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From Consensus to Disarray: A Century of Health Policy

The contemporary disarray in health affairs in the United States is a result of history. It is the cumulative result of inattention to the burden of chronic disabling illness. Contrary to what most people—even most experts—believe, deaths from chronic disease began to exceed deaths from acute infections almost three-quarters of a century ago. But U.S. policy, and therefore the institutions of the health sector, failed to respond adequately to that increasing burden. Today, leaders in government, business, and health affairs remain committed to policy priorities that have long been obsolete. Many of our most vexing problems in health care—soaring hospital and medical costs; limited insurance coverage, or no coverage at all, for managing chronic conditions; and the scarcity of primary care relative to specialized medical services—are the result of this failure to confront unpleasant facts.

Throughout this century, most of the people who helped make our health policy have assumed that policy should create a supply of useful scientific knowledge, specialized professionals, and facilities and equipment. On the demand side, they have assumed that policy should provide Americans with access to treatment known to prevent infectious diseases and should help them bear the costs of physician and hospital care when they are acutely ill.

During the past two decades, the persistence of this consensus—despite the changing burden of illness on the population—has contributed substantially to a policy that is largely ineffective in managing or preventing chronic illness. Changing the priorities of health policy so that resources are reallocated will require concerted, often painful, political action. Any new policy must be the result of compromises among conflicting interest groups.

These assertions summarize the story I tell in this book. I use information about the past, from the 1890s to the early 1990s, to explain the policies that Americans created to supply and pay for health services. On the basis of this analysis, I suggest more effective policies and explore the difficult politics of enacting them.

This introduction begins with a flashback to 1895 and a fast forward to 1995. Next I raise questions of method (How can historical analysis contribute to decisions about future policy?) and definition (How can the slippery phrase *chronic illness* be useful for historical and contemporary policy analysis?). Finally, I anticipate some of the recommendations about policy, and politics, that I will make in the final chapter.

Health Policy 1895

Imagine a meeting in 1895 to discuss what people a century later would describe as a policy for organizing and paying for health services. The meeting is one of a series on the same topic held in recent months in Boston, New York, Philadelphia, Baltimore, St. Louis, and Chicago. The participants are prominent physicians and leading philanthropists concerned with health and social welfare. The purpose of the meeting is to set priorities for policy in the twentieth century.[1]

The physicians are all men, mainly in their forties. Most of them have private practices, but each of them also has a faculty appointment in a medical school. A few are members or part-time employees of state or city boards of health. Almost all of them went to college for at least two years before entering medical school. After receiving their medical degrees, most of them spent a year

in a laboratory or a teaching hospital in Germany, or worked under a mentor in the United States who had done so.

The philanthropists are men whose wealth is of recent origin. They made money in shipping, banking, manufacturing, and coal and petroleum extraction and refining. Although no full-time government officials, elected or appointed, attend the meeting, the philanthropists are members of boards and commissions that determine what city and state governments will spend to care for the sick and house the destitute. They also make large contributions to the campaigns of a few Democratic and more Republican candidates for public office. No women are present, though several of the men consult their female relatives before they decide about the gifts they will make in order to promote health and welfare.

There are a few clergymen in the room. Some are presidents of universities that have medical schools. Others are advisers to philanthropists.

The men quickly agree on the major problem to be addressed by health policy: preventing and alleviating the pain and poverty caused by acute infectious diseases and two chronic infections, tuberculosis and syphilis. Tuberculosis is the most threatening of these diseases, the leading cause of death and disability for most of the past century. A little more than a decade ago, in Germany, Robert Koch isolated a bacillus that most people at the meeting regard as the cause of tuberculosis. Other diseases that alarm them are diphtheria, typhoid fever, typhus, and pneumonia. There is some talk about injuries caused by the negligence of workers, and sometimes by the lax oversight of their supervisors; by the increasing numbers of vehicles on city streets; and by violence, especially in homes, streets, and saloons in the neighborhoods of recent immigrants from southern and eastern Europe.

Next they agree on the priorities of health policy. The first priority is to stimulate research in bacteriology, physiology, and related sciences. For several decades, the results of this research have increased hope that diseases caused by microbes can be prevented and cured. In France, Louis Pasteur invented a cure for rabies. Children from many countries, including the United

States, have been rushed to Paris for treatment after being bitten by mad dogs. German investigators have recently devised an antitoxin for diphtheria. Just a year ago, during a diphtheria epidemic in New York City, considerable quantities of this antitoxin were distributed—for the first time anywhere—by the city's Health Department. Only a few years before this antitoxin became available, men attending this series of meetings, the famous New York pediatrician Abraham Jacobi for one, had watched their own children strangle to death when the membrane that accompanies diphtheria grew in their throats. There is no comparable treatment for tuberculosis, but this disease seems to spread less rapidly if infected people are isolated, and if local ordinances against public spitting reduce the amount of sputum people deposit on sidewalks and public vehicles. Physicians attending the meeting in New York City are winning a political battle to require their colleagues to report all persons suspected of having tuberculosis to the Health Department, so that their sputum can be tested and medical and social services coordinated.

