Health in America

Health is as much a cultural value as an objective state of being. Among the Indians of one South American tribe, reports microbiologist René Dubos, a skin ailment called *pinta* is so prevalent that the unaffected are considered to be ill. In China, health *(jian-kang)* is regarded as a matter of physical and psychic harmony. In France, *santé* is a quality one "possesses." Americans are of two minds. Since Colonial days, health has been associated with purity: of the soul, of food, of air and water, of "lifestyle." Health is also something Americans this year will spend one-quarter of a trillion dollars trying to buy—with some success—even as Congress weighs conflicting proposals to further subsidize its cost. Here, medical writer Cary Kimble traces the nation's evolving perceptions of health; sociologist Charles Bosk looks at the doctors; and author-physician Lewis Thomas, in a reflective essay drawn from his remarks at a recent Wilson Center seminar, surveys medical progress over the past two generations and speculates on contributions yet to come.

IN PURSUIT OF WELL-BEING

by Cary Kimble

If one has any doubts about the intensity with which Americans think about their health, the *New York Times* best-seller list—dominated during the 1970s by such books as *The Complete Book of Running* (772,000 copies sold) and the *American Heart Association Cookbook* (400,000)—should help dispel them.

Some other statistics may seal the argument. During the '70s, 18 medical schools opened, and total enrollment jumped from 35,000 to nearly 64,000. The number of persons employed in "health services" grew from 4.2 million to more than 7 million. In terms of total spending, health care became the nation's third largest "industry" (after construction and agriculture). By

the end of the decade, Americans were spending 11 cents of every dollar of personal after-tax income on medical care, compared to less than 5 cents 30 years ago.

In all, the United States will spend an estimated $244 billion on "health" this year, almost as much as the entire U.S. Gross National Product in 1950. And that figure does not include the money spent on "high-fiber" bran cereals, jogging togs, self-help books, or cleaning up the environment.

Author-physician Lewis Thomas recently wondered what some "alien historian" might make of this boom in health—or at least in health spending. Perhaps, the outsider might infer, the nation's health had suddenly disintegrated, prompting a kind of domestic Marshall Plan to meet the crisis. Or, maybe, the technology for dealing with illness had become so advanced that its cost had gone through the roof. There was a third possibility, too: that Americans had somehow been caught up in the momentum of a "huge, collective, ponderous set of errors" in public policy and private choice.

Healthy Hypochondriacs?

The alien historian's first impression would be wide of the mark. U.S. citizens can expect to live five years longer today than in 1950. Since 1968, death due to heart disease has actually decreased by a remarkable 25 percent in the United States, even as the toll continues to mount in Western Europe. In short, as U.S. Surgeon General Julius B. Richmond put it last year, "the health of the American people has never been better."

The second suggestion has a bit more merit. The issue here is not so much routine procedures like the 4.5 billion lab tests U.S. doctors ran in 1976 (more than 20 for every American), although these certainly cost money. The capital investment required for such "big-ticket technologies" as renal dialysis, computerized x-ray (CAT) scanners, and fetal monitoring becomes in itself an incentive for overuse; the potential benefits to patients become the justification. CAT scanners, each of which may cost $750,000 to buy and about the same amount to operate per year, will account for one-third of all diagnostic charges this year. Insurance reimbursements for technology are increasing far more rapidly than reimbursements for "physician-patient interaction," and doctors can double or triple their incomes

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Job and his Wife, *by Albrecht Dürer (1471–1528). Smitten with boils "from the sole of his foot unto his crown," Job bore his affliction stoically, refusing to curse God or, like many Americans today, to change his lifestyle.*

Städelsches Kunstinstitut, Frankfurt.

merely by adopting a high-technology "style." In all, inflation in health-care expenditures rose an average of 10.2 percent annually during the last three decades.

But, according to most estimates, technology accounts for only about 15 percent of the upsurge in spending. Thomas's third suggestion raises this possibility: that Americans' *perceptions* and, above all, *expectations* of good health have shaped their behavior—and the votes in Congress for medical funding; that we are, in short, "healthy hypochondriacs." The United States has eliminated starvation and all but a few pockets of absolute poverty. Now, it can be argued, Americans have fastened on perfect health as an unmet national need. Our forefathers would be astonished.

