Books

Christy Ford Chapin. *Ensuring America's Health: The Public Creation of the Corporate Health Care System.* Cambridge, UK: Cambridge University Press, 2015. 369 pp. $32.99 paper.

Nancy Tomes. *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers.* Chapel Hill, NC: University of North Carolina Press, 2016. 560 pp. $45.00 cloth.

On a steamy August morning, my friend, Bethany, was playing tennis when she felt a small pull in her back. Thinking nothing of it, she continued with her game. The next morning the pull had become an ache, and within a week the pain had so intensified that she had to limit her activity to walking to the mailbox. She called her general practitioner (GP), the gateway to her HMO, but he was unavailable for two weeks. When she finally got an appointment, her GP told her to take Advil, rest for two weeks, and then call back if her back hadn't improved. Back pain, he said, often healed itself. When there was no improvement three weeks later, her GP suggested she see a neurologist about an epidural. The neurologist was not available until November, so the GP made a second appointment with an orthopedic surgeon, who was available the week before the appointment with the neurologist. The orthopedic surgeon ordered an MRI for Bethany and then told her she had a herniated disc and needed an operation immediately. She decided to get a second opinion and kept her appointment with the neurologist. After sitting in his waiting room for two hours, she was told that an operation was unnecessary and that he would give her an epidural, but

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not until December. In the interim, he prescribed an opioid for the pain. By now she could hardly get out of bed in the morning.

As it turned out, Bethany's ordeal had only begun. In November, Bethany noticed that her left leg was swollen. She called her GP and texted him a photo of her leg. He diagnosed a blood clot, most likely due to inactivity, and prescribed a blood thinner. The problem was that as long as she was on the blood thinner, she could not get an epidural. To make matters worse, the combination of the opioid and the blood thinner aggravated Bethany's Chron's disease, which had been in remission for ten years. This resulted in internal bleeding, a 911 call, and a stay in the hospital. Finally in July, when she was off the blood thinner, Bethany was able to get an epidural and begin the road to recovery.

I recount this lengthy anecdote because it perfectly captures the main themes of these two interesting and thoroughly researched books. In *Ensuring America's Health*, Christy FordChapin documents the transcendence of what she calls the "insurance company model," which has resulted in care that is not only costly but also fragmented: "This structure forces elderly, chronically ill, and difficult-to-diagnose patients to navigate arduous and lengthy care routes in an attempt to obtain services from various specialists" (1). Nancy Tomes, in *Remaking the American Patient*, tells a similar tale but focuses on how changes in medicine have altered the doctor-patient relationship and thus turned patients into consumers:

> Americans are expected to be in charge of their medical fates, always in possession of the latest and best information and ready to choose wisely among the many health choices now available to them—at least if they have the right kind of insurance. The family doctor has been replaced by a platoon of specialists tending to different parts of our bodies with an ever-changing array of high-technology and pharmaceutical remedies. (x)

The problem with consumer-directed care, as Bethany's case so perfectly illuminates, is that patients do not necessarily have the knowledge or the access to negotiate their own way through the tangled health care web. The result, both authors would agree, is a flawed health care system. For Chapin the villain is the insurance model, for Tomes it is consumer capitalism. Regardless of the enemy, there is ample evidence that health care in the United States is exorbitantly expensive compared to most other nations, consuming nearly 18 percent of the GDP. The high cost is partially due to the overprovision of care, which in turn is driven by physicians' desire to

attract patients and their fear of being sued for malpractice. It also is a product of the way insurers have structured patient and provider incentives. As a result, despite numerous proposals to provide universal coverage, many people in the United States are uninsured or underinsured.

Both Chapin and Tomes trace the transformation of the health care system across the entire twentieth century, echoing a format used by Paul Starr in his path-breaking book *The Social Transformation of American Medicine* (1982). Starr described two long movements in the development of medical care in the United States—the rise of professional sovereignty and the transformation of medicine into an industry. Throughout the first two-thirds of the twentieth century, physicians, led by the American Medical Association (AMA), secured their autonomy through a series of triumphs: establishing dominance over a vastly upgraded hospital system (in the previous century, only the poor went to hospitals), restricting the range of services offered by community public health centers, defeating national health insurance proposals after World War II, and winning concessions (i.e., liberal reimbursement schedules) from Medicare and Medicaid. Doctor control of medical institutions would soon be lost, Starr predicted, as corporations took over local hospitals and health care centers. Instead of being autonomous professionals, doctors were becoming salaried employees who were forced to meet goals set by corporate managers.

