Health Policy in Medicine: Inside the Beltway

Government and Health Care: A Brief History

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The role of clinicians is to address the needs and concerns of people when they are most vulnerable, weakened by illness or injury, or distraught by the prospect of a loved one's suffering, death or disability. It is not surprising therefore that as early societies grew in complexity they undertook the formal regulation of health professionals. The Code of Hammurabi, the earliest recorded compilation of laws, specifies fees for medical and surgical services, as well as punishments for poor outcomes. (1)

In addition to managing the incentives for health professionals, governments have long employed physicians and regulated aspects of clinical practice. The early Roman Empire employed a highly organized medical corps as a key element of the infrastructure supporting each military legion in the field. And by the later Roman Empire the private practice of medicine was regulated as well. The Codex Theodosianus (a 5th Century compilation of the laws of the Roman Empire established since 312 CE) described a detailed, state supported network of medical examiners for regulating physicians throughout the cities and provinces. (2) The fall of the Western Empire led to erosion of the legal and regulatory apparatus of imperial government. However by the 13th Century the Holy Roman Empire had re-established professional licensure laws. In the 1500's, the English government gave the legal authority for medical licensure to the College of Physicians and Surgeons. (3, 4)

Beginning in the latter half of the 19th Century various European governments began directly intervening in the financing of health care thru the establishment of sickness funds and other forms of social insurance. (5) These efforts took different forms and introduced government influence into payment of physician services to varying degrees. Some approaches were quite radical. In England the playwright and Fabian Socialist George Bernard Shaw advocated vigorously for a fundamental reform of physician incentives. "That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg is enough to make one despair of political humanity." (6) Indeed a few European systems, including the UK, ultimately introduced direct employment of physicians as an integral part to their approach to assuring universal access to health care.

Of course the readers of this site are interested in US health care policy. Therefore I will now briefly highlight some elements of the history of US state and federal government involvement in health care. I will start by considering the history of regulation of the health professions in the US, government efforts in public health, and the history of government-run health care facilities. In subsequent months I will discuss public investments in the sciences that guide clinical practice, public involvement in the training of health professionals, and various federal efforts to expand access to health insurance. We will then turn our attention from the past to the future, considering the current challenges confronting health professionals and policy makers in 2011, and some of current health policy activities underway to address these.

Regulation of the health professions

In The Social Transformation of American Medicine, Paul Starr recounts the complicated history of health professional regulation and licensure in the United States.(5) He reports the first law for licensing physicians was passed in New York City in 1760, and that after the colonies achieved independence many state legislatures granted licensing authority to local medical societies. However, several factors converged to reduce the effectiveness of these medical societies in regulating either the education or practice of physicians, a trend exacerbated by the political philosophy associated with the rise of Andrew Jackson. Hostile to various privileges granted to special interests and "licensed monopolies," state legislatures began rescinding medical licensure laws, so by the mid 1800's most states had ceased regulating medical practice.

The late 19th century saw a resurgence of legislative interest in the licensure and regulation of physicians and pharmacists, as well as a variety of non-health care related services. Starr describes a typical series of incremental steps in progressively more restrictive licensure requirements. In 1889 the US Supreme Court upheld the regulation of the medical profession: "…comparatively few can judge the qualifications of learning and skill which…{a physician} possesses. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge …the requisite qualifications." (3) By 1901 twenty five states had enacted relatively strict requirements for a medical license, requiring physicians to both present diploma from a medical school deemed acceptable by a state board of medical examiners, as well as pass a state mandated independent examination. (5)

Jost describes 20th Century evolution of health professional licensure in The Regulation of the Health Professions. (3) Conflicts continue regarding the scope of practice of different health professionals as well as the appropriate mechanisms to assure continued competence. These conflicts are handled by the states, although local professional society advocacy may be guided by principles and even strategies established by national health professional associations. Considerable effort in health professional advocacy can be devoted to these issues; just in 1994, nearly 400 bills were introduced in state legislatures to expand the scope of practice of different groups of health professionals.

