IS HEALTH CARE A RIGHT?

It's a question that divides Americans. But it's possible to find common ground, too.

BY ATUL GAWANDE

Is health care a right? The United States remains the only developed country in the world unable to come to agreement on an answer. Earlier this year, I was visiting Athens, Ohio, the town in the Appalachian foothills where I grew up. The battle over whether to repeal, replace, or repair the Affordable Care Act raged then, as it continues to rage now. So I began asking people whether they thought that health care was a right. The responses were always interesting.

A friend had put me in touch with a forty-seven-year-old woman I'll call Maria Dutton. She lived with her husband, Joe, down a long gravel driveway that snaked into the woods off a rural road. "You may feel like you are in the movie 'Deliverance,'" she said, but it wasn't like that at all. They had a tidy, double-wide modular home with flowered wallpaper, family pictures on every surface, a vase of cut roses on a sideboard, and an absurdly friendly hound in the yard. Maria told me her story sitting at the kitchen table with Joe.

She had joined the Army out of high school and married her recruiter—Joe is eleven years older—but after a year she had to take a medical discharge. She had developed severe fatigue, double vision, joint and neck pains, and muscle weakness. At first, doctors thought that she had multiple sclerosis. When that was ruled out, they were at a loss. After Joe left the military, he found steady, secure work as an electrical technician at an industrial plant nearby. Maria did secretarial and office-manager jobs and had a daughter. But her condition worsened, and soon she became too ill to work.

"I didn't even have enough energy to fry a pound of hamburger," she said. "I'd have to fry half of it and then sit down, rest, and get up and fry the rest. I didn't have enough energy to vacuum one room of the house." Eventually, she was diagnosed with chronic-fatigue syndrome and depression. She became addicted to the opioids prescribed for her joint pains and was started on methadone. Her liver began to fail. In 2014, she was sent two hundred miles away to the Cleveland Clinic for a liver-transplant evaluation. There, after more than two decades of Maria's deteriorating health, doctors figured out what the problem was: sarcoidosis, an inflammatory condition that produces hardened nodules in organs throughout the body. The doctors gave her immunosuppressive medication, and the nodules shrank away. Within a year, she had weaned herself off the methadone.

"It was miraculous," she said. In middle age, with her daughter grown up and in the Army Reserves herself, Maria got her life back and returned to school. All along, she'd had coverage through her husband's work. "They have amazing insurance," she said. "I think one year the insurance paid out two hundred thousand dollars. But we paid out, too."

This was an understatement. Between a six-thousand-dollar deductible and hefty co-pays and premiums, the Duttons' annual costs reached fifteen thousand dollars. They were barely getting by. Then one day in 2001 Joe blacked out, for no apparent reason, at a Girl Scout meeting for their daughter and fell down two flights of stairs, resulting in a severe concussion. It put him out of work for six months. Given the healthcare costs and his loss of income, the couple ran out of money.

"We had to file for bankruptcy," Joe said. He told me this reluctantly. It took them more than five years to dig out of the hole. He considered the bankruptcy "pretty shameful," he said, and had told almost no one about it, not even his family. (This was why they didn't want me to use their names.) He saw it as a personal failure—not the government's. In fact, the whole idea that government would get involved in the financing of health care bothered him. One person's right to health care becomes another person's burden to pay for it, he said. Taking other people's money had to be justified, and he didn't see how it could be in cases like this.

"Everybody has a right to access health care," he allowed, "but they should be contributing to the cost." He pointed out that anyone could walk into a hospital with an emergency condition, get treated, and be billed afterward. "Yes, they may have collectors coming after them," he said. "But I believe everybody should contribute for the treatment they receive."

Like her husband, Maria leans conservative. In the 2016 election, Joe voted for Donald Trump. Maria voted for Gary Johnson, the Libertarian candidate. But on health care she was torn. Joe wanted Obamacare repealed. She didn't.

"I am becoming more liberal," she said. "I believe that people should be judged by how they treat the least of our society." At her sickest, she had been one of them. But she was reluctant to say that health care is a right. "There's where the conservative side comes in and says, 'You know what? I work really hard. I deserve a little more than the guy who sits around.'"

A right makes no distinction between the deserving and the undeserving, and that felt perverse to Maria and Joe. They both told me about people they know who don't work and yet get Medicaid coverage with no premiums, no deductibles, no co-pays, no costs at all—coverage that the Duttons couldn't dream of.

