Health Reform in 2007: What Can We Learn from History?

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History is about the past; but histories are written for the present – by historians who live and breathe in the present, and who devoutly hope their themes will resonate with themes and audiences today. What is a useful history of health reform for reformers in 2007?

This is not so easy to answer. There is nothing simple and tangible called "health reform." The history of American health care is as messy, disjunctive, and complex as is our present health care system. Battalions of lobbyists have argued for different reforms, together with platoons of politicians, skirmishing professionals and a battling throng of others, representing a wide variety of agendas. There is no single narrative of health care – a single explanatory history – that points to a logical way ahead. There are instead multiple histories, and some histories that are as yet unwritten. Hence the joy of studying history. More important for this gathering, it is liberating to recognize that there are many ways of moving forward, and multiple experiences on which to draw.

My plan here is to draw on the variegated history of health reform to bring out themes and points of particular relevance to thinking about reform in 2007. I will organize my talk under four broad themes:

I . Ends are more important than means;

II. The American system is dynamic and interdependent;

III. Expanding access is much easier than creating coordinated care and service organizations.

IV. Deliver Us from Doctrines, Bugaboos and Fears

Theme I: Ends are more important than means
Reforming Americans use the tools at hand. What does it matter who runs a particular program if that program is needed and it runs well?

The VA is a good example. I have long been interested in how on earth the United States invented and justified a top-down system of socialized medicine for veterans – our current veterans' health system – in of all times the period of the Russian revolution and anti-government sentiment following World War I. Wrong question. Practical solution. There was a strong commitment to "our boys," including the 4 million men who were drafted and a promise to provide them with good hospital care, vocational education and rehabilitation. Existing private and public hospitals could not provide what was needed. The federal government was the only obvious organization to do the job. This was an American problem and an American solution. Thus was created what was then the largest department in the federal government.

This was an unusual case, of course; the veterans' program is still an unusual (and valuable) component of health care in the United States. One might remark, though, that practically every health program in the United States has its own idiosyncratic history.

Health reform has long been distinguished in the United States as a disjointed series of practical solutions to perceived problems of the day, rather than as a response to a broad national reform agenda. We have made policy by accretion.

In the long history of successful and unsuccessful attempts to provide access to health care to different uninsured groups in the United States, multiple methods, means and ownership have been tried. The scope of solutions is worth looking at, because if useful they may be available to try again. There is nothing like a historical analogy or precedent!

1. Mandate: Legislation of 1798 required the master of every American ship arriving from a foreign port to pay 20 cents a month for each merchant seaman for health care. This was enforced through requiring masters to comply as a condition of obtaining a license, necessary for them to work.

2. Direct federal government provision: Even in the 18th century, there was little point in expanding access to care if there were no facilities or doctors to provide that care. Thus, also in the 1798 legislation, federally-funded Marine hospitals were set up at different ports under the President's direction. By 1802 there were marine hospitals in Norfolk, Boston, Newport and Charleston, with more to come.

3. Extension of existing programs to other uninsured groups: In 1916, during a burst of federal and state activity on workers' compensation programs, compensation was included for injured federal workers, to be provided as in-patient or outpatient care in the marine hospitals (soon to be labeled US Public Health Service hospitals.) During and after World War I the Public Health Service built additional hospitals specifically for veterans. These were transferred to the new Veterans' Bureau, established in 1921, while other hospitals remained with the PHS. From the 1950s following the Hoover Commission's reports of 1949 and 1955, official policy was to phase out the remaining PHS hospitals; only eight remained by 1981. The federal model remains, however, as one of many models, if needed in the future.

4. State and local government provision: The federal government became involved in protecting the health of sailors in order to protect local populations from infections and contagions brought in from abroad; and because there was often no place to drop off sailors who were sick, injured, or otherwise disabled. States set up mental hospitals, chiefly in the 19th century, for similar reasons: to protect the population by isolating dangerous and unwanted individuals, typically in an isolated institution located away from urban centers.