The second priority is to build and renovate general hospitals for people who are acutely ill. Unlike hospitals of the past, which were mainly substitutes for inadequate accommodations in the home, the modern hospital is a place where the most recent laboratory findings are applied in the treatment of infectious disease. Decisions about admitting, diagnosing, caring for, and discharging patients are now made by doctors on the basis of these scientific findings. Lay trustees and "lady visitors" no longer believe they are entitled to participate in making these decisions, or to make them unilaterally, as they did only a few years earlier. The physicians at this 1895 meeting agree that the largest hospitals should be owned or controlled by medical schools; that municipal and voluntary hospitals should be modernized and affiliated with these teaching institutions; and that all hospitals should be provided with the newest equipment, such as the X-ray device recently announced by Wilhelm Roentgen in Germany and reported on enthusiastically in both the medical and the popular press.

The next priority is to reform medical schools so that they resemble those at which the doctors who attend these meetings

hold faculty appointments. The modernized schools should emphasize the teaching of laboratory science, just as those in Germany do, and should offer supervised clinical training on the wards of teaching hospitals, as the great teaching hospitals of Britain do. The medical faculty should be appointed by universities and paid salaries for their teaching. Once appointed to a faculty, a physician should be accorded the privilege of practicing in the teaching hospital owned by or affiliated with the university. Physicians should not, as still happens at many medical schools, divide among themselves the tuition and fees that students pay. Medical schools, along with many other graduate and professional schools, should be units of the comprehensive universities being created out of older state and private institutions. Their faculties should set standards for admission and graduation and engage in scientific research as well as in teaching and patient care. The recently opened medical school and teaching hospital at the Johns Hopkins University in Baltimore is a model for others to emulate.

The men at the meeting accord the lowest priority to helping indigent people pay for medical care. Even though unemployment is still high as a result of the worldwide economic depression that began in 1893, the charity clinics and hospitals that serve the poor are raising enough money from philanthropy and city or state government to balance, if barely, their budgets. The new tuberculosis sanatoria, like the one that Edward Trudeau has established at Saranac Lake, New York, or the many that flourish in Colorado Springs, are filled with patients whose bills are paid by their families or, less often, by charitable organizations. States and cities are establishing similar sanatoria for the poor, or are creating substitutes that expose sufferers to fresh air on the roofs of hospitals or tenements. New voluntary agencies, like the visiting nurse service established in 1893 by Lillian Wald in New York, are caring for the sick poor in their own homes. The return of prosperity, expected in 1896 with the anticipated election of a Republican president to succeed Grover Cleveland, will enable most members of the middle and working classes to pay the modest out-of-pocket costs of their own health care.

In summary, the participants in the meeting agree that (in the

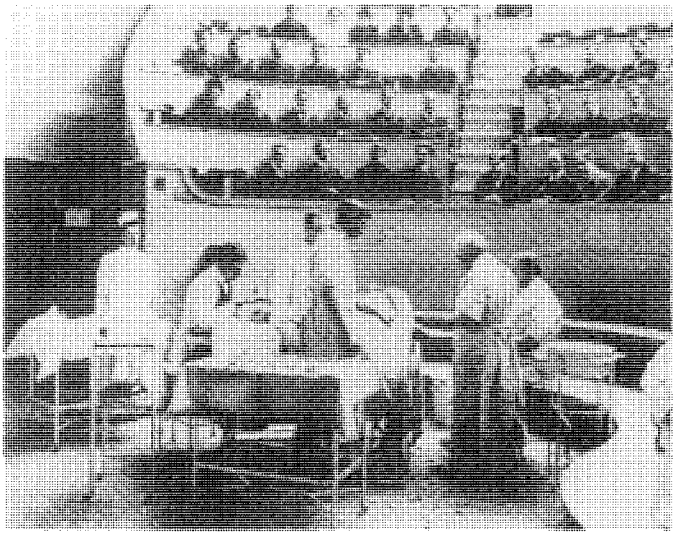
language of the late twentieth century) the highest priorities of health policy should be to improve the supply of useful knowledge, appropriate facilities, and trained personnel. Subsidizing health care or making it affordable—that is, paying the cost of services—is not a major problem for policy.