"I see people on the same road I live on who have never worked a lick in their life," Joe said, his voice rising. "They're living on disability incomes, and they're healthier than I am." Maria described a relative who got disability payments

A right doesn't distinguish between the deserving and the undeserving, and, for many in my Ohio home town, that rankled.

ILLUSTRATION BY GEOFF McFETRIDGE

and a Medicaid card for a supposedly bad back, while taking off-the-books roofing jobs.

"Frankly, it annoys the crap out of me—they're nothing but grasshoppers in the system," Joe said, recalling the fable about the thriftless grasshopper and the provident ant.

The Duttons were doing all they could to earn a living and pay their taxes—taxes that helped provide free health care for people who did nothing to earn it. Meanwhile, they faced thousands of dollars in medical bills themselves. That seemed wrong. And in their view government involvement had only made matters worse.

"My personal opinion is that anytime the government steps in and says, 'You must do this,' it's overstepping its boundaries," Joe said. "A father, mother, two kids working their asses off—they're making minimum wage and are barely getting by—I have no problem helping them. If I have someone who's spent his whole life a drunk and a wastrel, no, I have no desire to help. That's just the basics."

Such feelings are widely shared. They're what brought the country within a single vote of repealing major parts of President Obama's expansion of health-care coverage. Some people see rights as protections provided by government. But others, like the Duttons, see rights as protections from government.

Tim Williams, one of my closest childhood friends, disagreed with the Duttons. Tim is a quiet fifty-two-year-old with the physique of a bodybuilder—he once bench-pressed me when we were in high school—and tightly cropped gray hair that used to be flame red. He survived metastatic melanoma, in the nineties, and losing his job selling motorcycles, during the great recession. He went through a year of chemotherapy and, later, three years without a job. He can figure out how to fix and build almost anything, but, without a college degree, he had few employment options. Hundreds of job applications later, though, he was hired as an operator at our town's water-treatment plant, where I visited him.

The plant was built in the nineteen-fifties. We walked among giant pipes and valves and consoles that controlled the flow of water from local ground wells through a series of huge pools for filtration, softening, and chlorination, and out to the water towers on the tallest ridges surrounding the town. The low hum of the pump motors churned in the background.

People don't think about their water, Tim said, but we can't live without it. It is not a luxury; it's a necessity of human existence. An essential function of government, therefore, is to insure that people have clean water. And that's the way he sees health care. Joe wanted government to step back; Tim wanted government to step up. The divide seemed unbridgeable. Yet the concerns that came with each viewpoint were understandable, and I wondered if there were places where those concerns might come together.

Before I entered the field of public health, where it's a given that health care is a right and not a privilege, I had grown up steeped in a set of core Midwestern beliefs: that you can't get something for nothing, and that you should be reluctant to impose on others and, likewise, to be imposed upon. Here self-reliance is a totemic value. Athens, Ohio, is a place where people brew their own beer, shoot their own deer, fix their own cars (also grow their own weed, fight their own fights, get their own revenge). People here are survivors.

Monna French was one. She was fifty-three years old and the librarian at Athens Middle School. She'd been through a lot in life. She had started a local taxi company with her first husband, but they couldn't afford health insurance. When she gave birth to her daughter Maggie and then to her son, Mac, the couple had to pay cash, pray that there'd be no unaffordable complications, and try to leave the hospital the next morning to avoid extra charges. When Monna and her husband divorced, litigation over the business left her with no income or assets.

"I had twenty-six dollars, two kids, and a cat," she said.

She held down five part-time jobs, working as a teaching assistant for three different schools during the day, bartending at night, and selling furniture at Odd Lots department store on weekends, while her parents helped with the kids. Finally, she got the librarian job. It was classified as clerical work and didn't pay well. But it meant that her family had health insurance, and a roof over their heads. She also met Larry, an iron worker and Vietnam veteran, who became her second husband. He had two children, but he was older and they were grown. Together, Monna and Larry had a child of their own, named Macie. Then, thirteen years ago, Maggie, at age sixteen, was killed in a car accident. Seven years ago, Larry's son, Eric, who had spina bifida and multiple medical needs, died suddenly in his sleep, at the age of forty.