Some states set up general hospitals or special hospital for tuberculosis; there was no general rule of what states might do or not do. For example, in the late 19th century Pennsylvania set up a string of hospitals for miners in the coal mining areas, and provided generous tax funds to subsidize the building of nonprofit hospitals throughout the state. Many local governments were heavily invested in hospital provision to provide care to the uninsured poor in major cities, New York being a major example. In smaller towns and cities whose local populations wanted a hospital for the general population in the late 19th and early twentieth century, they simply chose the most convenient and comfortable way to do it: through local government, a religious group or a nonsectarian nonprofit form of organization. When a census was done of hospitals – the first such census-- in 1903, public subsidies to hospitals represented 10% or more of operating costs in thirteen states, with wide variations across the board. Concern about a "proper" governmental role in hospital care was largely a 20th century phenomenon, gaining additional traction with the useful phrase "socialized medicine," associated as it was with the Russian revolution.

5. <u>Cooperative public-private ventures</u> also go back a long way. In the 18th century Benjamin Franklin gained a grant from the Commonwealth of Pennsylvania to establish the private nonprofit Pennsylvanian Hospital, chartered in1751, provided that he raise required matching funds – which he did. There are many examples of joint action over the years, usually without government requirements to give care to those without funds. Indeed there was far less of a distinction in the meaning of "public" and "private" than we are accustomed to today.

Later examples of federal subsidy have built on the cooperative model. Think, for example, of the building of rural hospitals from the late 1940s, with the aid of federal Hill-Burton grants. Designed to provide access to care for rural populations, these hospitals also spread specialized medical services across different parts of the United States, thus in turn furthering an implicit policy agenda of access to medical specialists even outside major urban centers, and encouraging hospital services to expand as an increasingly expensive consumer good.

II. The American system is dynamic and interdependent

Narrowing the history of health reform to debates about national health insurance would give a misleading picture of reform efforts as a whole or possibilities for the future. A great strength of American health care is the willingness to experiment, accept and reject.

Nevertheless, there is a rich history of attempts to provide government-sponsored, if not universal coverage to the U.S. population, which needs to be taken into account in the array of reform efforts. Histories usually begin with the health insurance movement of 1913-1918, which was stimulated by the wider efforts of the American Association for Labor Legislation to improve the health and welfare of industrial workers, and initially supported by the American Medical Association, among others. Fifteen states introduced a standard health insurance bill in 1917; and eight states set up commissions to study the issue. But that is about as far as the movement went. "Dead on Arrival" is the apt title to Colin Gordon's book on failed and partial attempts to legislate for health insurance then, and later. As was to be true on later occasions, the health insurance proposals were weak on practical details and generated considerable confusion, even among their supporters.

By 1920 the heath insurance movement was dead – not even re-stimulated by the shocking inadequacy of the medical response to the influenza epidemic in 1918-1919 or the inadequate care available to returning veterans. Influenza was quickly forgotten. The response to veterans was to build a separate public health care system. The majority of veterans needing hospital care suffered from mental conditions and/or tuberculosis, which private hospitals did not want to treat. After the disruptions of World War I doctors were settling back into fee-for-service private practice, medical specialties were expanding, and community and university hospitals were flowering as centers for surgery and childbirth. Government's role was to pick up he slack.

Government-sponsored health insurance surfaced again in the 1930s and 1940s, to be achieved either as the sum of federally subsidized state programs or as a federal program organized through the social security system. By then this had become a contentious political issue for a variety of reasons, including (but by no means limited to) organized medical opposition, indecision about the advantages and disadvantages for business and labor, the promise of private health insurance as an alternative, and concern about "too much government" and states' rights.

By 1950, however, the arguments for and against health insurance were changing. The rapid growth of private health insurance, complemented by new and expanding hospitals and a national commitment to biomedical research in cancer and other areas (through funding to disease-focused institutes at the National Institutes of Health), changed the context and redefined the agenda. If the great majority of the working population and their dependents were to be covered by employer-sponsored, privately organized health insurance, the major gaps in insurance coverage would be for those who were not working because they were retired, disabled, or unemployed. The elderly were easily identified if the age of 65 was made a convenient marker for retirement, while those who were disabled and/or unemployed could be targeted through a combination of social security and safety net provisions -- at least in theory.

Over years of debate about ways and means, Medicare and Medicaid were created by legislation in 1965, representing three planks for universal coverage: Workers and their dependents were to be covered in the private sector (with continuing tax benefits for employers); the elderly (and soon people with disabilities and end-stage renal disease) were covered under Medicare; and Medicaid would cover the uninsured below state-specified income levels. Initially, Medicare and Medicaid were expected to pay providers at the same rates received for privately-insured patients. In the language of the time, the elderly and poor were to be "brought into the mainstream." In this model there would (theoretically) be one, undifferentiated, relatively egalitarian health system in terms of patient status, with three major vehicles for third party payment.