Chapin pursues a similar theme in describing the rise of physician sovereignty during the first two-thirds of the twentieth century and then its gradual decline. She seeks to explain why the practice of medicine is no longer defined as an art and how insurance companies have acquired such a dominant position in the health care system. Chapin's argument is centered on four themes. First, the health care system was constructed through intertwining public and private authority. Second, health care delivery cannot be comprehended apart from the architecture of the voluntary (private) insurance market, which as it expanded and matured, crowded out alternative possibilities. Third, evolving institutional norms endowed this particular economic model with cultural power and political authority. Finally, Chapin emphasizes the interrelated nature of political and economic power among private actors.

Drawing upon Starr's concept of cultural authority, Chapin argues that physicians achieved governing power over medicine during the late nineteenth century and, through the AMA, consolidated that power in the early twentieth century. During this period, physicians were able to assume control over the definition of a disease and stifle all attempts at government financing of health services. Then, during the economic crisis of the Great

Depression, hospitals created the first health insurance in the form of Blue Cross plans, a modest prepayment system where individuals could make monthly contributions and be guaranteed treatment should they need hospital care. Physicians reluctantly set up a similar system, Blue Shield, to fend off any government efforts to regulate health care and to guarantee that payment would be made on a fee-for-service basis.

During the 1940s and 50s, the AMA jockeyed with Blue Cross and the Health Insurance Association of America (HIAA) over political power and market position, and as the insurance model became firmly entrenched, physicians retained control. By the 1960s, however, it had become apparent that the private sector could not adequately cover all health care needs, especially for the aged. When Medicare was enacted in 1965, it utilized the institutional scaffolding created by insurers and physicians, thus obscuring other solutions. As Chapin explains, by 1965, "Insurance companies financed private medical services while coordinating arrangements and supervising the delivery of care for both the public and private sectors" (230). Medicare was financed by the federal government but run by private insurance companies that paid private health care providers for services rendered.

During the 1970s, health care costs rose rapidly, as Medicare paid all charges billed with no limit. Gradually, both the federal government and the "insurance companies expanded their mandate from simply underwriting the risks associated with medical services consumption to, ultimately, regulating health care" (5). As managed care gained prominence as a mechanism for reducing health expenditures, the power of third-party payers grew, and general practitioners gradually became gatekeepers, regulating patients' access to specialists. In the long run, the insurance model chosen by the AMA as the best way to protect professional power backfired, and insurers ascended to power over providers, inverting the initial relationship.

Although the bulk of Chapin's book covers the period up to the 1970s, she does include recent events in one chapter. In her view, the Patient Protection and Affordable Care Act of 2010 merely continued the path initiated in the 1930s. As she argues, under the ACA, "Once again, reform legislation became a vehicle for private interests to improve their position within the health care system's corporate arrangements" (244).

Chapin views the AMA as largely responsible for the adoption of the insurance model and the ensuing problems in the health care system. Yet, it is questionable whether the AMA actually was as influential as Chapin implies. Certainly media attention was focused on the AMA, especially

during the 1940s and 1950s, when that organization was at the forefront in the war against national health insurance. Behind the scenes, however, other powerful players had more clout, particularly business groups like the National Association of Manufacturers, the Chambers of Commerce, and the National Federation of Independent Businesses. It was these organizations that lobbied against any government-sponsored health insurance and for the private-insurance model that Chapin attributes primarily to the AMA.

Other key players played an equally significant role in the ascendance of the insurance model. During World War II, the trade unions first negotiated health insurance in lieu of wages (Hacker 2002) and then were a critical force in maintaining the momentum for Medicare during the 1950s and early 1960s. Chapin also fails to give the hospital industry its due for breaking with the AMA and supporting Medicare.

Chapin appears to dismiss Medicare as just one more example of the despised insurance model. Yet, despite its flaws, Medicare has been the most successful social program, second only to Social Security. Quite quickly Medicare helped pull millions of people out of poverty, providing insurance for close to one hundred percent of people aged sixty-five years and older and giving them access to the kind of health care that other Americans received through their jobs. Furthermore, even though Medicare is run by private insurance companies, its administrative costs are lower than any other form of insurance, public or private (Reinhardt 2015).

