable-news combatants eased into armchairs.
>
> But on the issues they could influence, the ones that mattered the most in their lives, the two were in harmony. Cochran hated the Affordable Care Act and Black backed it. Now, their bodies failing, both men support universal health care.
>
> "I'll give a little more out of my paycheck for everyone to be covered," Black had said in an earlier discussion with Cochran.
>
> "Me too," Cochran had agreed. "We pay more every year to be told no."[18]

The political debate over the ACA — in living rooms and classrooms, in statehouses[19] and on Capitol Hill — continues. So far, the backlash against the ACA has been surprisingly ineffectual.[20] Even as public support for universal health care and more radical routes to achieve it (including public-option and single-payer plans) has grown, attacks on Medicaid (a bedrock of the U.S. health system) continue to mount.[21]

What we really talk about when we talk about health reform — whether we acknowledge it openly or bury it in the details — is justice. As Dan Beauchamp wrote in 1976, "[The dream] that preventable death and disability ought to be minimized is a dream of social justice."[22] But social justice is not the only game in town. Notions of market justice and actuarial fairness also lay claim to moral rectitude. The struggle to agree on the next steps in health reform surfaces deep anxieties about our mutual interdependence and shared vulnerability. Which conditions should trigger a community response? Who is part of the community? Who should be the givers and takers and what should they be expected to give and take? Public discourse grappling with these questions has taken on a new tone of conciliation and goodwill in the past year. Friends and neighbors who disagree about so many other things are finding at least one point of agreement: the way things are now is not working.[23] As Ed Sparer wrote in 1984, "the very struggle to reconstruct health care, organized along mutual aid lines which stress cooperative and caring relations, helps to provide a grace…and character to society and to each person who struggles for it."[24] With gratitude for the many brilliant, committed colleagues I have the privilege of working with in this endeavor, many of whom have contributed to this symposium, I am ready to talk about health reform for the foreseeable future.

Note

The author has no conflicts to declare.

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