Why Federal Intervention in Health Care Works: A Historical Perspective

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Chairman Issa, Ranking Member Cummings, thank you for the opportunity to testify today regarding the past accomplishments and future potential of federal intervention in health care.

In 1900, a newborn American citizen had an average life expectancy of 47 years. A heartbreaking 10 percent of all infants died before their first birthday, and infant mortality was far higher among the rural and urban poor, whether on southern farms or in northern tenements. By contrast, an American born in 2000 could expect to live 75 years, and infant deaths had been cut by 93 percent.[1]

These striking reductions in morbidity and mortality rates resulted from not only a rising standard of living, but also the advent of effective methods for detecting, preventing, and treating disease; new breakthroughs in medical research; and markedly improved access to health facilities and services.

In all these areas of medical and public health progress, the Federal government has played a fundamental role as both sponsor and coordinator of a remarkably concerted effort involving communities, states, organizations, and institutions across American society. The Federal government therefore deserves a great deal of credit for doubling life expectancy for Americans, as well as for tackling a long and ever-changing list of problems regarded as the worst enemies of the nation's health, from tuberculosis and polio to cancer and AIDS.

Yet most critics of federal intervention in health care, particularly critics of the Affordable Care Act, define "intervention" as "interference." They see the health care industry as a group of private actors--health professionals, hospitals, insurance companies, drug manufacturers, etc. These private actors would, if left to their own unregulated devices, supposedly do a far better job of providing the American people with broad access to quality health services than a bunch of bumbling bureaucrats and special-interest politicians. These criticisms rely on sharp distinctions between the public and private sector, and misapply the same basic economic principles to all types of markets, whether the product is houses, handbags, or heart surgery.

Of all the industries that make up the American economy, health care most defies the classic model of the private market. Physicians are quintessential small business-owners who traditionally have fiercely defended fee-for-service practice as the best system for guarding their patients' health. Yet without publicly-funded medical education, research, and service-delivery systems, the medical profession would still be the small and straggling band of individualists who began the twentieth century with little scientific understanding of how disease spread, much less how to cure it.

The ideas presented in this document do not represent official positions of the Bloomberg School of Public Health or Johns Hopkins University.

You cannot sell what people are terrified to buy, and until at least the early 20th century, most American hospitals were charitable institutions where poor people with no family went to die. Paying patients came only after the introduction of anesthesia in childbirth and the first effective medical and surgical treatments for disease. Yet many aspects of health care remained patently unprofitable, particularly for patients with chronic disabilities. For example, by 1950, over half a million Americans were institutionalized in state mental hospitals. The conditions that responded least effectively to profit-driven medicine were ironically those generated by the highly lucrative markets for cigarettes, alcohol, and illegal drugs. In the 1960s and 1970s, drug addiction and alcoholism reached epidemic proportions. Rates of lung cancer rose steadily throughout what has been called "the cigarette century," increasing five-fold in males from 1930 to 1990 and continuing to rise in women.[2]

The Federal government has responded to every major public health problem with legislation and the expertise of agencies such as the Food and Drug Administration, U.S. Public Health Service, National Institutes of Health, and Centers for Disease Control. Government health agencies have worked closely with the so-called private health sector, both for-profit and non-profit, to bring more consumers into the health marketplace while promoting cost savings and coordinating resources, which remains the primary goal of the Affordable Care Act.

For example, public health departments and private physicians cooperated to make mass screening and immunization programs standard for American children--and a pillar of pediatric private practice.[3] By 1920, public health departments in large northern cities provided services including sanitation, communicable disease control, maternal and child health, health education, laboratory tests, and collection of vital statistics. But doctors, hospitals, and public health services were scarce or absent in much of the rural South and West.[4] Federal initiatives helped democratize advances in medicine and public health so that they reached areas of the country with the greatest need. The greatest beneficiary was the South, historically America's most anti-federal region.