As the men leave the meeting and pass through the corridor outside the room, they notice a display of photographs that will illustrate a pamphlet, *Health Policy 1895,* summarizing the policy recommended at the meeting. They all agree that photographs, unless deliberately distorted, are mirrors of reality. That is, they are privileged windows through which one can view past or contemporary experience. Physicians have been taking photographs and using them to illustrate lectures, textbooks, and journal articles ever since the technique for fixing images on paper was invented half a century earlier.

The men are pleased by the photographs on display, all of them recent. Most of the photographs depict surgery being performed in teaching hospitals. Modern surgery is performed in operating theaters, with each surgeon, the anesthetist, medical students, nurses, the patient, and an audience taking their appropriate roles (figure 1). No longer is most surgery performed in homes or open wards. Surgery now offers the most accessible visible imagery of modern science: surgeons, whose knowledge of anatomy and its pathology is unprecedented in history, using modern bacteriological knowledge to guard against infection.

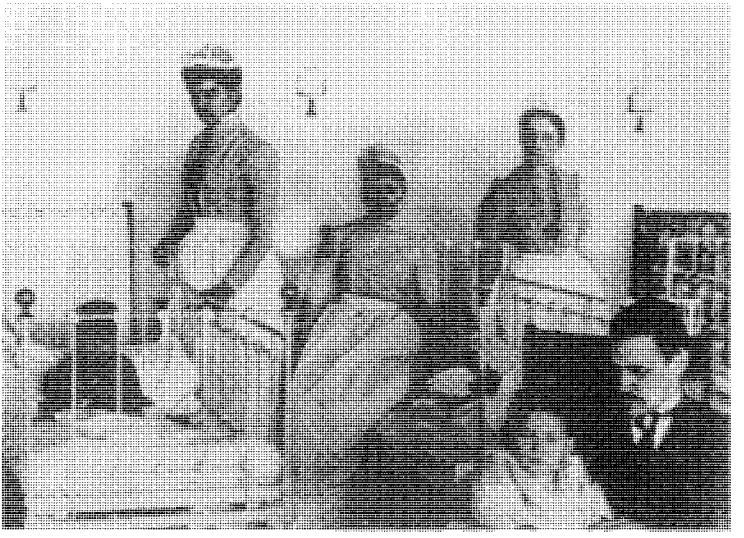
A few photographs present care in modern hospital wards. These wards are carefully organized to implement the most advanced contemporary knowledge of infection control. Nurses, who have worn uniforms in recent decades, stand as caring guardians of the new medical order (figure 2). But physicians are really in charge in the wards, just as they are in operating theaters. When the most celebrated physician in North America, William Osler, teaches on the wards at Johns Hopkins, he is the center of attention (figure 3).

The only photograph taken outside a hospital depicts a physician reading in his modern office in a large midwestern city (figure 4). Up-to-date equipment and furniture dominate the room. No