After twenty-two years as a librarian, Monna still makes only sixteen dollars and fifty cents an hour. Her take-home pay is less than a thousand dollars a month, after taxes and health-insurance contributions. Her annual deductible is three thousand dollars. Larry, now seventy-four, has retired, and his pension, military benefits, and Medicare helped keep them afloat.

For all her struggles, though, Monna is the kind of person who is always ready to offer a helping hand. When I visited her, there were stacks of posters on her porch, printed for a fund-raiser she was organizing for her daughter's high-school marching band. She raised money for her township's volunteer fire brigade. She was the vice-president of her local union,

one of the largest in the county, which represents school-bus drivers, clerical staff, custodians, and other non-certified workers. She'd been deeply involved in contract negotiations to try to hold on to their wages and health benefits in the face of cutbacks.

"I don't know anything about health care," she protested when I asked her for her thoughts on the subject. In fact, she knew a lot. And, as she spoke, I thought I glimpsed a place where the health-care divide might just allow a bridge.

Monna considered herself a conservative. The notion of health care as a right struck her as another way of undermining work and responsibility: "Would I love to have health insurance provided to me and be able to stay home?" Of course, she said. "But I guess I'm going to be honest and tell you that I'm old school, and I'm not really good at accepting anything I don't work for."

She could quit her job and get Medicaid free, she pointed out, just as some of her neighbors had. "They have a card that comes in the mail, and they get everything they need!" she said. "Where does it end? I mean, how much responsibility do tax-paying people like me have? How much is too much?" She went on, "I understand that there's going to be a percentage of the population that we are going to have to provide for." When she was a young mother with two children and no home, she'd had to fall back on welfare and Medicaid for three months. Her stepson, Eric, had been on Medicaid and Social Security Disability Insurance before he died. Her eighty-three-year-old mother, who has dementia and requires twenty-four-hour care, was also on Medicaid. "If you're disabled, if you're mentally ill, fine, I get it," Monna said. "But I know so many folks on Medicaid that just don't work. They're lazy." Like the Duttons, she felt that those people didn't deserve what they were getting.

But then we talked about Medicare, which provided much of her husband's health care and would one day provide hers. That was different, Monna told me. Liberals often say that conservative voters who oppose government-guaranteed health care and yet support Medicare are either hypocrites or dunces. But Monna, like almost everyone I spoke to, understood perfectly well what Medicare was and was glad to have it.

I asked her what made it different.

"We all pay in for that," she pointed out, "and we all benefit." That made all the difference in the world. From the moment we earn an income, we all contribute to Medicare, and, in return, when we reach sixty-five we can all count on it, regardless of our circumstances. There is genuine reciprocity. You don't know whether you'll need more health care than you pay for or less. Her husband thus far has needed much less than he's paid for. Others need more. But we all get the same deal, and, she felt, that's what makes it O.K.

"I believe one hundred per cent that Medicare needs to exist the way it does," she said. This was how almost everyone I spoke to saw it. To them, Medicare was less about a universal right than about a universal agreement on how much we give and how much we get.

Understanding this seems key to breaking the current political impasse. The deal we each get on health care has a profound impact on our lives—on our savings, on our well-being, on our life expectancy. In the American health-care system, however, different people get astonishingly different deals. That disparity is having a corrosive effect on how we view our country, our government, and one another.

The Oxford political philosopher Henry Shue observed that our typical way of looking at rights is incomplete. People are used to thinking of rights as moral trump cards, near-absolute requirements that all of us can demand. But, Shue argued, rights are as much about our duties as about our freedoms. Even the basic right to physical security—to be free of threats or harm—has no meaning without a vast system of police departments, courts, and prisons, a system that requires extracting large amounts of money and effort from others. Once costs and mechanisms of implementation enter the picture, things get complicated. Trade-offs now have to be considered. And saying that something is a basic right starts to seem the equivalent of saying only, "It is very, very important."

Shue held that what we really mean by "basic rights" are those which are necessary in order for us to enjoy any rights or privileges at all. In his analysis, basic rights include physical security, water, shelter, and health care. Meeting these basics is, he maintained, among government's highest purposes and priorities. But how much aid and protection a society should provide, given the costs, is ultimately a complex choice for democracies. Debate often becomes focussed on the scale of the benefits conferred and the costs extracted. Yet the critical question may be how widely shared these benefits and costs are.