A NEW DEAL FOR AMERICAN HEALTH

During the 1930s and 1940s, the federal government assumed the lead in all public health efforts as national and international crises exhausted private sector resources and fostered public-private cooperation to address a new wave of health problems besieging the nation. The Great Depression had a catastrophic impact on the health of Americans who could no longer afford medical care or even adequate diets. Rising levels of unemployment and poverty began to erase the recent gains in health status, particularly among those hit hardest and earliest in the agricultural sector. Between 1925 and 1935, death rates rose from pellagra, pneumonia/influenza, malaria, meningitis, and measles.[5]

New Deal public works programs constructed thousands of miles of water and sewer lines and built new treatment plants at a time when cheap labor was available but local governments could not afford to make improvements. Works Progress Administration (WPA) sanitation projects drastically reduced the incidence of typhoid and dysentery in rural communities, which were also the primary beneficiaries of PHS and WPA malaria control programs. To curtail mosquito breeding, the WPA drained several million acres of swamp and PHS officers sprayed mosquito-ridden areas with larvacides from airplanes and on foot. The incidence of waterborne illnesses dropped steadily, and the national typhoid mortality rate

decreased by 90 percent from 1920 to 1945. These programs made vast areas of the South safe for business and contributed significantly to the rise of the booming Sunbelt economy.[6]

The 1935 Social Security Act is known primarily as a retirement program, but Titles V and VI aided maternal and child health and helped support health departments by providing matching grants to stimulate state and local spending. During the Franklin Roosevelt administration, policymakers increasingly relied on public health programs as a versatile tool to solve a wide range of problems, from reducing rates of loan defaults among farm families (commonly caused by health crises that left farmers unable to work) to ensuring the maximum productivity of defense industry workers and rehabilitating soldiers who had been rejected for military service.[7]

By the late 1930s, New Deal reformers were eager to enact legislation to create a national system of financing health care for all who needed it. The framers of the Social Security Act had considered including health insurance as a benefit, but President Roosevelt had opposed the idea as too controversial.

Many reform groups, however, including organized labor, farmers, civic organizations, and philanthropies, grew more vocal in their calls for federal action to promote broader access to medical and hospital care. Senator Robert Wagner of New York introduced the first comprehensive national health legislation in 1939, and the Wagner-Murray-Dingell National Health Bill, introduced in 1943, was the first proposal for universal health insurance coverage underwritten by the federal government. But the American Medical Association attacked national health insurance as "socialized medicine" that would interfere with the sacred relationship between doctor and patient and result in lower standards of care.[8]

Nonetheless, still-unmet health needs and the success of New Deal public health efforts prompted many doctors to acknowledge, along with North Carolina's state health officer, Carl V. Reynolds, "the government has a definite responsibility in the prevention and cure of disease and the preservation of health."[9]

WORLD WAR II AND THE HEALTH FRONT

The appeal of national health legislation surged after the attack on Pearl Harbor. Rising employment as well as wartime shortages of health professionals increased public demand for health care, the aspect of social policy (along with labor) most critical to national defense. When newspaper headlines announced high rates of draft rejections for various health reasons, national leaders recognized that serious existing health deficiencies threatened America's fighting effectiveness and economic productivity. Draft rejection statistics also revealed that illness and disability disproportionately affected southerners, rural residents, and African Americans, which further fueled the drive for health reform targeted at these groups.

The numbers were sobering: at least 40 percent of the 22 million men of military age were unfit for general military duty, and 4.5 million of these were classified as "IV-F," including half of southern recruits versus only one-third of non-southerners. In North Carolina, which posted the highest rejection rate, 71 percent of black and 49 percent of white recruits were deemed unfit for service.[10]

The wartime drive to pass federal health legislation also fueled civil rights activism. During an era of hostility to any civil rights measures and strict segregation of the private health system North and South, Congressional hearings on the national health legislation of the 1940s

gave representatives of every major national black organization an alternative forum to promote equality and the full inclusion of blacks in federally-sponsored health programs.

The medical civil rights movement succeeded in enacting federally enforced non-discrimination provisions that ensured that black patients could receive equal care in public health clinics and modern new hospitals that accepted federal grants, although southern facilities maintained racial separation by ward or floor. Federal support for training programs such as the Army Cadet Nurse Corps and medical residencies in Veterans Administration Hospitals increased the ranks of health professionals while also offering equal opportunity to Americans of all races and religions.[11] As Surgeon General Thomas Parran put it, "[e]very citizen, North and South, colored and white, rich and poor, has an inalienable right to his citizen's share of health protection."

To develop solutions to high-priority health problems of military importance, the PHS and the Armed Forces Epidemiological Board took responsibility for protecting the health of American troops through measures such as venereal disease and malaria control, tropical disease research, and mental hygiene programs to prevent and treat combat-related disorders. Parran's mobilization of the PHS for the war effort was a master strategic stroke that framed health reform as an urgent matter of national defense and garnered unprecedented federal funding for broad-based programs to support public health and sanitation services, medical research, and hospital construction. Wartime federal spending rose to ten times that for peacetime New Deal programs, and health was among the top beneficiaries.[12]

Dollar for dollar, two of the most valuable investments of federal funding for medical research were the wartime trials of antimalarial drugs and the determination of effective regimens for treating syphilis with penicillin.

