Health Care

Politics, Policy, and Distributive Justice

The Ironic Triumph

Robert P. Rhodes

Health Care Politics, Policy, and Distributive Justice

The Ironic Triumph

Robert P. Rhodes

State University of New York Press

Published by
State University of New York Press, Albany

For information, address State University of New York
Press, State University Plaza, Albany, N.Y., 12246

Production by M. R. Mulholland
Marketing by Dana E. Yanulavich

Library of Congress Cataloging in Publication Data

Rhodes, Robert P., 1938–
Health care politics, policy, and distributive justice : the ironic triumph / Robert P. Rhodes.
p. cm.—(SUNY series in health care politics and policy)
Includes bibliographical references (p.) and index.
ISBN 0–7914–0777–2 (cloth : alk. paper).—ISBN 0–7914–0778–0 (paper : alk. paper)
1. Medical policy—United States. 2. Medical care—Political aspects—United States. 3. Medical laws and legislation—Political aspects—United States. I. Title. II. Series.
RA395.A3R49 1992
362.1'0973—dc20 90–10364
CIP

10 9 8 7 6 5 4 3

Acknowledgments

The idea for this book started almost a decade ago while I was a National Endowment for the Humanities Fellow at Indiana University. I owe many warm thanks to a wonderful teacher and friend, David Smith at Indiana University, Bloomington, who read an early version of the manuscript, and to all my NEH colleagues in philosophy who had to put up with a political scientist in a year long seminar on bio-ethics. Fred Meyer of Ball State University made many helpful comments in his review. Edward Abegg of the Edinboro University philosophy department also read the earlier stages of the book and challenged my positions on health care rights. Robert Cornesky, Dean of Science and Technology at Edinboro and an epidemiologist, read the entire manuscript as did the chair of the nursing department at Edinboro, Harriet Phillips. Both demonstrated what collegiality means by providing skillful editing of a politics and policy book from the vantage point of their professions.

Contents

Figures

Tables

Preface

"American Nursing Association Warns of Nursing Shortage—Calls for Federally Funded Nurse Training"; "Gynecologists Abandoning Practice Due to Malpractice Insurance"; "Elderly Dumped into Unskilled Nursing Homes"; "Hospital Costs and Physician Prices Bankrupting Medicare"; "Infant Mortality Rates for Inner City Children Higher Than Some Third World Countries"; "Gays Blame White House Homophobia for Inadequate Research Funding for AIDS." Headlines such as these are commonplace today; health care is high on the political agenda.

In the famous aphorism of Harold Lasswell, politics is the study of "Who gets what, when, and how." Health care providers are apt to think of medicine in scientific and technical terms, quite removed from issue of power and influence. But the health care industry has changed in magnitude, and that change has forced health care onto the front page. It is now more than a $700 billion industry, and government finances over 40 percent of that sum.

Students of politics are interested in describing and evaluating how health care goods and services are created, administered, and distributed as indications of power and influence in health care. As is true for any science, political scientists develop and apply empirical theory to predict behavior affecting power relationships under specified circumstances. The pages that follow will certainly try to illustrate the distribution of power and influence in health care. But we are equally concerned about distributive justice. Who ought to receive more (or less) health care? How should we decide these distributions? In the past, these questions were usually relegated to political philosophy and bioethics. Distributive justice and ethical questions are central to political analysis of health and policy just as bioethical criticism of health care policy is very naive without a thorough understanding of power relationships illuminated by the social sciences.

Basic conflicts in health care policy today are helpfully illuminated by interjecting themes as old as the Greeks—irony and tragedy. The Greek story of Daedalus is a good place to start. Daedalus, a great inventor and builder, constructed the labyrinth in Crete for King Minos, only to be imprisoned in his own creation by the king. Ever inventive, Daedalus constructed wings held together with wax, with which he and his son Icarus could fly away. They were successful, but Icarus was greatly taken by his power of flight. Heedless of the warning from his father not to fly close to

the sun, his wax melted, and Icarus plunged to his death. Icarus' pride in flight overwhelmed courage and inventiveness necessary for escape.