In colonial times, the United States was what would now be considered a very poor "underdeveloped" country. By present standards, death rates were intolerably high, owing to childhood illness and frequent outbreaks of typhus, typhoid,

smallpox, and cholera. In such circumstances, it was perhaps fortunate that the early settlers saw sickness visited and health restored as part of God's Plan. The physician may have had the medications and the instruments to relieve pain in some cases, even (rarely) to prolong life. But it was God who ultimately determined who would die and who would live.

Cotton Mather (1663–1728), the outspoken Boston clergyman and physician, spelled out both the prevailing attitudes toward health and the direction American medicine would eventually take. Sin, he explained, "brings on a sickness in the Spirit [which] will naturally cause a sickness in the Body." On the other hand, Mather believed, "a skillful and faithful physician will do more for a poor patient than all the saints in the Roman Calendar."

"Spiritual Kinship"

The 19th century brought some hope in this regard. While Americans still faced devastating epidemics, notably in the immigrant-packed cities of the East, medical schools began producing the first generations of genuinely "scientific" doctors. Public hospitals emerged as centers of medical care throughout the country. Surgery of all kinds—orthopedic, abdominal, neurological—became somewhat more sophisticated and, due primarily to the general use of anesthesia (ether) beginning in the 1840s, considerably less hazardous. Concern for public health led to water-flushed sewer systems and the public parks of Frederick Law Olmsted. The verification of the germ theory of disease by French chemist Louis Pasteur in 1860 brought a new understanding of the relationship between specific microorganisms and specific illnesses.

Such developments gradually reinforced a lasting transformation in Americans' perception of health, a realization that disease was sometimes conquerable and often preventable. Capitalizing on this notion, reformers like Sylvester Graham (1794–1851), now remembered chiefly for his Graham cracker, toured the land promoting vegetarianism, natural foods, roughage, exercise, sunshine, fresh air, weekend bathing, and sex hygiene. Not for the last time, Americans began to change their "lifestyles." The middle class, especially, enjoyed an upsurge in participatory sports—tennis, golf, baseball, bicycling. Spas and "hydropathic institutes" became the vogue, and newsletters like the *Herald of Health* graced bourgeois parlors. Among proponents of the new fads, there was, as one historian has noted, a kind of "spiritual kinship."

THE TOP 10 HEALTH BOOKS OF THE 1970s

		Sales since 1970
1	**Better Homes and Gardens Family Medical Guide** (1964)	3,129,000
2	**Dr. Atkins' Diet Revolution: The High Calorie Way to Stay Thin Forever,** Robert C. Atkins (1972)	1,000,000
3	**Weight Watchers New Program Cookbook,** Jean Nidetch (1979)	900,000
4	**The Complete Book of Running,** James F. Fixx (1977)	771,958
5	**The Complete Scarsdale Medical Diet Plus Dr. Tarnower's Keep-Slim Program,** Herman Tarnower and Samm S. Baker (1979)	650,000
6	**The American Heart Association Cookbook,** Ruthe Eshleman and Mary Winston (1973)	400,000
7	**Total Fitness in 30 Minutes a Week,** Laurence E. Morehouse and Leonard Gross (1975)	206,000
8	**Doctor's Quick Inches Off Diet,** Irwin Stillman and Samm S. Baker (1969)	200,000
9	**The Save Your Life Diet: High Fiber Protection from Six of the Most Serious Diseases of Civilization,** David Reuben (1975)	175,000
10	**Dr. Atkins' Superenergy Diet: The Diet Revolution's Answer to Fatigue and Depression,** Robert C. Atkins and Shirley M. Linde (1977)	131,954

Note: All sales are publishers' estimates, in hardcover only. None of the figures include book club sales.