Arnold Jonas is another childhood friend of mine. Blond, ruddy-faced, and sporting a paunch at fifty-two, he has rarely had a nine-to-five job and isn't looking for one. The work he loves is in art and design—he once designed a project for the Smithsonian—but what usually pays the bills is physical labor or mechanical work. He lives from paycheck to paycheck. ("Retirement savings? Ha! You're funny, Atul.") Still, he has always known how to take care of himself. "I own my house," he told me. "I have no debts."

This is a guy who's so handy that the cars he drives are rehabbed wrecks rebuilt from spare parts—including the old Volvo that he drove to the strip-mall Mexican restaurant near my family's house, where we were catching up. But when I asked him about health care he could only shake his head.

"I just try not to think about it," he said. He hadn't seen a doctor in at least a decade. He got a health-care plan through an insurance-agent friend, but could only afford one with minimal benefits. He wasn't sure whether he'd got an Obamacare subsidy. "I don't read the fine print, because it's going to be completely confusing anyway." All he knew was that the plan cost him a hundred and ten dollars a month, and the high deductible (however many thousands of dollars it was, it was well beyond his savings account) made doctors' visits almost out of the question.

"I am lucky I can get my teeth looked at because I'm dating a dental hygienist. But"—here he showed me his white-toothed grin—"I can't date a dental hygienist *and* a cardiologist."

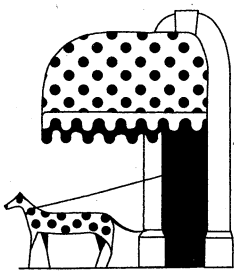
Arnold, with his code of self-reliance, had eliminated nearly all sources of insecurity from his life. But here was one that

was beyond his control. "The biggest worry I have would be some sort of health-care need," he said. A serious medical issue would cost him his income. As an independent contractor, he isn't eligible for unemployment benefits. And, having passed the age of fifty, he was just waiting for some health problem to happen.

So did he feel that he had a right to health care? No. "I never thought about it as a matter of rights," he said. "A lot of these things we think are rights, we actually end up paying for." He thinks that the left typically plays down the reality of the costs, which drives him crazy. But the right typically plays down the reality of the needs, which drives him crazy, too.

In his view, everyone has certain needs that neither self-reliance nor the free market can meet. He can fix his house, but he needs the help of others if it catches fire. He can keep his car running, but he needs the help of others to pave and maintain the roads. And, whatever he does to look after himself, he will eventually need the help of others for his medical care.

"I think the goal should be security," he said of health care. "Not just financial security but mental security—knowing that, no matter how bad things get, this shouldn't be what you worry about. We don't worry about the Fire Department, or the police. We don't worry about the roads we travel on. And it's not, like, 'Here's the traffic lane for the ones who did well and saved money, and you poor people, you have to drive over here.' " He went on, "Somebody I know said to me, 'If we give everybody health care, it'll be abused.' I told her that's a risk we take. The roads are abused. A lot of things are abused. It's part of the deal."



He told me about a friend who'd undergone an emergency appendectomy. "She panicked when she woke up in the hospital realizing it would cost her a fortune," he said. "Think about that. A lot of people will take a crappy job just to get the health benefits rather than start an entrepreneurial idea. If we're talking about tax breaks for rich people to create jobs and entrepreneurialism, why not health care to allow regular people to do the same thing?"

As he saw it, government existed to provide basic services like trash pickup, a sewer system, roadways, police and fire protection, schools, and health care. Do people have a *right* to trash pickup? It seemed odd to say so, and largely irrelevant. The key point was that these necessities can be provided only through collective effort and shared costs. When people get very different deals on these things, the pact breaks down. And that's what has happened with American health care.

The reason goes back to a seemingly innocuous decision made during the Second World War, when a huge part of the workforce was sent off to fight. To keep labor costs from skyrocketing, the Roosevelt Administration imposed a wage freeze. Employers and unions wanted some flexibility, in order to attract desired employees, so the Administration permitted increases in health-insurance benefits, and made them tax-exempt. It didn't seem a big thing. But, ever since, we've been trying to figure out how to cover the vast portion of the country that doesn't have employer-provided health insurance: low-wage workers, children, retirees, the unemployed, small-business owners, the self-employed, the disabled. We've had to stitch together different rules and systems for each of these categories, and the result is an unholy, expensive mess that leaves millions unprotected.