Alas, these expectations were not to be. Medicaid almost immediately fell into difficulties, including unexpected cost overruns, charges of corruption and fraud, and in some states a backlash against allegedly high, state-mandated income levels for eligibility. As recent trends have made only too clear, Medicare has had its problems, with growing calls for "reform" of one kind or another. Meanwhile the third plank, employer-based insurance for the working population and their families, has weakened in the face both of rising costs, but also of shifts in the structure and nature of the job market. The Clinton proposals of 1993-94 attempted to move from the three planks and redefine the issue as universal access to health insurance; but failed. Here we are in 2007 with a heterogeneous population of 47 million uninsured individuals.

The history of health insurance proposals in the United States is by definition a history of failure if its goal is seen as covering the whole population. Its policy message is that the United States has failed to achieve universal national health insurance, and we must now bite the bullet or drift along in national stalemate and international embarrassment. But while this history is important, it is not the only lens or even the most important one through which to define the issues today. The history of the uninsured and underinsured can be described in other ways, with different policy messages for today.

For example, Medicare and Medicaid are in many ways successes, transforming the lives and health of millions of individuals.

One can argue equally well that the United States has been remarkably successful in achieving highly specialized, valued, life-improving health care for most members of the population in the years since World War II. The large number of uninsured is a byproduct of this success, and must be dealt with in that context.

Alternatively, we might note that the United States has long been committed to providing safety-net services, including Medicaid, SCHIP, right of access to emergency rooms (EMTALA), and provision of government-supported clinics. These programs all call out for reform -- from relieving excess burdens on, and inappropriate use of hospital emergency rooms, through signing up everyone eligible for existing programs, to getting affordable insurance to all those who can pay for it. This conference promises to include a rich variety of ways and means.

III   Expanding access is much easier than creating coordinated care and service organizations.
A patient-centered service requires one of two things: access to a coordinated health care organization <u>or</u> consumer control of standardized patient records and producer measures so that he or she may be sufficiently informed to make good health care decisions; or of course, both.

Expanding access to insurance alone does not ensure more efficient or effective care. Quite the reverse in some instances. The 1965 Medicare legislation promised not to interfere with the existing health care system. Examples of such "interference" might include subsidizing local (public or private) comprehensive health organizations, targeting primary care, developing coordinated services for older members of the population, or requiring standardized measures of the quality of care. Instead the additional purchasing power unleashed by Medicare and Medicaid led to huge changes in disconnected aspects of health care provision. These included the building of a new nursing home industry; encouraging a business orientation for hospitals and doctors; allowing major public hospitals to close their doors (such as the large Philadelphia General Hospital in the early 1970s) on grounds that the poor would now be covered under Medicare and Medicaid; and giving seniors the privilege of direct access to medical specialists in private practice, heralding the decline of primary and coordinated medical care and the rise of single-specialty firms.

By the 1980s the old idea that nonprofit hospitals were "charities" with public responsibilities had diminished almost to extinction. Investor owned hospitals and nonprofits competed in a single, profit-oriented, health care market. Patients, or "consumers," could not generally tell under which kind of ownership each operated. There was nothing particularly new about diverse ownership patterns for hospitals in the United States. What was new after Medicare and Medicaid was the expectation that hospitals were not responsible to their communities for the uninsured. In Philadelphia, for example, no one did a good study of what happened to patients after the closure of PGH. The city put money into health centers, and moved on.

Mental health services played out a different scenario with a similar result. States began to close their mental hospitals before the great push for de-institutionalization in the 1970s. California reduced its state mental hospital population by three-quarters between 1955 and 1973. The advent of psychotropic drugs allowed for community-based care for many individuals with mental illness through physicians in private practice or in government-supported clinics, thus avoiding hospitalization. Federal legislation spurred the closing of beds. The Community Mental Health Centers Act of 1963 provided subsidies to communities which could raise money and the will to build and operate mental health facilities at the local level for individuals needing care who lived in the

community. Beneath the rhetoric that problems of the mentally ill were solvable through private and community efforts were the realities described by Mechanic and Grob: The community centers generated a new crop of patients rather than served the chronically ill who had been inpatients in the state hospitals; many of those patients ended up in nursing homes; others lived on the streets of major cities or became a growing population in the nation's prisons.

