WHERE DOES IT HURT? Rx

America's Medical Crisis and the Politics of Health Reform

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SPECIAL ISSUE

INTRODUCTION Rx

"Within limits," the English sociologist Richard M. Titmuss once observed, "each distinctive culture gets the medical priesthood it wants." Today a majority of Americans, if still surprisingly loyal to the priesthood, appears ready to reform large sections of the liturgy—i.e., the loosely woven network of medical services that commentators now call "the national health distribution system," and that each year collects from the public more money (it was $83 billion in fiscal 1973) without seeming to offer correspondingly greater chances of salvation.

Nearly everyone agrees that "something ought to be done." Congress, in its customarily haphazard way, has accumulated for consideration 47 separate "health reform" bills, each defining its version of the problem and recommending its unique solution. And last January, in his State of the Union message, President Nixon made it 48 by proposing "a sweeping new program that will assure comprehensive health insurance protection to millions of Americans. . . ."

Much earlier Richard Nixon had given the creeping health reform wagon a hard shove. "We face a massive crisis in health care," he warned almost five years ago, "and unless action is taken . . . within the next two or three years, we will have a breakdown in our medical care system." Very little has been accomplished since then, of course, yet our medical care system lurches right along. It may not be workable but it is certainly viable, and it may well survive us all.

The crisis that everyone senses and no one can solve has been gathering force for at least half a century. Until the early 1900s virtually all of the existing medical technology was contained in the doctor's little black bag. The practice of physicians was long on superstition and short on science. "I firmly believe," complained Dr. Oliver Wendell Holmes in 1860, "that if the whole *materia medica* as now used could be sunk to the bottom of the sea, it would be all the better for mankind—and all the worse for the fishes."

After the turn of the century, the medical clan belatedly accepted the scientific revolution inaugurated by Anton van Leeuwenhoek and his microscope 250 years earlier. In consequence, though doctors continued to see themselves as free-lance entrepreneurs, they also began to identify as members of a profession. From that point on, they rapidly coalesced into a powerful society, with all the attendant benefits and drawbacks to the public. Soon the American patient was confronted with that infernal invention of capitalism, an oligopoly, which pampers the vendor at the expense of the consumer.

People have long been worrying about the effects of medical oligopoly. Here is Louis I. Dublin, the great health demographer, fretting in 1927: "Large numbers of middle-class families pay their bills, but chafe under what they generally consider the unjustifiably heavy cost of medical services. Only the very rich can afford a serious sickness without concern over their medical bills. Everywhere, within and without the medical profession, there is the feeling that something is seriously wrong with the economics of medical service. Neither doctors nor patients are satisfied with the present situation. . . ."

Dublin's lament has more than stood the test of time, as has the fee-for-service system he tried to discourage. Meanwhile, in the absence of clear-cut political solutions, more actors and institutions have gradually joined the cast: In the 1930s, Blue Cross and the beginnings of hospital-dominated medicine; in the '40s and '50s, the burgeoning health insurance industry; and in the '60s, the Federal government through Medicare and Medicaid, programs serving 50 million Americans at an annual cost of $15 billion.

Each of these players on our health care stage has entered in the guise of "the solution" and remained to become part of the problem. We are in the presence, then, of a set of social and economic miseries that feed off our chronic inability, thus far, to organize an adequate re-

sponse. One feels we are racing history, hoping to shape the future by shucking a good deal of the past.

This study offers no instant remedies. Surely it is clear by now that our health care system, for all its creakiness, has a built-in durability that is at once the joy of its partisans and the frustration of its critics. It will not improve with a stroke of the pen. Besides, the current literature on health care is bulging with tedious explanations and exposés, as well as loud calls for our deliverance; we need no more.

Our purpose is therefore mainly interpretive—to organize and make sense of what others have already learned, and to focus on those elements that suggest possibilities for change in our social policies. To begin with, we shall briefly describe the pain of it all—that is, the various woes and indignities our health care system too often inflicts upon its patients.

Next, we shall look at the origins of the medical establishment—that odd amalgam of altruism and laissez-faire rapacity—at how it grew and, in some instances, how it failed to grow.

In the third section, we shall examine some of the many links that exist between hospitals and the health insurance industry—they constitute a kind of symbiosis—and we shall ask whether this thriving partnership is in the public's best interests.

Fourth, we shall look at a few alternatives, focusing on the older, established prototypes for "health maintenance organizations," those much-maligned and much-touted substitutes for conventional fee-for-service arrangements. We shall attempt to learn how they work and *if* they work, and whether their services can be expanded to benefit more Americans.

Finally, we shall explore the politics of health reform, citing recent lobbying efforts by the insurance industry, the American Medical Association (AMA) and the labor unions, and analyzing some of the major health bills now before Congress. The study concludes with a short trek through that political swampland we call "prospects."