Provisions for public health

Calkins et al trace the rise of state government involvement in public health to the epidemics of cholera, smallpox, and yellow fever in the late 18th and early 19th centuries. (7) Physicians appointed by state governments often oversaw the efforts at quarantine and improved community sanitation. Local Health Boards were established and later grew into health departments. In the later 1800's, breakthroughs in the science of human illness, specifically bacteriology, powered the establishment of robust state boards of health. Calkins et al note that by the 1930's "state and local health departments became the major vehicle by which these advances in both microbial science and environmental sanitation were made available to the public." (7)

Ongoing federal government involvement in public health can be traced to wartime efforts to control malaria, which were followed by the formal establishment of the Communicable Disease Center (CDC) on July 1, 1946 in Atlanta, Georgia. (8) The CDC, initially focused on eradicating mosquitoes, had entomologists and engineers as its key staff, with only seven medical officers in 1946. Over nearly 65 years, the CDC's role has grown dramatically. Its current strategic plan outlines a focus on five strategic areas: supporting state and local health departments, improving global health, implementing measures to decrease leading causes of death, strengthening surveillance and epidemiology, and reforming health policies.

Health professionals have been frequent advocates for as well as occasional opponents of formal government efforts in public health in the US. The American Medical Association (AMA) supported the expansion of health department regulatory powers in the late 1800's and Starr reports that when the American Public Health Association (APHA) was founded, its membership was largely comprised of physicians who were state and local health officials. (5) Health professional associations like the AMA remain staunch advocates for the CDC and professional codes of ethics routinely acknowledge clinician responsibility to promote the "betterment of the public health." The APHA reports that it now represents "over 50,000 health professionals and others who work to promote health, prevent disease and ensure conditions in which we all can be safe and healthy." (9)

In addition to frequent support of, and involvement in, public health efforts by physicians and other health professionals, organized medicine has also historically resisted certain activities by public health agencies, especially the provision of health services to individuals by public health facilities. We will briefly consider these issues under the topic "Government-run Health Care Facilities."

Government-run Health Care Facilities

Starr describes the history of public hospitals in the US, arising from almshouses and other institutions for the care of the infirm poor. Reforms after the Civil War led to the development of specific institutions for care of the poor with different conditions, for example the mentally ill, the blind, and those with physical illnesses. Since no specific therapeutic technology was required prior to the 20th century, those with physical illness could usually be tended by family members. Thus public and voluntary hospitals developed initially in seaports or river towns where ill travelers or workers would have no family available to care for them. (5) The Marine Hospital Services Act of 1789 established the forerunner of the US Public Health Service and authorized it to care for merchant seamen (as well as US military personnel). Private physician interest in access to hospital facilities increased with the expansion of relatively safe and successful surgical procedures, enabled by the discoveries of anesthesia and antisepsis. As a result in the late 19th century physicians increasingly advocated to relevant governmental authorities for access to hospital privileges, greater involvement in hospital governance, or permission to establish physician owned hospitals. (5)

Around the same time, public health departments began making available to physicians and the public resources for laboratory diagnoses of infectious diseases, as well as treatments in the form of sera and vaccines. While these efforts were supported by medical societies, early 20th century efforts to expand these capabilities into community health centers were not. Physicians advocated that county health departments could provide no "curative" interventions, limiting their scope considerably. (5)

However as effective diagnostic and therapeutic technologies became more numerous and more expensive to provide, physician opposition to public support for care of the indigent became less consistent. The Sheppard-Towner Act of 1921

established funding for state health agencies to support the provision of certain health services to individuals (e.g. maternal and child health programs). In the 1960's, concurrent with the establishment of the Medicare program to provide financial access to private medical care for seniors, health care access for poor children and impoverished working age people was expanded by both the Medicaid program and expanded authority for federally supported community health centers. (7) The reasoning was that since the Medicaid program required state matching and control, federally supported community health centers could address access problems in poor, medically underserved communities.

Since 2000 the money appropriated for community health centers nearly doubled in an effort to address problems with access to care for the uninsured and for those in health professional shortage areas. Currently "more than 1,000 health centers operate 6,000 service delivery sites in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin."(10) The National Association of Community Health Centers (NACHC) reports that in 2008 some 20 million Americans received care from these health centers, which employed nearly 10,000 nurses, over 8400 physicians, 5100 nurse practitioners and physician assistants, 7400 dentists, and 2400 pharmacists. (11)

Of course the military has employed physicians and operated medical facilities throughout US history. Continued advocacy by World War I veterans and their families led to the establishment of the Veterans Administration (now the Department of Veterans Affairs) in 1930. At that time the Federal government operated 54 hospitals for veterans. World War II caused not only a dramatic increase in the population of injured veterans, but also was followed by many new veterans' benefits (including expanded health benefits) enacted by the Congress. Accordingly the VA Health system has grown to 171 medical centers as well as numerous outpatient, community, and outreach clinics. (12) The VA Health system now employs thousands of generalist and specialist physicians and nurses, well as many nurse practitioners, pharmacists, physician assistants, physical and occupational therapists, and other clinicians.

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