This list excludes sex manuals like Alex Comfort's The Joy of Sex *(1972) and David Reuben's* Everything You Always Wanted to Know About Sex But Were Afraid to Ask *(1969)—which sold 1 million and 600,000 copies respectively. (To put these figures in perspective, the No. 1 hardcover nonfiction, nonhealth best seller of the decade was Alex Haley's* Roots, *published in 1976; it sold 1,174,000 copies.) After sex, Americans like food: Seven of the Top 10 books are guides to dieting or healthful cooking. Dr. Benjamin Spock's* Baby and Child Care *does not rank among the Top 10 for the 1970s, but it has sold more than 23 million copies, almost all in paperback, since it was first published in 1946.*

The federal government, too, stepped tentatively into the health business in the 19th century. In 1813, Congress passed a bill "encouraging" the use of Edward Jenner's cowpox vaccine. Later came the Import Drugs Act (1848) and the Animal Inspection Act (1892). A landmark Food and Drug Act was signed into law by President Theodore Roosevelt in 1906. These and other

legislative initiatives reflected a new feeling among U.S. politicians, encouraged by some of the new philanthropic foundations, that there existed some kind of citizen "right" to health, be it the positive right to vaccination or the right to be free from harmful food, drugs, and other products. This laudable notion underlay the establishment of charitable hospitals and, eventually, the growth of tax-subsidized health care, notably Medicare and Medicaid.*

As America entered the 20th century, great accomplishments lay ahead. A baby born in 1900 could expect to live 47 years. By 1980, life expectancy would be about 73 years. The annual death rate in the United States would drop from 17 to about 9 per 1,000. The United States was riding a seemingly endless crest of hope: the discovery of vitamins in 1912; the isolation of the hormone insulin in 1921; the discovery of penicillin in 1928; the mass-production of antibiotics spurred by World War II; the development of open-heart surgery in 1954; the triumph over dreaded polio in 1955; the first human-heart transplant by South Africa's Dr. Christiaan Barnard in 1967.

One Organ at a Time

By then, one could almost say, the only dangerous infectious disease left seemed to be optimism. A 1965 Gallup poll found that 77 percent of those surveyed believed a cure for cancer would be found by 1985; almost half thought the common cold would be licked. A decade later, the President's 1976 Biomedical Research Panel boldly proclaimed that science had at last reached the stage where the capacity to conquer all human disease was within reach. There do not appear, the panel reported, to be any more "impenetrable, incomprehensible diseases."

Yet, inevitably, rapid progress has provoked re-examination. Despite obvious scientific progress on many fronts, Americans are increasingly worried about the sheer cost of medical care. (A simple appendicitis operation and a five-day hospital stay, for example, can cost $3,500.) Already the taxpayers pay up to $40,000 a year per patient for kidney dialysis (in effect im-

*The Medicare and Medicaid programs were established by Congress in 1965 at the behest of President Lyndon Johnson to help aged and poor persons meet the cost of medical care. Both programs are lodged in the Department of Health, Education, and Welfare. *Medicare* is essentially a national health insurance program for people age 65 or older and for certain disabled persons. *Medicaid,* which is funded by state and federal governments, and which varies from state to state, is a "medical assistance" program for people with low incomes and for the "medically needy"—i.e., those who may earn enough to cover daily living expenses but not enough to pay for medical care. Total program costs for both Medicare and Medicaid are projected at $56.3 billion in 1980.

PSYCHIATRY TODAY

In 1939, there were 3,000 psychiatrists in the United States. By 1978, the number had grown to 28,000. Between 1963 and 1973, psychiatry was the third fastest growing specialty in the United States, after internal medicine and radiology.

At least one out of every four psychiatrists in the world today is American—and probably white. Only 3.3 percent of U.S. psychiatrists are of Hispanic background; 2.1 percent are black; 0.5 percent, American Indian. Fourteen percent of U.S. psychiatrists are women. While the national average is 12.4 psychiatrists per 100,000 people, New York, Massachusetts, Connecticut, and Maryland all have more than 20 per 100,000. The District of Columbia enjoys the highest ratio: 58.9 psychiatrists per 100,000 people. (One reason is that health insurance for federal workers automatically pays for extensive psychiatric as well as physical care.)

