

History & Health Policy in the United States: Putting the Past Back In

Rosemary A. Stevens, Ph.D., M.P.H.

In today's health policy world, there's no shortage of pressing issues: the frustrations of many Americans with their health care system, the ever-increasing number of people without health insurance, the tremendous opportunities and conflicts caused by technological innovation and its associated costs, and overflowing emergency rooms that serve as an access point of last resort. And that's only scratching the surface.

Yet these issues are far from new; in fact, many of them have roots that go back 60 years or more.

What can we learn from exploring the changing patterns of health policy over time? What are the links between history, health policy, and current health policy challenges?

A 2006 book supported by the Robert Wood Johnson Foundation (RWJF) Investigator Awards in Health Policy Research program examines these and other questions. Published by the Rutgers University Press, *History & Health Policy in the United States: Putting the Past Back In* is a collection of essays by distinguished historians, political scientists, sociologists, physicians, public health researchers, and policy scholars that explores how history can be used to better understand and solve emerging and future health policy challenges.

"History matters," writes Rosemary A. Stevens, Ph.D., M.P.H., a Dewitt Wallace Distinguished Scholar in the Social Medicine and Public Policy Program at Weill Cornell Medical College and Stanley I. Sheerr Professor Emerita at the University of Pennsylvania. Stevens shaped and edited the volume with Charles E. Rosenberg, Ph.D., a historian at Harvard University, and Lawton R. Burns, Ph.D., M.B.A., a sociologist at The Wharton School, University of Pennsylvania.

"Shared perceptions of history can move audiences, offer powerful explanatory narratives for the present, suggest intriguing analogies with past events, and help build consensus around policy goals," Stevens continues. Yet policy history tends to play only a minor role in policymaking, which is "strewn with dubious historical analogies and powerful myths."

The essays in *History & Health Policy in the United States: Putting the Past Back In* provide an overview of health care delivery, examine the roles played by key actors, and analyze how values, ideological positions, and conflicts have led us to where we are today.

Taking a Wide View of Health Policy History

In health policy—as in other areas of policymaking—history has had a way of playing out in often unexpected ways.

For example, although overcrowding in emergency rooms across the country is viewed as a relatively recent "crisis," the "emergency room emergency" was publicly deplored as far back as the early 1960s, as Beatrix Hoffman, Ph.D., explains in her essay on how ERs have become the nation's "reluctant safety net." A number of factors after World War II—an influx of federal dollars for hospital construction, increasing public preference for hospital care over office visits,

A National Program of
the Robert Wood Johnson Foundation

National Program Office:
Rutgers, The State University
of New Jersey

Institute for Health, Health Care Policy,
and Aging Research

55 Commercial Avenue, Third Floor
New Brunswick, NJ 08901

phone: 732.932.3817
fax: 732.932.3819

email: depdir@ifh.rutgers.edu
www.investigatorawards.org

the end of house calls, better insurance coverage for medical care provided in a hospital, and the surge of the automobile—all played a role in the rise of the ER. So too did hospitals' public relations efforts to portray themselves as 24/7 providers to patients whose access to that level of physician care was diminishing.

Patient dumping, or emergency care refusal, is another practice with a long history, which Hoffman traces back to the late 19th century. Although a number of legal and regulatory restrictions were put into place during the 20th century, the effects were spotty and abuses continued. It was not until Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 that all U.S. hospitals receiving Medicare funds were required to evaluate and stabilize patients seeking care in hospital ERs.

Today, though, ERs serve not only as a social safety net for the uninsured and other patients seeking immediate care, but also as a “*political* safety net against universal coverage,” Hoffman notes. “As bad as things might get, Americans and their elected officials can fall back on the comforting notion that the nation doesn’t leave sick people to die in the streets—they will always be taken care of in an emergency room.” Indeed, as President Bush recently observed, “People have access to health care in America. After all, you just go to an emergency room.” But Hoffman probes whether it is wise policy to continue to rely on the emergency room as the only place in the American health care system where access to care is guaranteed.