The development of synthetic antimalarial drugs was a top priority for the U.S. military, particularly after the supply of quinine was cut off in 1942 by the Japanese offensive in Southeast Asia. The malaria research program proved to be the largest biomedical undertaking to date and it became a model for postwar scientific medical research that marshaled the resources of academia, government, and private industry. From 1942 to 1946, the Office for the Survey of Antimalarial Drugs conducted tests on ducklings and yielded precise pharmacological and toxicological data on over 14,000 drugs, roughly ten a day for four years. The survey decisively identified cloroquine as the drug of choice against malaria.[13]

Along with malaria, syphilis was the disease that posed the greatest threat to the fighting effectiveness of American soldiers. Before methods to mass-produce penicillin were perfected in 1943, the standard treatment regimen for syphilis was long, complicated, and relied on potentially toxic arsenic and mercury compounds. Private physicians struggled to master the skills necessary to inject patients with the right combination of drugs to kill the spirochetes but not the patient. The PHS Venereal Disease Clinic at Hot Springs, Arkansas developed a new, more efficient method of administering intravenous drug therapy for syphilis and gonorrhea to large numbers of in-patients with a minimum number of personnel.

With ample federal funds from the Social Security Act and the 1938 National Venereal Disease Control Act, the number of venereal disease rapid treatment centers had tripled to more than 2,400 by the end of 1939, with 9 million treatments given annually to over 100,000 patients. New syphilis cases declined by over half from 1936 to 1939, and infant deaths from congenital syphilis were halved.[14]

[It should be acknowledged that during this period, the PHS was conducting the longest nontherapeutic medical study in U.S. history, the Tuskegee Study of Untreated Syphilis in the Negro Male, which was grounded in assumptions that reflected the pervasive scientific racism among white medical professionals of the era.[15]]

During the war, the federal Office of Scientific Research and Development's cooperative clinical trials of penicillin to treat early-stage syphilis demonstrated that penicillin could drastically shorten the length of treatment to only ten days for syphilis patients and three days for gonorrhea cases, with some requiring only a single injection. Using the penicillin studies as a guide, the Public Health Service also used randomized controls to evaluate streptomycin in treating tuberculosis.

The PHS energetically promoted VD screening, prevention, and education programs for military and civilian populations, with special attention to military bases and defense production areas. As the country celebrated victory and prepared for demobilization, the PHS announced that rates of venereal disease among civilians had not markedly increased during wartime, as they had in every previous conflict.[16]

After the war, Congress authorized the highest funding levels yet to continue treating VD patients in rapid treatment centers and hospitals, which reduced venereal disease rates to such low figures in the civilian as well as military populations that most rapid treatment centers had closed by the early 1950s.[17]

But venereal disease became a cautionary tale that demonstrated the danger of declaring victory too soon: after the reduction of federal venereal disease control expenditures during the 1950s, rates of syphilis and gonorrhea resurged to epidemic proportions during the 1960s and 1970s, and by 1980, an estimated 20 million Americans had contracted genital herpes.[18]

Federally funded and orchestrated wartime research yielded therapeutic compounds to prevent and cure three of the top killers of all time, malaria, syphilis, and tuberculosis. More than just fighting specific diseases, these efforts made fundamental contributions to the development of basic medical research methodology.

For the modern pharmacopeia from which nearly every American has benefited, we can thank the federally sponsored model of research and development provided by the intensive laboratory evaluations of antimalarial drugs. Likewise, the government-coordinated experiments to test the effectiveness of penicillin set the scientific standard for the modern clinical trial that forms the basis for another essential federal role in health, the regulation of the drug industry to ensure the safety and effectiveness of thousands of new pharmaceutical compounds before they reach the market.[19]