About 3 out of 10 Americans, not all of them mentally ill, are given mental health care at some point in their lives. In any one year, according to the U.S. Department of Health, Education, and Welfare, about 15 percent of the American people suffer "mental disorders." Relatively few receive formal treatment. In 1975, some 6.7 million Americans (3 percent of the population) consulted psychiatrists, psychologists, or counselors. Almost half of those who did so for the first time were diagnosed as depressed (17 percent), schizophrenic (16 percent), or alcoholic (11 percent). Men and women consult private psychiatrists in equal proportions, according to a 1976 American Psychiatric Association Survey.

Twenty-five years ago, a diagnosis of mental illness virtually guaranteed that the patient would be institutionalized. In 1955, three out of four mentally ill persons were treated in hospitals; 20 years later, the proportion dropped to one in four as the number of patients in state and county mental hospitals fell from 559,000 to 191,000. Reasons for the shift include the discovery and widespread use of tranquilizers and other mood-altering drugs; the development of community mental health centers; the transfer (thanks to Medicaid and Medicare) of mentally ill aged people from hospitals to nursing homes; and, perhaps, a growing tolerance in the United States of unusual behavior.

Within the field of psychiatry, two increasingly prominent specialties are child psychiatry and biological psychiatry, the latter reflecting a new emphasis on the chemical and nutritional roots of mental illness. Yet, for medical students in general, the attraction of psychiatry seems to be waning. Many now disdain the field as "professional handholding." In 1970, 11 percent of graduating medical students went into psychiatry; by 1978, that figure had dwindled to 3.6 percent.

PAYING THE BILLS

The 1980s will probably see Congress enact some kind of tax-paid national health insurance plan, served up with great expectations. If so, chances are that the dull but crucial details of "implementation" will have been largely ignored in the debate. National politics, observe the authors of a new Urban Institute study,* "highlight questions of whether or not to enact a program; issues of administrative design usually attract less interest."

Yet these "nuts-and-bolts" details—who makes the rules, who writes the policies, who signs the checks—could mean the difference between costly success and costly failure.

For example, should the federal government unilaterally promulgate guidelines and control the purse strings of the nation's health insurance from Washington? Should it relegate part of the task (and cost) to state governments? Should private insurance carriers be tapped as Washington's surrogates in the hinterland? Each approach, the authors demonstrate, has unique advantages and built-in flaws.

Purely federal administration would promote "uniform" and "equitable" treatment of beneficiaries nationwide—at the expense of efficiency. Part of the problem here is the rigid federal bureaucracy. And Washington, with its rising tax revenues and penchant for deficit spending, has little incentive to control costs. States show more flexibility, and, thanks to pressure from Washington, have generally done well in administering Medicaid programs. Several states (e.g., New York, California, Wisconsin) have even set up innovative programs to curb health-care costs. But *no* state has kept within the federally set "maximum error rate"; allegations of Medicaid fraud by patients, doctors, and hospitals are common.

Using private insurance carriers as "administrative agents" (as is done in Medicare) would allow the greatest amount of "individual preference." The risk is that private insurers would be tempted to shift overhead costs from their private business to their public operations. Alternatively, the government could provide tax credits or vouchers to help individuals buy health insurance on the open market. But the dollar value of the vouchers would have to increase steadily to keep up with rising premiums. And insurance companies might then avoid "high-risk" individuals.

There are many "wrong" ways to administer a multibillion-dollar national health insurance program, the authors conclude. But careful thinking about the headaches—in advance—can narrow the gap between legislative goals and bureaucratic results.

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*National Health Insurance: Conflicting Goals and Policy Choices, *edited by Judith Feder, John Holahan, and Theodore Marmor, Washington, D.C.: The Urban Institute.*

plementing a national health insurance program one organ at a time, as a congressional staff member observed). Should we do the same for heart transplants? Can we afford any more lifesaving breakthroughs?

New ethical questions—e.g., when to halt treatment for the terminally ill—prompt fierce arguments in courts of law, as well as hospital corridors. The post-1950s concern over environmental causes of illness—chemical pesticides, radiation, pollutants—has belatedly uncovered some genuine hazards; but a certain unreality sometimes pervades the discussion: *No* risk is deemed acceptable. Many Americans appear to seek what never was, a prophylactic, "zero defect" environment.