Industry, the Environment, and Public Health

In another essay, Gerald Markowitz, Ph.D., and David Rosner, Ph.D., describe how industry uses its power and money to avoid responsibility for toxic products or byproducts, how scientific research has been ignored or manipulated, and how industry shapes policy debates. In many cases, companies are able to effectively bury troubling scientific information about dangerous products or manufacturing processes, only to have the issue resurface years later. An obvious example is silicosis, an occupational lung disease caused by inhalation of silica sand, identified by scientists as “perhaps the most serious industrial poison in the nation” in the 1930s. Yet by the end of the 1940s, industry managed to have silicosis declared a “disease of the past,” thus avoiding unwanted regulation.

In the meantime, outbreaks of silicosis among workers continued to occur. An attempt in the early 1970s by the National Institute of Occupational Safety and Health (NIOSH) to reduce the permissible exposure limit for silica was successfully opposed by the organized efforts of sand producers, equipment manufacturers, painting companies, and sand-blasting contractors. Fifteen years later, in 1997, the Department of Labor launched a campaign to eliminate silicosis. As of today, no new silica standard has been approved. Yet Markowitz and Rosner say that “lawsuits brought by injured workers and the publicizing of historical records have led many companies to abandon the practice of using silica sand, which should lead in coming years to a reduction in silicosis among workers.”

The story of industry’s use of aggressive public relations campaigns, manipulation and suppression of scientific research, and political influence to avoid responsibility for creating public health hazards has been replayed again and again: tobacco, lead, and polyvinyl chloride are just a few examples. Markowitz and Rosner stress that historians have a crucial role to play in documenting the scientific record on toxins and pollutants accurately and honestly, in using their access to archival materials to reveal past knowledge about health dangers, and in applying their analytic expertise to health policy disputes.

“Historians have a crucial role to play in documenting the scientific record on toxins and pollutants accurately and honestly, in using their access to archival materials to reveal past knowledge about health dangers, and in applying their analytic expertise to health policy disputes.”

The Rise of the Health Care Consumer and the Super-Specialist

Essays by Nancy Tomes and Rosemary Stevens describe some of the unique aspects of the health care market.

Nancy Tomes traces the idea of the patient as consumer back to the mid-19th century, a time “when dissatisfied patients did not hesitate to vote with their feet and doctor-shop until they found a physician more to their liking.” Between 1890 and 1930, however, major scientific advances and the growing professional power of organized medicine ushered in a new era of physician dominance over the doctor-patient relationship.

Change arrived in the 1960s and 70s, when activists began to apply ideas about consumers’ rights to challenge organized medicine and its dominance over patients. Consumer advocacy groups, including Ralph Nader and his associates, took on the medical establishment for refusing to share information with patients, ignoring their rights to make their own treatment decisions, and subordinating professional ethics to economic gain. Tomes notes that it was patient activists, not market enthusiasts, who initially embraced the phrase “health care consumer”. But as she points out, patient activists were more successful at increasing consumer access to information and undermining medical paternalism than helping to bring about broader reforms.

By and large, Tomes believes that the rights that patient-consumer activists sought to expand have actually diminished over time. Why? Simply put, because more powerful stakeholders—such as payers, providers, and pharmaceutical companies—have the money to dominate the process of policymaking.

Although health care choices have expanded since the 1970s, today’s health care consumers continue to operate in a “uniquely constructed, highly specialized marketplace over which they have comparatively little control,” says Tomes. Moving toward a more patient-centered health care system in the 21st century will require solutions based on a realistic sense of what “empowered” patients can actually do as purchasers of care, as voters, and as participants in policymaking.

Rosemary Stevens examines one of the most significant features of America’s highly segmented health care market—the increasing specialization of medical training and professional practice. With its 37 specialties and 92 subspecialties, American medicine has become a highly complex, self-regulated enterprise that can baffle even the most savvy health-care consumer.

Today 24 boards, each sponsored by one or more national specialty associations, certify almost 90 percent of all practicing physicians in the United States. The American Board of Medical Specialties (ABMS), an umbrella organization for the certifying boards, plays a coordinating role.