In parallel, increased burdens have been placed on patients' families, and on state and local governments. The need for a "safety net" as advocated by President Ronald Reagan in the 1980s, was in part to deal with the fallout from federal programs that were very successful for those whom they served -- expanding access to care for many Americans -- while leaving others out in the cold.

The uninsured or underinsured and medically needy patient who is without a family is at particularly high risk in the United States. Though brave efforts are being made in many parts of the country, there is typically no organized network of services to sustain a person with, for example, a traumatic brain injury, a chronic mental illness, or the inability to stand up after falling.

The symbiosis between providing health insurance and providing appropriate services has long been an issue for health reformers. It was perhaps best stated by the foundation-supported Committee on the Costs of Medical Care in 1932. An ideal system of health provision requires prepaid group payment (i.e. health insurance covering the financial risks of sickness) and organized services, such as the coordinated services of specialists, disease management, and supportive services.

In retrospect, the major health policy failure in the United States has been our inability to create good local and regional health service systems. If we looked forward to our present from the 1930s, 1940s or even the 1970s, I think we would be shocked by the huge number of uninsured and underinsured individuals, but also surprised and depressed at the sheer profligacy, disorganization and irresponsibility of health care provision. The overall effect of health reform policies of the past has been to make the health care system more, rather than less fragmented in terms of actual service provision.

If the dominant form of health care in the United States today was a collection of competing, consumer-sensitive, well-coordinated service systems, operated at the local level through investor-owned health care corporations, nonprofit groups, or government agencies (whichever), there would at least be visible, self-assigned organizational responsibility for successes and failures in patient care along a spectrum of prevention, diagnosis, treatment, and life effects. Many of today's policy questions would also be easier to address through comprehensive service organizations, including covering the uninsured, creating standard information systems as a basis for quality improvement, improving health literacy, and providing better consumer information.

The focus on expanding insurance coverage, though contested, has been far less controversial in the past than efforts to reform health care. That is how we have gotten to where we are. In 1970 it seemed logical to set up a federal program to subsidize private nonprofit service organizations, then dubbed health maintenance organizations. The HMO Act of 1973 was an attempt to do this. But the very idea soon became attenuated by folding insurance networks (which did not directly provide services) into the meaning of "HMO". In the 1990s HMOs became synonymous with managed care; that movement in turn created a backlash against restrictions on services, including the use of "gatekeepers"

to refer patients to specialists and coordinate individual care. Sociologist Bradford Gray has aptly called this history the "rise and decline" of the HMO. Whatever the interpretation of the history, we are left with some major health service corporations, including the Kaiser and Mayo systems. Most of the privately insured population and Medicare beneficiaries shop for services in a fragmented system.

History suggests that efforts to "reform" Medicare through offering HMO coverage (Medicare Part C) will have limited application unless there are bricks and mortar polyclinics – real service systems --to assure beneficiaries that their health care will be there for them long-term. Insurance companies provide risk coverage as a fiscal device; a critically and socially important device, but fiscal rules can change rapidly and insurance networks can vanish in a puff of wind, leaving no trace. Less so with bricks, mortar, and an organizational base.

Medicaid managed care offers a more contained model for reform and experiment, with responsibly for clients more clearly visible than in Medicare. In this as in multiple ways, national health policy has thrust responsibility, deliberately or inadvertently, on states and local governments in recent years. We will see the fruits of diverse programs at this conference. Whether national policy can be built up from state experiments is an open question. History is largely silent on this point.

What is striking from the historical perspective is that, despite all the emphasis on national health policy in the past, with its emphasis on insurance and provision of care in the private sector, in 2007 the two domains of most interest from an experimental and entrepreneurial health care perspective are governmental: First, the states; Second the federal Veterans Health Administration with its vast, reorganized service system. Both are grappling with extending coverage to the uninsured and underinsured at a practical level, while acutely sensitive to health care costs in the broader context of service provision.