Humor occurs when incongruous situations appear: a Charlie Chaplin "little tramp" figure dressed in a rumpled tuxedo and slipping on a banana peel. Irony takes over when the consequences of trying to do one thing lead perversely to the opposite and the result is more pain than humor. When professional associations such as the American Medical Association succeed at raising educational standards for members, they also produce increased specialized organizations (such as the American College of Surgeons), which eventually weaken the influence of the parent organization. That is irony. At the core of tragedy is moral conflict wrapped with suffering and irony so heavy it is no longer merely "wry." Tragedy is more than irony, for it involves moral purpose whose very attempt leads to death and suffering.*

Most of health care politics is routine conflict over who gets what, when, and how. Conflict can be bitter between winners and losers. But at some junctures, health care politics is best informed by an ironic and sometimes tragic perspective on the part of the observer. Here the source of the conflict has a deeper dimension than economic advantage, protection of social authority, and preservation of influence over policy decisions. I refer to those kinds of conflict whose very resolution undermines the fundamental values on which social cooperation depends. Here politics takes on a singular character and health care politics disproportionately is characterized by that character.

We have a medical delivery system second to none in the world; that includes, with some glaring exceptions, health care for the poor. We have extended life with modern medical technology and pharmaceuticals. Medical science stands triumphant in our generation. Yet we are uneasy about the fact that 10 percent of our health care budget is spent on the process of dying, 12 percent of our gross national product, (GNP) is consumed by health care costs, and inflation in health care has consistently been double that of the consumer price index, (CPI) since the 1960s. Per capita medical expenditures are higher in the United States than in any other country, without very convincing evidence that the addition is correlated with better health. Yet to cut back on health care costs seems to threaten the well being of those who most need it. The elderly, those suffering from AIDS, those in need of transplants or dialysis, the poor in rural and urban pockets of poverty, and the first to suffer the consequences of cost-saving measures. On the other hand, it is clear that too much medical attention can produce iatrogenic results—where medical care is harmful. Excessive X-ray exposure, staph infections in hospitals, unnecessary surgery, are all examples, and there are many others at the level of public policy.

It would be ironic indeed if public expenditures for health care, driven by political pressures, divert resources needed to fulfill needs, notwithstanding their nonmedical character, that are vital to the health of our citizens: Unemployment and poverty among single female-headed households with children seriously affect health, an underclass grows in our cities, while suicide, homicide, and other criminal violence are epidemic among our young. Looming ahead is a double deficit of balance-of-payment problems and a $1 trillion debt.

For many years, I have taught health care politics and policy at undergraduate and graduate levels. My students are in the main senior nurses in community health, as well as majors in social work, gerontology, political science, philosophy, and the general liberal arts. In many respects, those in the "helping professions" in health care, particularly in nursing, are in a better position to migrate from a totally medical model to alternative perspectives on what policies promote health. After all, they deal with individuals in their social settings, as well as with their bodies. Many of the readers of this volume will be involved in professional programs or are already on staff in health care settings. Possibly they may find some conclusions here unsettling. Nurses, physicians, medical technicians, social workers, health care educators, and others in the industry, after all, are also political actors with their own interests and perspectives, working in industries directly affected by public policy. Many of these perspectives will be challenged in these pages, for it is an important theme that a just distribution of health is often not dependent upon further expansion of the health care industry, but on alternative strategies in health policy. In a sense, my approach is to take ecological or "holistic" health care seriously. Those who do take it seriously quickly recognize a schizoid reality for health care professionals. On the one hand is the medical model of the world's problems: alcohol and drug abuse, sexual problems, infectious diseases, insomnia, obesity, low birth weight. On the other are nonmedical models of the same problems.

When holistic health is taken seriously, the most highly skilled of the "helping professions," general practitioners, social workers, and especially nurses, play pivotal roles. Nurses are well situated to coordinate social services with primary health care and family relationships. Nurses do not require technologically intense environments to perform most of their functions. And nurses are much less expensive, allowing limited budgets to reach wider needs. Holistic health care is not central to the health care delivery system today, in spite of rhetoric to the contrary, and powerful institutions in that system shaped and obtained public funding for an alternate system in which nurses (and holistic care) were decidedly subordinated. In the political process of shaping the health care system, the

political impotence and ignorance of the "helping professions" often made such groups unwitting allies of much more powerful organizations.

The American health care delivery system is a product of the entire spectrum of American politics. Physicians and hospitals have produced a high-quality product that dominant political coalitions—most of which are outside the medical industry—wanted and got from government. But the product is expensive and not well distributed. Most of our health care policy dilemma is how to balance extraordinary costs, still escalating, with maintaining quality care and improved distribution.