And, too, people have vested medicine with great responsibilities, greater responsibilities, in some cases, than they are willing to shoulder themselves.*

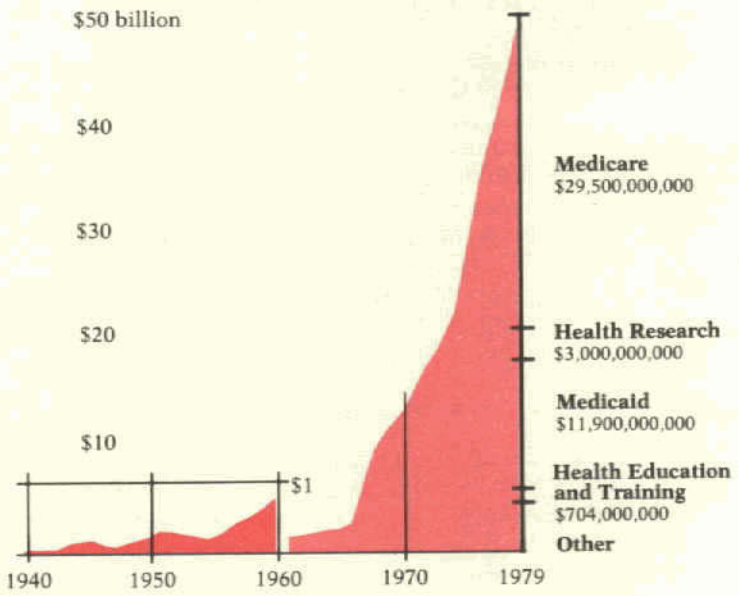
Legislating Health

Such inflated hopes and confused aims are enshrined in the charter of the UN's World Health Organization (WHO). Promulgated in 1946, it remains an expansive definition of health, a definition that has triggered debate ever since among academics, doctors, diplomats, and politicians—but also one that many American "laymen" might endorse without giving the matter much thought. Health, reads the preamble of WHO's charter, "is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

With these words, the WHO charter set hopelessly unattainable objectives for medicine, in effect "gerrymandering" the definition of health, as Georgetown neurologist Leon Kass put it, thereby making even happiness the doctor's business. As a result, Kass observed, a whole grab bag of complaints has been placed at medicine's doorstep, "from sagging anatomies to suicides, . . . from marital difficulties to learning difficulties, from genetic counseling to drug addiction, from laziness to crime." Just as America's public schools have been saddled with responsibility for curing a broad spectrum of social problems, so medicine is now held accountable for any "ill" that happens to involve a human body or a human mind. There is growing confusion between medical *needs* and individual *desires*. Under which category do nose jobs and straight teeth fall, for example? What about the estimated 20 million Americans using Valium

*In some cities, more than a third of all schoolchildren have not received measles or polio vaccination, the result of parental neglect—and perhaps a sense of false security. Among teenagers, venereal disease has reached epidemic proportions, despite its easy treatment.

FEDERAL SPENDING ON HEALTH, 1940–79* (in current dollars)



*not including hospital and medical care programs administered by the Veterans Administration or the Department of Defense.

Source: Office of Management and Budget; U.S. Department of Health, Education, and Welfare; *Health Care Financing Review*, Summer 1979.