No other country in the world has built its health-care system this way, and, in the era of the gig economy, it's becoming only more problematic. Between 2005 and 2015, according to analysis by the economists Alan Krueger and Lawrence Katz, ninety-four per cent of net job growth has been in "alternative work arrangements"—freelancing, independent contracting, temping, and the like—which typically offer no health benefits. And we've all found ourselves battling over who deserves less and who deserves more.

The Berkeley sociologist Arlie Russell Hochschild spent five years listening to Tea Party supporters in Louisiana, and in her masterly book "Strangers in Their Own Land" she identifies what she calls the deep story that they lived and felt. Visualize a long line of people snaking up a hill, she says. Just over the hill is the American Dream. You are somewhere in the middle of that line. But instead of moving forward you find that you are falling back. Ahead of you, people are cutting in line. You see immigrants and shirkers among them. It's not hard to imagine how infuriating this could be to some, how it could fuel an America First ideal, aiming to give pride of place to "real" Americans and demoting those who would undermine that identity—foreigners, Muslims, Black Lives Matter supporters, feminists, "snowflakes."

Our political debates seem to focus on what the rules should be for our place in line. Should the most highly educated get to move up to the front? The most talented? Does seniority matter? What about people whose ancestors were cheated and mistreated?

The mistake is accepting the line, and its dismal conception of life as a zero-sum proposition. It gives up on the more encompassing possibilities of shared belonging, mutual loyalty, and collective gains. America's founders believed these possibilities to be fundamental. They held life, liberty, and the pursuit of happiness to be "unalienable rights" possessed equally by all members of their new nation. The terms of membership have had to be rewritten a few times since, sometimes in blood. But the aspiration has endured, even as what we need to fulfill it has changed.

When the new country embarked on its experiment in democracy, health care was too primitive to matter to life or liberty. The average citizen was a hardscrabble rural farmer who lived just forty years. People mainly needed government to insure physical security and the rule of law. Knowledge and technology, however, expanded the prospects of life and liberty, and, accordingly, the requirements of government. During the next two centuries, we relied on government to establish a system of compulsory public education, infrastructure for everything from running water to the electric grid, and old-age pensions, along with tax systems to pay for it all. As in other countries, these programs were designed to be universal. For the most part, we didn't divide families between those who qualified and those who didn't, between participants and patrons. This inclusiveness is likely a major reason that these policies have garnered such enduring support.

Health care has been the cavernous

exception. Medical discoveries have enabled the average American to live eighty years or longer, and with a higher quality of life than ever before. Achieving this requires access not only to emergency care but also, crucially, to routine care and medicines, which is how we stave off and manage the series of chronic health issues that accumulate with long life. We get high blood pressure and hepatitis, diabetes and depression, cholesterol problems and colon cancer. Those who can't afford the requisite care get sicker and die sooner. Yet, in a country where pretty much everyone has trash pickup and K-12 schooling for the kids, we've been reluctant to address our Second World War mistake and establish a basic system of health-care coverage that's open to all. Some even argue that such a system is un-American, stepping beyond the powers the Founders envisioned for our government.

"He spent the last half hour trying to piratesplain sea shanties to me."

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In fact, in a largely forgotten episode in American history, Thomas Jefferson found himself confronting this very matter, shortly after his Inauguration as our third President, in 1801. Edward Jenner, in England, had recently developed a smallpox vaccine—a momentous medical breakthrough. Investigating the lore that milkmaids never got smallpox, he discovered that material from scabs produced by cowpox, a similar condition that afflicts cattle, induced a mild illness in people that left them immune to smallpox. Smallpox epidemics came with a mortality rate of thirty per cent or higher, and wiped out upward of five per cent of the population of cities like Boston and New York. Jefferson read Jenner's report and arranged for the vaccination of two hundred relatives, neighbors, and slaves at Monticello. The President soon became vaccination's preëminent American champion.

But supplies were difficult to produce, and the market price was beyond the means of most families. Jefferson, along with his successor, James Madison, believed in a limited role for the federal government. They did not take expanding its power and its commitments lightly. By the time Jefferson finished his two terms as President, however, city and state governments had almost entirely failed to establish programs to provide vaccines for their citizens. Thousands of lives continued to be lost to smallpox outbreaks. Meanwhile, vaccination programs in England, France, and Denmark had dramatically curbed the disease and measurably raised the national life expectancy. So, at Jefferson's prompting, and with Madison's unhesitating support, Congress passed the Vaccine Act of 1813 with virtually no opposition. A National Vaccine Agent was appointed to maintain stocks of vaccine and supply it to any American who requested it. The government was soon providing free vaccine for tens of thousands of people each year. It was the country's first health-care entitlement for the general population. And its passage wasn't in the least controversial.