MOTHERS, BABIES, AND HOSPITALS

As the U.S. birth rate topped four million in 1954, the largest category of PHS public health grants to states was for maternal and child health programs. Amendments to the Social Security Act between 1950 and 1963 continuously increased the annual appropriations for maternal and child health and crippled children's services, which rose from a combined $1.9 million the first year of Social Security in 1936-37 to $87.3 million by 1966-67. Congress recognized the importance of maternal and child health research by authorizing the National Institute of Child Health and Human Development in 1962 and by including a research

component in new Social Security initiatives passed in 1963 and 1965 to improve the health of low-income pregnant women and young children who lived in substandard housing and lacked access to primary care. During this era, pediatricians enjoyed both growing financial success and social status, yet their commitment to private practice was compatible with broad support for government-sponsored child health programs. Such positions often put the American Academy of Pediatrics at odds with the more conservative American Medical Association.[20]

Closely related to the problems of maternal and infant health was access to hospital care. In the South in 1941, only one-third of all births took place in hospitals versus three-quarters of non-southern births, and 23 percent of southern babies were delivered by midwives versus only 1.5 percent of non-southern births. In 1938, toxemia killed women in southern states at rates from 50 to 150 percent higher than in the rest of the United States, largely due to lack of medical care. Since most southern hospitals did not admit blacks and many rural counties had no hospital at all, rural black mothers and infants benefited least from the medical advances available from trained professionals in modern hospitals.[21]

From 1947 to 1971 the Hill-Burton Hospital Survey and Construction Act built a modern health care infrastructure with $3.7 billion in federal funds, matched by $9.1 billion from state and local governments, to create space for nearly a half million beds in 10,748 projects, including nursing homes and other specialized facilities.[22] Hill-Burton was among the first and most successful examples of a new postwar brand of federal reform that garnered bipartisan support by blending centralized planning, economic development, and a rationale for domestic spending based on national defense.[23]

In the absence of a national health insurance program, Hill-Burton substantially increased access to charity care by expanding the number of government-owned hospitals and the overall proportion of beds in public hospitals, particularly teaching institutions affiliated with medical schools. This had major implications for the racial desegregation of hospitals, since participation in the Hill-Burton program constituted "state action" that placed private as well as public hospitals under the equal protection clause of the Fourteenth Amendment and obligated them to admit patients without regard to race.[24]

Hill-Burton's provisions benefited the South most of all. The program's graduated, need-based allocation formula paved the way for federal sponsorship of southern health, education, and welfare as well as costly new infrastructure that undergirded Sun Belt prosperity while allowing southern states to maintain low taxes. By 1955, southern states drew 20 percent of their revenues from federal sources, well above the national average of 14 percent.

Ironically Mississippi, the epicenter of antifederal sentiment and the backlash against federally mandated desegregation, tied for fourth with Arkansas among states with the highest percentage of their budgets from federal funds. Today, despite the marked improvement of the southern economy since the Great Depression, many southern states receive more in federal aid than they pay in federal taxes. As the culmination of the post-1938 New Deal that targeted federal resources to the South, Hill-Burton was the last and most progressive expression of redistributive mid-century liberalism.[25]

ON THE CUTTING EDGE OF RESEARCH: THE NIH

In 1930, the PHS Hygienic Laboratory was renamed the National Institute of Health (NIH), which signaled an increased federal investment in medical research, particularly on

chronic diseases, which had replaced infectious diseases as the most common killers. The National Cancer Institute was the first disease-specific institute to be established, in 1937. Since the end of World War II, the NIH along with the CDC have been the main channels through which the federal government has invested in protecting and promoting the health of Americans through research, training, and disease tracking programs.

After World War II, the NIH (with "institutes" now a plural) grew rapidly to become the world's single largest funder of biomedical research on cancer, heart disease, microbiology, dentistry, mental health, neurological diseases and blindness, and arthritis and metabolic diseases. From the 1950s on, the agency emphasized basic science research, particularly the cellular and molecular biology of disease, which in turn underwrote the establishment and expansion of a nationwide network of academic medical centers whose primary mission was research. These centers partnered closely with private drug firms, who employed a steady stream of top-notch graduates subsidized by federal training grants, the G.I. Bill, and the 1958 National Defense Education Act.

Of all arms of federal health policy, the NIH has enjoyed the largest and most consistent appropriations and the greatest bipartisan support. Unlike other areas of federal research and development funding, which have fluctuated based on external events, the NIH budget has grown steadily decade after decade. Its annual appropriation increased from $81 million in 1954 to $1.6 billion by 1968. By 2004, it had reached nearly $28 billion.