Our understanding of health is politically contested. Is abortion, or alcoholism, or drug dependence, or stress-related pathology a medical problem? Can we decide yea or nay on intravenous treatment and feeding for a long-term comatose patient on medical criteria alone? Clearly, these are medical *and* political *and* moral *and* justice questions. How should we respond to low birth weight? With additional neonatal centers? More intensive prenatal care? Or should we consider programs that enhance employment, family stability, income, nourishment, and education. Should government, or parents, or physicians have final decision-making authority for treating newborns. If newborns are aggressively treated (surviving neonates under 1,000 grams have greater incidents of mental retardation and are more technically dependent) and increased number are institutionalized and require expensive therapies, who should pay for their continued care? Should there be a right to health care? Equal access to health care? Should rights be expanded to provide redress through liability actions? Different interest groups, in and out of health care provider communities, have very different responses to these questions. Given the complexities, determining who has power, where justice lies, and what constitutes a prudent and just health policy is a somewhat grandiose project. However limited the success of such an enterprise, that is what his book intends.

Robert Rhodes
Edinboro

Note

*This conception of tragedy will not be acceptable to classicists where the tragic hero must pass through awareness of his fate, suffering, admission, and reconciliation. I mean tragedy in its more popular sense here.

Part I

Modern Miracles, Hard Choices

1

Health Care Past and Present

"Most Men Live Lives That Are Short, Nasty and Brutish"

—Thomas Hobbes

"Man that is born of woman is of few days and full of trouble. He cometh forth like a flower and is cut down. He fleeth also as a shadow and continueth not."

—The Book of Job

Death before the nineteenth century was an ever-looming presence in our ancestors' thoughts and a frequent visitor to their families. They feared it and had little control over it. Sudden death was as central to attitudes prior to the twentieth century as the cemetery was to every village and town. In disproportionate numbers, early death came to infants, but all ages and classes felt its sting in high proportion compared to modern times. In the 1640s, between one quarter and one third of all children of English peers and peasants died before the age of fifteen.[1]

Bubonic plague in the fifteenth century and smallpox in the sixteenth century led the list of diseases. Dysentery and fever and intestinal worms were also mentioned by contemporary sources in 1745 England as common causes of infant mortality. Certainly, inadequate diet, especially the lack of milk until the late eighteenth century, played an important role, as did appalling ignorance of minimal personal and public hygiene. Polluted water and contaminated food were common. As late as the eighteenth century, towns still depended upon open ditches for latrines and refuse (such as the offal of butchers). Standing water from these ditches provided breeding grounds for mosquitoes and bacteria[2]which polluted wells and streams. In America, public health won reluctant acceptance only slowly and with much finger pointing. One of the earliest legislative reports on public health, in 1850, lamented "the sanitary evils arising from foreign emigration."[3] "Every man in whose veins courses any puritan blood, as he

looks back upon the events of the past, or forward to the hopes of the future, is appalled and astounded,''[4] stated the report in a mix of nativism and factual understanding of the desperate plight of many newly arrived Americans. The report chronicled the rate of immigration and the levels of poverty, crime, immorality, and disease that members of the Massachusetts legislature associated with it. Concern for public consequences, however, did lead to a concern for public health that was new to Boston and that included education in sanitation, better constructed tenement buildings, and especially the construction of public bathing houses and wash houses for newcomers to the city who had no running water.

In our own age, adolescents are robust and healthy. That was not true prior to the nineteenth century. Infectious disease did not spare the young. After 1750, upper-class mortality rates were lower for those who had reached twenty-one years of age, presumably because they could afford to live in the countryside and escape plague in the towns, but infant mortality rates were high for all classes. both lower and peer classes in England experienced very high mortality rates for children until the mid 1700s.

Death and Fatalism

The specter of death influenced family behavior and divorce. In an age where moralists lament that American divorce rates are the highest in recorded history, demographers like to point out that the American ''durability'' rate, or average period of married people remaining with the same spouse, is also the highest in recorded history. Prior to the twentieth century, divorce rates were low, not only as a function of moral principles and economic interdependence, but also as a function of high mortality among husbands and wives. In many cases, death rendered divorce moot.

Frequent death affected child rearing. Parents were more aloof from their children, anticipating childhood death and resigning themselves to it. Ironically, there is evidence that parental neglect itself was a major contributing factor to early death for children. In seventeenth- and eighteenth-century England, upper-class mothers customarily sent away their newborn infants to be reared by wet nurses, a practice that further reduced the survivability of their infants compared with upper-class infants who were kept at home.[5] Fatalism and resignation toughened maternal attitudes. ''Well, I only lost two out o' six babies, that's not so bad,'' wrote a nineteenth-century mother, thankful for her natal odds. Like this mother, parents tended to distance themselves from their children lest their frequent loss overwhelm them with grief. ''Death, ain't you got no shame?'' asked the old folk song, but the answer was already known.

Resignation and fatalism toward natural occurrences characterize pre-industrial societies, just as a sense of self-direction and control characterize