Two centuries later, the Affordable Care Act was passed to serve a similar purpose: to provide all Americans with access to the life-preserving breakthroughs of our own generation. The law narrowed the yawning disparities in access to care, levied the taxes needed to pay for it, and measurably improved the health of tens of millions. But, to win passage, the A.C.A. postponed reckoning with our generations-old error of yoking health care to our jobs—an error that has made it disastrously difficult to discipline costs and insure quality, while severing care from our foundational agreement that, when it comes to the most basic needs and burdens of life and liberty, all lives have equal worth. The prospects and costs for health care in America still vary wildly, and incomprehensibly, according to your job, your state, your age, your income, your marital status, your gender, and your medical history, not to mention your ability to read fine print.

Few want the system we have, but many fear losing what we've got. And we disagree profoundly about where we want to go. Do we want a single, nationwide payer of care (Medicare for all), each state to have its own payer of care (Medicaid for all), a nationwide marketplace where we all choose among a selection of health plans (Healthcare.gov for all), or personal accounts that we can use to pay directly for health care (Health Savings Accounts for all)? Any of these can work. Each has been made to work universally somewhere in the world. They all have their supporters and their opponents. We disagree about which benefits should be covered, how generous the financial protection should be, and how we should pay for it. We disagree, as well, about the trade-offs we will accept: for instance,

between increasing simplicity and increasing choice; or between advancing innovation and reducing costs.

What we agree on, broadly, is that the rules should apply to everyone. But we've yet to put this moral principle into practice. The challenge for any plan is to avoid the political perils of a big, overnight switch that could leave many people with higher costs and lower benefits. There are, however, many options for a gradual transition. Just this June, the Nevada legislature passed a bill that would have allowed residents to buy into the state's Medicaid plan—if the governor hadn't vetoed it. A similar bill to allow people to buy into Medicare was recently introduced in Congress. We need to push such options forward. Maintaining the link between health coverage and jobs is growing increasingly difficult, expensive, and self-defeating. But deciding to build on what's currently working requires overcoming a well of mistrust about whether such investments will really serve a shared benefit.

My friend Betsy Anderson, who taught eighth-grade English at Athens Middle School for fifteen years, told me something that made me see how deep that well is. When she first started out as a teacher, she said, her most satisfying experiences came from working with eager, talented kids who were hungry for her help in preparing them for a path to college and success. But she soon realized that her class, like America as a whole, would see fewer than half of its students earn a bachelor's degree. Her job was therefore to try to help all of her students reach their potential—to contribute in their own way and to pursue happiness on their own terms.

But, she said, by eighth grade profound divisions had already been cemented. The honors kids—the Hillary Clintons and Mitt Romneys of the school—sat at the top of the meritocratic heap, getting attention and encouragement. The kids with the greatest needs had special-education support. But, across America, the large mass of kids in the middle—the ones without money, book smarts, or athletic prowess—were outsiders in their own schools. Few others cared about what they felt or believed or experienced. They were the unspecial and unpromising, looked down upon by and almost completely separated from the college-bound crowd. Life was already understood to be a game of winners and losers; they were the designated losers, and they resented it. The most consistent message these students had received was that their lives were of less value than others'. Is it so surprising that some of them find satisfaction in a politics that says, essentially, Screw 'em all?