Yet if there was a special interest in Congress that could rival biomedical research, it was Big Tobacco. The majority of credit for reducing rates of cancer (as opposed to treating it) goes to the 1964 Surgeon General's Report on Smoking and Health, which definitively linked cigarette smoking with significantly higher risks of lung cancer as well as heart disease, emphysema, and bronchitis. Annual per capita cigarette consumption increased from 54 cigarettes in 1900 to an astounding 4345 cigarettes in 1963, but then slowly decreased to 2261 in 1998.[26]

Despite the tobacco industry's best efforts, the report was widely distributed and reported in the media, creating the necessary atmosphere for public health officials to pursue regulations. These included placing the now-ubiquitous Surgeon General's warnings on packaging, and Federal bans on cigarette advertising on radio, television, or billboards. The 1964 Surgeon General's Report set a precedent for establishing and publicizing all types of health risks, as well as for the scientific resolution of controversial issues via the collective, objective review of evidence. Finally, the report accorded the Surgeon General and the federal government a powerful new level of authority in protecting national health.[27]

NATIONAL HEALTH INSURANCE: A DREAM DEFERRED?

During the 1960s and 1970s, a highly favorable social and political climate fostered innovation and expansion in federal health programs. As a keystone of President Lyndon B. Johnson's Great Society, the 1965 Medicare-Medicaid amendments to Social Security together helped to extend medical and hospital care to millions of Americans who had been excluded from the private health system on the basis of both race and income. By the mid-1960s, more than 40 million of America's 193 million people--nearly 20 percent--remained uninsured. Not only did Medicare-Medicaid remove financial barriers for the elderly and many (but not all) of those under 65 who could not afford care, it also brought about the racial desegregation of

health care by requiring compliance with the 1964 Civil Rights Act for all participating hospitals.[28]

Medicare and Medicaid, originally intended to include the two largest groups of uninsured who lacked employer-based coverage, now function as much to preserve the financial status of middle-class Americans as to enable the poor to purchase health care. Many middle-class individuals become beneficiaries of both Medicare and Medicaid, which pays at least part of costs for 70 percent of nursing home residents, thereby sparing them from having to rely as heavily on their families' resources. Medicare foots the bill for health care at the age when it is typically most expensive, while Medicaid subsidizes the long-term care needs of the nation's elderly and chronically disabled. Medical and nursing home care rank alongside postsecondary education and home mortgages as the most expensive items that most Americans will buy in their lifetimes. All three are federally subsidized, but college loans and mortgage interest are less universal and the federal government pays a much lower share of the total than for long-term care and medical costs over age 65.[29]

With the passage of the 2010 Affordable Care Act, President Barack Obama signed into law a major milestone in federal health reform. While it still fell short of the long-pursued goal of universal comprehensive health coverage, the act won important concessions from the insurance industry, such as ending the practice of denying coverage to children under nineteen based on a pre-existing health condition, enabling parents to keep their children as beneficiaries on their health insurance up to age twenty-six, ending lifetime and most annual limits on care, and providing free access to recommended preventive services such as colonoscopies and mammograms. The law also offered tax credits to encourage small businesses to insure more workers and grants to enable states to establish affordable insurance exchanges designed to increase competition among health insurance providers.[30]

The Affordable Care Act's passage marked a historical first: the American Medical Association solidly endorsed federal health insurance legislation, although it opposed the president's public option plan to compete with private insurers. The AMA had supported the goal of universal health care in 1921, but the AMA's policy stance had been to oppose vigorously every national health insurance bill since 1939.[31] The AMA's leaders (notwithstanding considerable dissent among the membership) held fast to the private insurance system as the only acceptable method of financing health care, which pitted the organization against any proposed government-sponsored health plan.

With the passage of Medicare, however, physicians became dependent on reimbursements from the program and lobbied hard to preserve rates they deemed acceptable. The AMA's support for the Obama administration's bill can be interpreted in part as a strategic move to retain the allegiance of key Democrats for the group's Medicare and other policy positions. Yet it was also a striking departure for the AMA's executive vice president, Michael D. Maves, to admit that "We do not believe that maintaining the status quo is an acceptable option for physicians or the patients we serve."

It remains to be seen how the law will be implemented, but the AMA committed its support for "achieving enactment of comprehensive health system reform legislation that improves access to affordable, high-quality care and reduces unnecessary costs."[32] As long ago as 1969 the group called adequate health care "a basic right of every citizen," and given time, the Affordable Care Act will move the country forward toward that goal.

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Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: Karen Kruse Thomas

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2011. Include the source and amount of each grant or contract.

None

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

None

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2010, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

I certify that the above information is true and correct.

Signature: Karen Kruse Thomas Date: 12-3-2013