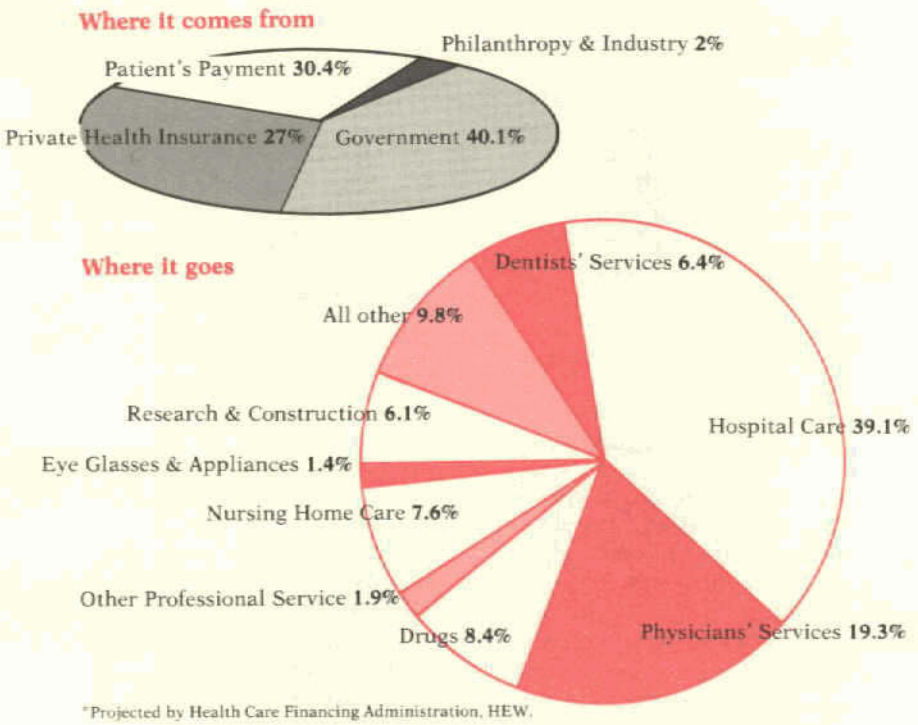
on doctors' prescriptions?*

Such an all-embracing concept of health poses an immense challenge to the resources of any nation, particularly one like the United States where the "pursuit of happiness" has official sanction to begin with, and where there is a chronic impulse—born of good intentions and crowd-pleasing politics—to take social challenges seriously. In some ways, the WHO charter seems to have shaped the agenda of Congress and the White House for more than three decades.

The federal health-care effort has three major elements.

*In 1977, agents acting on the central nervous system (including tranquilizers, hypnotics, antidepressants, narcotics, and stimulants) accounted for more than 25 percent of the U.S. sales (but only 14 percent of foreign sales) of the 140 member firms of the Pharmaceutical Manufacturers Association. Total U.S. sales of the 140 PMA firms topped $8 billion in 1977.

AMERICA'S HEALTH BUDGET: $244 BILLION IN 1980*



*Projected by Health Care Financing Administration, HEW.

Source: American Medical Association, *Socioeconomic Issues of Health*, 1979; Health Care Financing Administration.

First and most obvious is the fight against disease, beginning, as noted earlier, with smallpox vaccination, expanding during the 1930s with VD prevention and the establishment of the National Cancer Institute and the National Institutes of Health, and accelerating after World War II to encompass mental health, polio vaccination, and research into heart and lung disease, stroke, Cooley's anemia, sickle cell anemia, diabetes, lead poisoning, kidney disease, and much else. In more recent years, Washington's interest has broadened to include combating alcoholism, drug addiction, and (with Food Stamps and school lunches) malnutrition. Buttressing all of the above has been the federal government's postwar "capacity building" effort: manpower training, subsidies for hospital construction,

grants to medical schools.

The second element, and one that consumes more than 80 percent of all federal health outlays, involves controlling—or subsidizing—health-care costs. Public discussion of some kind of national health insurance began as early as 1910, but the first major health insurance bill—the Wagner-Murray-Dingell Bill—was not introduced into Congress until 1943. It died. During the next two decades, Congress set into place a patchwork of programs providing for limited health-care assistance for the aged and destitute, as well as for disability insurance. With passage of the multi-billion-dollar Medicare and Medicaid programs in 1965, Congress crossed the Rubicon, so to speak. Subsidized health insurance was no longer assailed by conservatives as "socialized medicine." Today, a dozen national health insurance bills are in the congressional hopper; passage of some version now appears to be only a matter of time.

Enemies and Ingrates

The third element of the federal effort encompasses what may loosely be called "regulation." From the 19th century on, the U.S. government has periodically acted to ban hazardous substances, regulate the food and drug industries, and clean up air and water. Since 1960, that effort has mushroomed to include not only toughened clean-air and clean-water statutes but also pesticide bans, noise restrictions, radiation emission guidelines, and stiff regulations concerning cigarette advertising, mine safety, factory safety, auto safety, and consumer-product safety. The government monitors doctors, hospitals, and the manufacture of wooden legs and glass eyes. And, over the years, Washington has used an array of legal and financial incentives and disincentives to "fine-tune" the supply of nurses, doctors, dentists, and therapists, much as the Federal Reserve Board intervenes to expand or contract the money supply.