Chapin also pays little attention to Medicaid, the federal-state program of health insurance for poor and low-income people, which also was a part of the 1965 amendments that created Medicare. This is understandable given the time frame of her research, but it is important to recognize that Medicaid grew substantially after 1965, and by 2010 it had become the fourth largest program in the federal budget and the primary source of health insurance for poor and low-income people, covering more than twenty percent of the population (Olson 2012). Medicaid also plays a critical role in long-term care for the frail elderly, paying forty percent of nursing home care at a cost of about one-fourth of the Medicaid budget (Henry J. Kaiser Family Foundation 2013). It would be helpful if future researchers would use Chapin's insurance model to determine how the Medicaid payment system has affected health care for-low income people and the frail elderly.

Chapin convincingly describes the flaws in the insurance model but fails to explain which alternative vision for the health care system she prefers. She does briefly discuss a single-payer plan originally proposed by Senator

Ted Kennedy (D-MA) in the early 1970s, which would have eliminated the private insurance industry and placed the entire US population under a federal program. She also laments the failure of the public option under the ACA, which might have morphed into a single-payer system over the long run. She does not, however, explain whether either of these options would have been feasible or possible. Given that the single-payer system has once again appeared on the political spectrum following the failed Republican effort in 2017 to repeal the ACA, it would be interesting to have her thoughts on this issue.

Chapin's strength is in the enormous amount of detail she provides about each policy. Anyone seeking to understand the historical trajectory of any policy proposal across two-thirds of the twentieth century need only read *Ensuring America's Health.* It should be a primer for any graduate seminar on the health care system. What would make these issues come to life, however, is a sense of the wider historical context that created the distinctively American health care system. The failed battle over universal coverage was shaped by the struggles of labor unions during the 1940s, President Lyndon B. Johnson's War on Poverty during the 1960s, and the radicalization associated with the civil rights, anti-war, and feminist movements of the 1960s and 1970s.

Whereas Chapin's analysis focuses narrowly on the medical profession and the related organizations that influenced the evolution of the health care system, Tomes casts a wider net. In her lively and detailed history, she places the development of modern medicine and the consumer culture associated with it more generally in larger societal trends. Her core argument is that for most of the twentiethcentury, physicians championed the concept of autonomy while resisting all forms of professional control. This principle elevated the idea that a personal relationship between a doctor and a patient was the hallmark of good medicine, thus making it more likely that patients would want more of the services rendered. Tomes denies that a golden age of placid doctor-patient relationships ever existed, however, and challenges the idea that medicine was ever practiced independently of business. Instead, there was the ascendance of what she terms "medical consumerism," which took place during three periods: the Progressive Era (1890s–1920s), the 1930s, and the late 1960s and early 1970s.

Tomes argues that the concept of the patient as a consumer originated in the nineteenth century with the rise of consumer capitalism. While the ascendance of capitalism as an economic system created wealth and opportunity, it also left in its wake a host of social problems, including abusive labor practices, threats to public health, and toxic environments. In

response, a wave of consumer protection movements emerged during the Progressive Era. Some, such as the pure food and drug crusade, focused on threats to health, leading to regulations that protected the quality of goods and services. The regulatory environment expanded during the 1920s with more licensing laws and greater federal oversight. By eliminating competition from quacks and medicine men, these restrictions gave physicians greater control over the practice of medicine and increased the power of the AMA, who could determine physicians' access to hospitals and whose seal of approval was required for a product to be advertised in key medical publications.

Tomes recounts the well-known story of how the AMA created Blue Shield during the 1930s, softened its opposition to private health insurance during the 1940s, and then led the war against President Harry S. Truman's proposal for national health insurance. As part of its battle plan, the AMA hired a public relations firm to create a campaign against Truman. The campaign featured a painting by Luke Filde titled *The Doctor*, which "idealized the sacred tie between doctor and patient" (144).