Over the past 30 years, these boards have been pushed into the policy arena—by consumer activists who questioned medical authority in the 1970s, by managed care companies seeking to reduce utilization and costs in the 1980s and 1990s, and by the fallout from the Institute of Medicine report *To Err Is Human* in 1999. The boards have responded to concerns about medical quality and physician competence by banding together through the ABMS and committing to the establishment of maintenance of certification (MOC) programs for physicians. Such programs would replace certification with a more continuous process of learning and evaluation that spans a physician’s entire medical career.

Today’s boards have a more united purpose and much is riding on the success of the MOC initiative—“this history is still being written,” Stevens says. While specialty organizations and their boards have played a useful and important role in improving health care quality, Stevens believes they could do more by working together with the health services management and research communities on improving the U.S. health care system.

“By and large, Tomes believes that the rights that patient-consumer activists sought to expand have actually diminished over time.”

About the Investigator

Rosemary A. Stevens, Ph.D., M.P.H., is a Dewitt Wallace Distinguished Scholar in the Department of Psychiatry at Weill Cornell Medical College.



A health policy historian, Dr. Stevens has examined specialization in American medicine during the past 25 years, as well as the organization of care in the U.S., and physician practice arrangements.

Previously she was the Stanley I. Sheerr Professor in Arts and Sciences at the University of Pennsylvania, where she was a member of the Department of History and Sociology of Science and a senior fellow at the Leonard Davis Institute of Health Economics. She was also chair of history and sociology of science, and she was the first woman dean of the School of Arts and Sciences at Penn.

Dr. Stevens has an M.P.H. in health services administration and policy and a Ph.D. in epidemiology, both from Yale. She has held professorial positions at the Yale University Medical School and at Tulane University, where she served as chair of the Department of Health Systems Management.

Dr. Stevens has published seven books and numerous articles. She has won national awards in the history of medicine, history of public health, and health services research. She is a member of the Institute of Medicine of the National Academy of Sciences and of the American Academy of Arts and Sciences.

Looking Ahead

Stevens notes that “there are no simple solutions.” Health policy serves multiple interests and is frequently shaped by what happens to be politically feasible at the time, not by a coherent vision or plan. Yet she also observes that the essays in *History & Health Policy in the United States: Putting the Past Back In* “depict extraordinary instances of energy, experiment, and willingness to take risks on behalf of a multitude of participants. History, she believes, provides reason for optimism, and shows that “health care is not on an inevitable trajectory, that choices have been made in the past, and that new choices can be made in the future. That future is more malleable than many of us might think.”

To order a copy of *History & Health Policy in the United States: Putting the Past Back In*, edited by Rosemary A. Stevens, Charles E. Rosenberg, and Lawton R. Burns, please contact the Rutgers University Press at <http://rutgerspress.rutgers.edu/acatalog/catalogbody.html> or 1-800-848-6224, or by emailing: customerservice@longleafservices.org.



Publications

Rosemary A. Stevens discusses health policy issues in America in the following publications:

- Stevens RA. *The Public Private Health Care State: Essays on the History of American Health Care Policy* (New Brunswick and London: Transaction Publishers), 2007.
- Stevens RA. Specialization, Specialty Organizations, and the Quality of Health Care. In *Policy Challenges in Modern Health Care*, edited by Mechanic D, Rogut L, Colby D, and Knickman, J (New Brunswick: Rutgers University Press), 2005.
- Stevens RA. Themes in the History of Medical Professionalism. *Mt. Sinai Journal of Medicine*, 2002; 69 (6): 357-62.
- Stevens RA. The Americanization of Family Medicine: Contradictions, Challenges, and Change, 1969-2000. *Family Medicine*, 2001; 33 (4): 232-43.
- Stevens RA. Public Roles for the Medical Profession in the U.S.: Beyond Theories of Decline and Fall. *Milbank Quarterly*, 2001; 79 (3): 327-53, III.
- Stevens RA. *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore: Johns Hopkins University Press), 1999.

For additional copies of this *Research in Profile* (Issue 21) and past issues, please visit www.investigatowards.org or contact the National Program Office of the RWJF Investigator Awards in Health Policy Research at 732-932-3817 or depdir@ifh.rutgers.edu.