Thomas Jefferson once complained that every presidential patronage appointment he made created 12 enemies and 1 ingrate. Washington's efforts to bring forth a healthy society have at times had similar consequences. Scores of "public-interest" lobbies now exist in Washington to press for new regulations and belabor old ones as inadequate. And, because medicine, even with Washington's succor, cannot deal with everything dumped in its lap, there has been a backlash—against doctors, against the drug industry, against seemingly "frivolous" basic research, against technology itself.

Out of this reaction has come a revived interest among many

THE TOP TEN KILLERS

1929	Per 100,000 population	As % of all deaths
Heart Disease	211.2	17.7
Pneumonia & Influenza	146.5	12.3
Cancer	95.8	8.0
Chronic Kidney Infection	91.1	7.6
Strokes	90.8	7.5
Tuberculosis	75.3	6.3
Accidents*	55.0	4.6
Certain Conditions of Infants	32.9	2.7
Auto Accidents	25.5	2.1
Gastrointestinal Infections	23.8	1.9

1978	Per 100,000 population	As % of all deaths
Heart Disease	333.9	37.8
Cancer	181.6	70.6
Strokes	79.1	9.0
Accidents	49.5	5.6
Pneumonia & Influenza	26.7	3.0
Diabetes Mellitus	15.0	1.7
Cirrhosis of the Liver	13.7	1.6
Arteriosclerosis	13.4	1.5
Suicides	12.6	1.4
Certain Conditions of Infants	10.1	1.1

*including legal executions

Source: U.S. Public Health Service.

Owing to advances in combating infectious illness, a shrinking handful of diseases now claims the lives of a growing proportion of Americans. The 10 leading causes of death in 1978 accounted for more than 83 percent of all deaths (versus 70.7 percent in 1929). Because Americans live longer, the incidence of death due to cancer and heart disorders has doubled.

Americans in "lifestyle" health care: jogging and bicycling, health foods, special diets, sports and exercise, yoga and meditation, health spas, reformed smoking and drinking habits. The nation's top popular health magazine, Robert Rodale's *Prevention* (circulation: 2,225,000), has grown faster in the last five years than any other U.S. magazine except *People*. A "new" branch of medicine, the holistic school, stresses the interdependence of body, mind, emotions, and spirit in maintaining a general (presumably WHO-approved) state of "wellness." Thus, the Omega Institute of Hoosick, New York, offers well-attended summer seminars on "holistic massage," "health through living foods," "biofeedback and stress control techniques," and "consciousness dying." As before, there is a kind of "spiritual kinship" among the devotees of health cults.

Even among doctors, there appears to be growing support for a technological slowdown and a partial return to earlier

values. "It is difficult to say which is the more troubling image," says Dr. Louis Lasagna, a teaching physician at the University of Rochester, "the primitively limited ability to practice medicine properly in the 18th century, our own century's failure to integrate technological progress with a personal, caring approach, or the grim prospect of a 21st century characterized by a totally dehumanized, computer-governed practice of medicine."

There are limits to what formal medicine and medical technology can do. A national health insurance scheme, whatever its ultimate financial costs and benefits, is not likely to improve *health.* Even a cure for cancer would not lengthen average life spans much; there are other things to die from. The fact is that every medical advance has simply taken us closer to a point one can never reach; that the shrinking "residuum of sickness," as historian Morris Vogel has called it, now comprises the most difficult research problems; that future breakthroughs will be relatively discrete and undramatic.

Money cannot change these facts, and even greater public investment will not appreciably speed up the rate of scientific return. Indeed, the most dramatic step Americans could take to improve today's general level of health would be to start living properly, rather than just urging Washington to spend more money on fighting disease or on regulating the environment. With its novel implication that an individual shares some responsibility for his own fate, this notion conflicts with the assumptions behind much congressional legislation in recent decades. It may be the only pill Americans won't swallow.