

We must all hang together or assuredly  
we shall all hang separately.

—Benjamin Franklin

# Solidarity

## *Unfashionable, But Still American*

WILLIAM M. SAGE

Illness, we are often told, is a private matter. Accordingly, none must interfere in the medical decisions that emerge from the confidential relationship between physician and patient. Yet evidence of interdependence is ubiquitous in health care. One person's malady can harm families, workplaces, clubs, churches, and sometimes entire communities. Similarly, a suffering patient must rely on many individuals, associational groups, corporate entities, and government agencies for support and assistance. It is, therefore, unsurprising that various social units claim an interest and a voice in maintaining health and treating disease.

However, explicit solidarity has long been out of vogue in America's value system, despite persistent lack of affordable medical care. Instead, the public has prized scientific innovation, consumer sovereignty, and personal autonomy, and has installed physicians as benevolent oligarchs to oversee these functions. The resulting system delivers idiosyncratic care at enormous expense to most Americans, while a sizable minority often goes without.

Calls for solidarity in American health care reach receptive ears mainly when spoken in fear—recently of pandemic disease, bioterrorism, and natural disaster. Although crisis is a perpetual and therefore meaningless adjective in health policy debates, calamity seems to breed togetherness. Foxholes tend to convert libertarians into communitarians as well as atheists into believers. Special

concern is provoked by novel pathogens, runaway technologies, and random, large-scale events.

The economic downturn, with its emerging consensus that something must be done to universalize the U.S. health care system, presents an unexpected opportunity to revisit health solidarity. Whether hard economic times are sufficiently calamitous to become a unifying force remains to be seen. If so, we should be grateful that the streets are littered merely with dead businesses, not with dead bodies, and that toxic assets rather than toxic agents are responsible.

Beyond these base emotions, one can identify three sources of solidarity that reflect American society's better nature. I shall call them mutual assistance, patriotism, and coordinated investment.

### **Mutual Assistance**

Mutual assistance rooted in both compassion and expectation of reciprocity accounts for the bulk of U.S. health solidarity. Misfortune attributable to chance or resulting inevitably from the passage of time—not temptation or moral failing—typically triggers collective support to prevent avoidable deaths, ameliorate suffering, and save victims' families from impoverishment.

Sharing the financial risk of poor health can be accomplished through processes of varying formality, ranging from charitable campaigns (such as donations to hospitals) to means-tested entitlements (Medicaid) to full-blown social insurance (Medicare Part A). These efforts openly redistribute wealth but greatly assist recipients

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*William M. Sage, MD, JD, is vice provost for health affairs and James R. Dougherty Chair for Faculty Excellence at the University of Texas in Austin.*

and, at least for voluntary charity, enhance the well-being of donors. Health is a natural area for mutual aid because those contributing believe that those receiving aid are seriously ill and thus have no higher use for resources than medical care. This mitigates concerns that aid might discourage self-help and promote welfare dependency. Mutual assistance is strongest when donors can identify with potential beneficiaries; nations with the most generous social insurance programs tend to be those that are demographically homogeneous.

Mutual assistance occurs in private health insurance as well as public programs. Group rates for employment-based coverage redistribute resources from healthier to sicker members of workplace risk pools. Americans readily accept this mode of mutual support because they identify with fellow workers. It is undoubtedly made more palatable by the selective subsidy awarded employee benefit plans under the federal tax code, by lack of transparency regarding the magnitude of the transfer, and by the widely credited fiction that the money involved is the employer's rather than the employees'.

Similarly, Americans routinely empower health care providers to make decisions about how to distribute shared resources because they can imagine lives being saved. A seldom-noted aspect of the backlash against managed care derived from perceptions that HMOs were converting otherwise acceptable cross-subsidies into corporate profits and thereby depriving the health care system of needed funds. Historically, physicians charged higher fees to wealthy patients and offered free service to poor ones, a practice that eventually yielded to the bureaucratic constraints of government programs and lack of equal charity from suppliers of necessary diagnostic and therapeutic complements. Nonprofit hospitals continue to redistribute in this fashion, reflecting the social mission assigned them by their constituents and the insistence of the taxing authorities

that charity care should be the touchstone for “community benefit.”

### **Patriotism**

**P**atriotism is a less common source of interconnectedness in American health care. America's commitment to tolerance and liberal pluralism is very effective at creating associational groups with shared values, which in health care spawns agendas as diverse as those of the American Cancer Society, the Hemlock Society, Physicians for Human Rights, and the Association of American Physicians and Surgeons. But it is not very effective at motivating large national projects during peacetime.

*The severity of the economic downturn—and the aggressive response it has provoked—creates an opportunity to overcome entrenched political positions and recalibrate public values in support of solidarity.*

Building loyalty to centralized governments, fostering political stability, and avoiding class warfare—the conventional explanations for the welfare states of Western Europe—seem unnecessary given our long-standing federal union, our melting-pot heritage, and our belief that continued upward mobility serves as a social safety valve. Even in post-cold war America, compulsory redistribution to achieve explicit ideological goals of equality in health care access sounds disturbingly Soviet (“from each according to his ability, to each according to his need”). Accusations of “socialized medicine,” most recently hurled by former New York City Mayor Rudy Giuliani during his brief 2008 presidential campaign, retain rhetorical impact because we continue to fear state intrusion into intimate personal and family decisions.