IV   Deliver Us from Doctrines, Bugaboos and Fears
The fourth and final point I want to make is the extraordinary hold rhetoric and deep fears have held in health policy debates in the United States, and still do. Even as the government role has grown in the United States, we hear old fears about the dangers of big government, and predictions that another incremental step in health care coverage may move us inexorably into a government-run health system. Long after the end of the Cold War and after moves toward privatizing health and welfare in the old European welfare states, the dread phrase "socialized medicine" is still in play over here. Though our avowedly private health care system has not provided care at reasonable cost for all (at least not yet), dogmatic claims for more privatization are made. And there is ongoing suspicion that subsidized programs that are "too generous" will make large numbers of people take up, say SCHIP, when they could afford to buy their own insurance.

These fears are based on political philosophy to some extent, and on judgments about the desired character of American society and perceptions of human behavior. A long history of social stratification of health and welfare services by economic class was made explicit in American hospitals in the early 20th century through the provision of distinctly different accommodations for different social groups: the lowest class being the general wards, the highest served in a separate private wing. Over time an intermediate level was invented for the middle-class: "semi-private" rooms. An influential writer on

social issues advised charitable givers to make "the pauper somewhat less comfortable than the man who is self-dependent." (1919)

More than a whiff of inegalitarianism lingers on. Though Medicare and Medicaid came in with avowedly egalitarian goals, there does not seem to be an egalitarian sentiment across the health system as a whole. There is greater concern that expansion of coverage may mean the flattening of services for all. For some, "Reform" is another word for "Rationing." In turn, "Rationing" is another word for cutting back services for those in higher social echelons. In some ways "Choice" may be the new proxy for social class, allowing consumers to find their own level of economic and social comfort through their insurance purchasing decisions (including Medicare supplements) and ability to pay out of pocket, as well as in selecting desired sources for treatment. While primary care continues to decline for the general population, the affluent are offered private concierge services.

What do we make of this from a practical perspective? That Americans do not want a uniform health care service for all – indeed there is something of this sentiment in statements that oppose a "single payer" system.

Political rhetoric poses different questions. Reform debates of the past have burned through many fiery phrases. Critics of Progressive health insurance proposals in the early 20th century attacked the proposals as class legislation (here we go again), socialistic, tyrannical, un-American, and (at the time of World War I) "German." "Socialized medicine" came into vogue with the Russian revolution, and proved of lasting, powerfully threatening utility.

Rhetoric can be useful as a political weapon in fighting for and against a piece of legislation, and in establishing consensus across diverse groups, but words do not necessarily predict subsequent actions. As political scientist Lawrence Brown has pointed out, government's role in health care grew steadily in scope and scale in the years from Presidents Nixon to George W. Bush, when "official" ideology was (and is) anti-governmental. If the United States is to provide effective regulatory leadership to stimulate creative change in our largely private but heavily subsidized health care system in the future, much more federal investment may be needed.

There is no clear conception of purpose for the future. Stuart Butler and others in the Hamilton Project have re-established the idea of a "social contract," with its notions of mutual responsibilities; and perhaps this will help to crystallize the issues and possibilities for insuring many, if not all, of the uninsured and underinsured.

Conclusion

I remarked at the beginning that in terms of practical approaches, the lack of a blueprint is a good thing. Ends are more important than means; as in the past, a variety of ways are available to ensure timely health services to those who need them. In the past Americans have organized health insurance to the population group by group, depending on the exigencies and opportunities of the time. This conference will discuss whether the insured and underinsured are best regarded as one group or multiple groups in 2007, for the purpose of suggesting practical next steps.

The American system is dynamic and interdependent. However, expanding individual access to health insurance has proved much easier in the past than creating

coordinated health care and effective service organizations. A major challenge is to lay aside old doctrines, bugaboos and fears. Practical problems demand practical solutions.

I will leave you with the words of President Theodore Roosevelt, from his last message to Congress, 99 years ago:

"It is highly advisable that there should be intelligent action on the part of the Nation on the question of preserving the health of the country…There are numerous diseases, which are now known to be preventable, which are, nevertheless, not prevented…This Nation can not afford to lag behind in the world-wide battle now being waged by all civilized people with the microscopic foes of mankind, nor ought we longer to ignore the reproach that this government takes more pains to protect the lives of hogs and of cattle than of human beings." (December 8, 1908. Quoted by Schmeckebier at 33-34)

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