FRANCIS A. COUNTWAY LIBRARY OF MEDICINE, BOSTON, MA

Figure 1. Amphitheater, Boston City Hospital, c. 1910

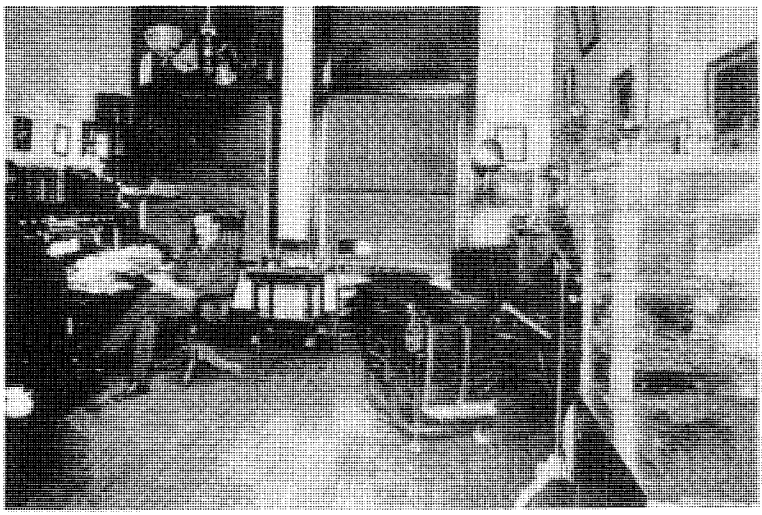


SMITHSONIAN INSTITUTION, NATIONAL MUSEUM OF AMERICAN HISTORY

Figure 2. Pediatric ward, Bellevue Hospital, New York, 1900

THE ALAN MASON CHESNEY MEDICAL ARCHIVES
OF THE JOHNS HOPKINS MEDICAL INSTITUTIONS

Figure 3. Medical ward, Johns Hopkins Hospital, Baltimore, c. 1895



THE FLASHLIGHTERS PHOTO, MINNESOTA HISTORICAL SOCIETY

Figure 4. Physician's office, Minneapolis, c. 1900

patient is present. Physicians and their patients are photographed together only in small-town offices or in hospital wards for low-income patients. Urban physicians and their affluent patients regard medical encounters as separate from ordinary life; photographs resembling those taken on social occasions make them uncomfortable.

The photographs on the wall, taken together, offer a coherent visualization of the priorities of health policy. The participants routinely look at other contemporary photographs about health care. They see many pictures of, for example, persons with tuberculosis being cared for in sanatoria or, if they are poor, seeking fresh air on the roofs of tenements or hospitals. They are familiar with photographs of nurses visiting bedridden patients in the slums. But they do not regard these as *medical* pictures that should be displayed and published to support recommendations for policy. Such images are best used to illustrate the fund-raising brochures of charities that assist poor people for whose diseases medicine still must find explanations and treatments. The photographs that will illustrate the pamphlet confirm the policy agreements reached at the recent meeting.

Health Policy 1995

Now imagine a meeting about the priorities of health policy in 1995. Many more people are in a much larger room, in Washington, D.C. They include representatives of about seventy medical specialty and subspecialty societies and about a hundred other licensed professions, the largest of which is nursing. A group of Ph.D.s attend on behalf of physiology, cellular and molecular biology, biochemistry, and the other basic medical sciences. Many service providers also are present: managers of large hospitals and their affiliated health care systems and of health maintenance organizations, nursing homes, and home health care agencies; representatives of corporations that make and sell pharmaceuticals, medical supplies, and equipment; and members of the trade associations created by each of these groups. Instead of the large contingent of philanthropists who attended the earlier meeting, a few foundation presidents attend as observers. Almost all of them are physicians or social scientists. Other observers include a few economists and ethicists, most of whom work at universities or private research organizations.[2]

Representatives of another group, people who purchase and pay for health services, were not present at the meeting in 1895. These people include officials of federal, state, and local government; nonprofit and commercial insurance companies; and some of the largest corporations in the country, which "self-insure" to pay for their employees' health care. These purchasers of care are accompanied by representatives of firms that assist them in making and controlling payment—people, for example, who process data, pay bills, collect premiums, and authorize or review the use of services.

A few people introduce themselves as representatives of consumers. Some of them speak on behalf of people with particular diseases or disabling conditions. Others claim to represent minority groups, women, children, the elderly, or what they call the "public interest." Still others represent unions, mainly of public employees, service industry employees, and automobile workers.

Many lawyers are present. Some work for people who call

themselves providers, others for payers. Off to one side, talking only with members of their own group, are trial lawyers who specialize in malpractice claims.

Hundreds of print and electronic journalists attend the meeting. Most of them regularly cover health and medical affairs, either for the general press and television or for large-circulation weeklies published by professional and trade associations in health affairs. Each of the speakers begins and ends with a brisk thirty-second summary, during which he or she glances at the press table to see who is taking notes and which cameras are in play.

The participants in the meeting agree about the priorities for health policy; but they disagree, often strongly, about the relative importance of these priorities. The leaders of each group of providers and payers make coherent, informed, and passionate arguments. The words *access, quality,* and *cost* are repeated many times. Every time the participants seem to reach consensus that health policy should emphasize research, hospitals, and primary and long-term care, somebody precipitates renewed controversy by talking about the importance of controlling costs. Then a debate ensues about the relative effectiveness of different ways to cut costs: setting global budgets, regulating physicians' and hospitals' prices, reducing administrative costs, and applying the results of research on the outcomes of alternative treatments.

There is, however, considerable agreement about the underlying problems that drive health policy. People are living longer and as a result are suffering more chronic disabling illnesses, which require both continuous management and intervention in acute episodes. Some people remember that, for two decades before the recognition of AIDS in 1981, many experts, even a surgeon general of the United States, said that we knew how to solve the problems of infectious disease. Now it is clear that AIDS itself is a disease of long duration and considerable cost and must be regarded as a chronic infectious disease. It is like tuberculosis except that it remains uncurable.

The participants have conflicting opinions about the health policy reforms of the Clinton administration and the half-dozen or