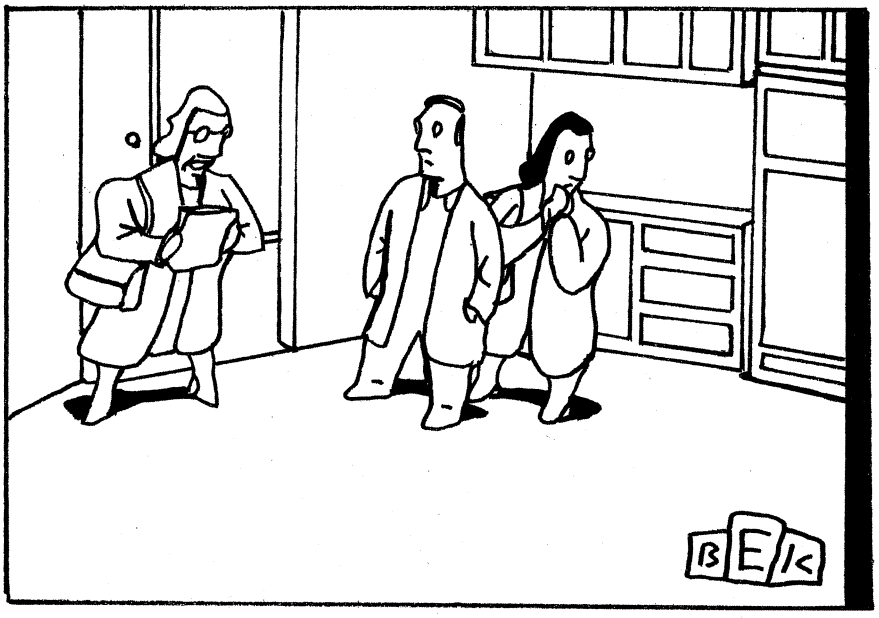
I met with Mark, a friend of Arnold's, at the Union Street Diner, uptown near the campus of Ohio University, which makes Athens its home. The diner was a low-key place that stayed open twenty-four hours, with Formica tables and plastic cups, and a late-night clientele that was a mixture of townies and drunken students. I ordered a cheeseburger and onion rings. Mark ordered something healthier. (He asked me not to use his last name.) The son of a state highway patrolman, he had graduated from Athens High School five years ahead of me. Afterward, he worked as a cable installer, and got married at twenty-three. His wife worked at the Super Duper grocery store. Their pay was meagre and they were at the mercy of their bosses. So, the next year, they decided to buy a convenience store on the edge of town.

Mark's father-in-law was a builder, and he helped them secure a bank loan. They manned the register day and night, and figured out how to make a decent living. It was never a lot of money, but over time they built up the business, opening gas pumps, and hiring college students to work the counter part time. They were able to make a life of it.

They adopted a child, a boy who was now a twenty-five-year-old graduate of the local university. Mark turned fifty-seven and remained a lifelong conservative. In general, he didn't trust politicians. But he felt that Democrats in particular didn't seem to recognize when they were pushing taxes and regulations too far. Health-care reform was a prime example. "It's just the whole time they were coming up with this idea from copying some European model," he said. "And I'm going, 'Oh shit. This is not going to end up good for Mark.'" (Yes, he sometimes talks about himself in the third person.)

For his health coverage, Mark trusted his insurance agent, whom he'd known for decades, more than he trusted the government. He'd always chosen the minimum necessary, a bare-bones, high-deductible plan. He and his wife weren't able to conceive, so they didn't have to buy maternity or contraceptive coverage. With Obamacare, though, he felt forced to pay extra to help others get benefits that he'd never had or needed. "I thought, Well, here we go, I guess I'm now kicking in for Bill Gates's daughter's pregnancy, too." He wanted to keep government small and taxes low. He was opposed to Obamacare.

Then, one morning a year ago, Mark's back started to hurt. "It was a workday. I grabbed a Tylenol and I go, 'No, this



"And it's just a ten-minute walk to much nicer apartments."

isn't going to work, the pain's too weird.'" It got worse, and when the pain began to affect his breathing he asked his wife to drive him to the emergency room.

"They put me in a bed, and eight minutes later I'm out," he recalled. "I'm dying." Someone started chest compressions. A defibrillator was wheeled in, and his heart was given a series of shocks. When he woke up, he learned that he'd suffered cardiac arrest. "They said, 'Well, you're going to Riverside'"—a larger hospital, in Columbus, eighty miles away. "And I went back out again."

He'd had a second cardiac arrest, but doctors were able to shock him back to life once more. An electrocardiogram showed that he'd had a massive heart attack. If he was going to survive, he needed to get to Columbus immediately for emergency cardiac catheterization. The hospital got him a life-flight helicopter, but high winds made it unsafe to fly. So they took him by ground as fast as an ambulance could go. On the procedure table, a cardiologist found a blockage in the left main artery to his heart—a "widow-maker," doctors call it—and stented it open.

"The medicine is just crazy good," Mark said. "By twelve-thirty, I was fixed."