America's preference for low taxation further discourages a collectivist political orientation. Proposals for government to assume responsibility

for health care are widely perceived as fiscal power plays—schemes not only to raise revenue, but also to divert private spending on health into other, unspecified government projects. Many Americans suspect that the inevitable result would be reduced investment in facilities and innovation, quality reductions, supply constraints, and rationing. These concerns are reinforced by the American medical profession—a grass roots army of talented small businesspeople who, with fierce conviction if little historical justification, continue to construe their social prominence and financial success as the result of rugged individualism rather than

sheltered competition and lavish public subsidy.

Nevertheless, patriotism partially motivates several core features in the U. S. health care system. Those who render military service to the nation are repaid in part with health care: the Veterans Health Administration is the largest component of the Department of Veterans Affairs and provides lifetime benefits to millions of individuals. The enactment of Medicare can be viewed similarly, as health security to compensate generations of Americans who worked through two world wars and the Great Depression and who became old and infirm during the sustained period of peace and prosperity that followed. As evidenced by the temporal connection between Medicaid and the civil rights movement, patriotism to redress prior regional and national discrimination can also generate health solidarity.

## Coordinated Investment

A third source of health solidarity is a loosely organized but potentially powerful array of coordinated investments that Americans can make to safeguard and advance their futures. The objective of these activities is to increase overall welfare, not to define citizenship or to redistribute resources from better- to worse-off. Traditional public health functions fall into this category. Epidemics and disasters generate widespread willingness both to contribute funds and to submit to physical restrictions in order to prevent additional physical harm and to keep critical infrastructure functioning.

Equally important is reducing spillover economic harm through prevention and control of noncommunicable chronic diseases—many of which derive from smoking, poor nutrition, and lack of physical activity. Unconstrained government spending on chronic disease crowds out other productive uses of public funds. The burden of chronic disease also diminishes both near-term workplace productivity and long-term prospects for overall economic growth. This collective project is a more controversial exercise of government authority because, at first glance, interventions appear aimed at protecting individuals from the consequences of their own conduct rather than someone else's. However, research on social networking reveals that many chronic health conditions are “communicable” through shared norms, and that improved design of workplaces, schools, and communities can alter common environments and reduce risk factors.

The production of medical knowledge as a public good is another established form of coordinated investment, as is support for hospital construction, education of health professionals, and patenting of biomedical technology (at least following the enactment in 1980 of the Bayh-Dole Act, which encouraged commercialization of publicly sup-

ported research). Surprisingly, far fewer resources have been directed at improving the productivity of health care providers on the assumption that professional self-governance and market discipline are sufficient to generate and disseminate best practices. Recently, however, policy-makers have come to understand that decades of regulation and subsidy have artificially fragmented health care delivery and rewarded unproductive behavior, rekindling interest in public support for health informatics and comparative effectiveness research.

A final, widely accepted justification for coordinated investment in health care is the elimination of waste. Reducing “waste, fraud, and abuse” in Medicare has maintained universal political appeal for decades while, unfortunately, providing little actual relief from persistent growth in expenditures. Today's proponents of tax-financed universal health coverage argue, somewhat more persuasively, that leaving a large percentage of the U.S. population uninsured reduces access to cost-effective primary care, wastes expensive emergency services, and misses opportunities to prevent, detect, and offer timely treatment for disease. In Texas, for example, the most marketable argument for health reform among the general public is that roughly \$1,500 of the annual premium paid by each insured family is spent on care for the uninsured. The risk of this approach, of course, is that voter sentiment could turn from “please spend my money more wisely” to “please give me my money back.”

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### ★ Policy Implications ★

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Many strands of social solidarity exist in American health policy, even if an explicit commitment to universal health coverage continues to elude us. The severity of the economic downturn—and the aggressive response it has provoked—create an opportunity to overcome entrenched

political positions and recalibrate public values in support of solidarity. In my view, however, three barriers must be removed in order to create a more accessible, affordable, and productive health care system.

First, federal fiscal politics cannot continue to impede collective investment in restructuring health care—an investment that will almost certainly have a large long-term payoff. In addition to funding the marginal costs of expanding coverage, the trillion dollars or so that have been committed as economic stimulus can provide the activation energy (in both knowledge and infrastructure) necessary to transition the health care delivery system to a new, more efficient equilibrium.

Second, “medical individualism” cannot be allowed to paralyze the debate. Americans have built a mental wall between supporting aggregate change and resisting personal change that entrenched interests exploit by portraying every serious reform proposal as a threat to one's own care or the care of one's family. Effective reform must connect individual services to population health at as many junctures as possible.

Third, health is a major component of America's long-term creditworthiness and prosperity in both our public and private sectors. Industry stakeholders must accept that those who receive government support in these difficult times cannot merely continue business as usual, and the general public must agree that the stakes justify shared sacrifice and require sustained commitment to a common purpose. ★