After that, he needed five days in the hospital and several weeks at home to recover. Although he had to take a pile of drugs to reduce the chance of a recurrence, he got his strength back. He was able to resume work, hang out with his buddies, live his life.

It was only after this experience that Mark realized what the A.C.A. had given him. Like twenty-seven per cent of adults under sixty-five, he now had a preëxisting condition that would have made him uninsurable on the individual market before health-care reform went into effect. But the A.C.A. requires insurers to accept everyone, regardless of health history, and to charge the healthy and the less healthy the same community rate.

"This would have been a bad story for Mark," he said. "Because the same time you're being life-flighted is the same time you lose value to an employer. Your income is done."

He no longer opposed the requirement that people get insurance coverage. Fire insurance wouldn't work if people paid for it only when their house was on fire, and health insurance wouldn't work if people bought it only when they needed it. He was no longer interested in repealing protections for people like him.

In this, he was like a lot of others. In 2013, before the implementation of the A.C.A., Americans were asked whether it was the government's responsibility to make sure that everyone had health-care coverage, and fifty-six per cent said no. Four years after implementation, sixty per cent say yes.

"But that doesn't mean I have to sign on for full-blown socialism—cradle-to-grave everything," Mark said. "It's a balance." Our willingness to trust in efforts like health reform can be built on experience, as happened with Mark, though we must recognize how tenuous that trust remains. Two sets of values are in tension. We want to reward work, ingenuity, self-reliance. And we want to protect the weak and the vulnerable—not least because, over time, we all become the weak and vulnerable, unable to get by without the help of others. Finding the balance is not a matter of achieving policy perfection; whatever program we devise, some people will put in more and some will take out more. Progress ultimately depends on whether we can build and sustain the belief that collective action genuinely results in collective benefit. No policy will be possible otherwise.

Eight years after the passage of the Vaccine Act of 1813, a terrible mistake occurred. The Agent accidentally sent to North Carolina samples containing smallpox, instead of cowpox, causing an outbreak around the town of Tarboro that, in the next few months, claimed ten lives. The outrage over the "Tarboro Tragedy" spurred Congress to repeal the program, rather than to repair it, despite its considerable success. As a consequence, the United States probably lost hundreds of thousands of lives to a disease that several European programs had made vanishingly rare. It was eighty years before Congress again acted to insure safe, effective supplies of smallpox vaccine.

When I told this story to people in Athens, everyone took the repeal to be a clear mistake. But some could understand how such things happen. One conservative thought that the people in North Carolina might wonder whether the reports of lives saved by the vaccine were fake news. They saw the lives lost from the supposed accident. They knew the victims' names. As for the lives supposedly saved because of outbreaks that didn't occur—if you don't trust the government's vaccines, you don't necessarily trust the government's statistics, either.

These days, trust in our major professions—in politicians, journalists, business leaders—is at a low ebb. Members of the medical profession are an exception; they still command relatively high levels of trust. It does not seem a coincidence that medical centers are commonly the most culturally, politically, economically, and racially diverse institutions you will find in a community. These are places devoted to making sure that all lives have equal worth. But they also pride themselves on having some of the hardest-working, best-trained, and most innovative people in society. This isn't to say that doctors, nurses, and others in health care fully live up to the values they profess. We can be condescending and heedless of the costs we impose on patients' lives and bank accounts. We still often fail in our commitment to treating equally everyone who comes through our doors. But we're embarrassed by this. We are expected to do better every day.

The repeal of the Vaccine Act of 1813 represented a basic failure of government to deliver on its duty to protect the life and liberty of all. But the fact that public vaccination programs eventually became ubiquitous (even if it took generations) might tell us something about the ultimate direction of our history—the direction in which we are still slowly, fitfully creeping.

On Mark's last day in the hospital, the whole team came in to see him. He thanked them. "But I didn't thank them for taking care of me," he said. "I thanked them for when I was smoking, drinking, and eating chicken wings. They were all here working and studying, and I appreciated it."

"That's what you thanked them for?"

"Yeah," he said. "Because if Mark wasn't going to stop this, they were going to have to keep working hard. Something had to happen because Mark was clogging up." And those people did keep working hard. They were there getting ready for Mark, regardless of who he would turn out to be—rich or poor, spendthrift or provident, wise or foolish. "I said, I am glad they do this every day, but I'm hoping to do it only once." ♦