This idealized portrait of the doctor-patient relationship became somewhat tarnished in the 1960s, as rising medical costs and the rush toward specialization and technology created what the media called "a crisis in American medicine" (196). Although the AMA vehemently denied it was responsible or that a crisis even existed, it was clear that the public was increasingly concerned about high charges for services, the overprescribing of prescription drugs, and poor quality coverage under fee-for-service plans. The result was a new crusade for "critical consumerism," which focused on the failure of doctors to serve as patient advocates and educators.

Like Starr, Tomes views the 1970s as a turning point where medical consumerism evolved into an approach "endorsed by powerful political and business interests" (5), and consumerism became associated with cutting costs. During this period, doctors expanded their role not only by providing patients with more information and choices about available products and procedures but also by urging compliance to avoid lawsuits. Physician autonomy, which was promoted by the AMA, encouraged an "anything goes mentality that made forms of medical entrepreneurship more commercial than professional" (9). Thus, the medical profession, and specifically the AMA, promoted the trend that turned patients into doctor shoppers.

Tomes, like Chapin, gives the AMA an outsized impact on the development of the health care system, but by the 1970s, the AMA had lost much of its clout. For example, when President Jimmy Carter introduced a plan

for an across-the-board cap on hospital charges in 1979, it was the Federation of American Hospitals—the organization of for-profit hospitals—that formed a coalition to defeat him. As a result, the Carter plan never made it out of the Senate Finance Committee (Quadagno 2005). Tomes also emphasizes the AMA's claims during the 1990s that certain provisions of the Clinton Health Security bill would "limit choices by patients and physicians" (243). By then, however, the voice of the AMA had been drowned out by other physician groups, business organizations, and the managed care industry.

Tomes demonstrates how the consumer's role in health care expanded during the 1990s, when physicians "faced enormous pressure to provide patients access to the latest medical technology" (339). Hospitals and clinics advertised innovations in such areas as diagnostic scanning and cardiac care, and doctors attracted patients with luxurious waiting rooms and the newest technology. Despite these efforts, Tomes argues that two aspects of consumerism doomed it to failure. The first is that it is a concept more likely to be adopted by middle-class educated people who do not see physicians as hallowed figures and instead read up on their medical conditions, ask questions, and challenge authority. This is ironic, however, as modern medicine has "become identified with a scientific and technological complexity that even the most 'educated layperson finds difficult to comprehend'" (10). For poor, less-educated people, the challenge of shopping for the best physician at the best price is even more daunting. For this reason, it is not all patients that doctors seek to lure but only middle-class insured patients who will be paying customers. A second factor that impedes medical consumer shopping on the basis of price is that it only works, if it works at all, among relatively healthy people. As Tomes reminds us, there are no medical consumers in the emergency room.

To Tomes's three periods of transformation, I would add a fourth: the era of consumer-directed policy. The consumer-based health care movement (CDHC) originated out of a desire by political leaders and citizen groups to control costs while maintaining quality, but it quickly became a weapon used by conservatives to undermine any proposal for universal coverage. CDHC involves enrollment in consumer-directed health plans, and it refers to insurance that provides financial incentives for patients to become involved in purchasing decisions regarding their health care. Its main policy vehicle is the health savings account (HSA). CDHC first came to fruition through legislation enacted in 2003 that paved the way for tax-free HSAs to be paired with high-deductible insurance policies, an arrangement intended to make consumers cost-sensitive without subjecting them

to the financial risk of a catastrophic illness. Also, CDHC policy has been inserted into Medicare in the form of Part C, which allows private health insurance companies to provide Medicare benefits through Medicare Advantage Plans. These plans seek to lure beneficiaries by promising extra benefits not provided by traditional Medicare, including even health club memberships.

CDHC advocates contend that health care costs are high and quality is low because our current system fails to provide consumers with incentives for using care wisely and shopping for high-value services. They believe that giving consumers incentives to be prudent managers of their own health care will engage market forces in controlling costs and improving quality and outcomes. Yet, the evidence on the effects of CDHC is mixed. Anecdotal reports in the trade literature tend to support the view that CDHC helps lower costs. Well-designed research studies are more skeptical. They find that individuals in consumer-directed plans are more likely to adopt cost-saving behavior but through choices that can have adverse health consequences (Buntin 2006).

Ensuring American's Health and *Remaking the American Patients* provide complimentary histories of the health care system in the United States. Although the former focuses primarily on policy and the latter on the doctor-patient relationship, both adopt the trajectory originally outlined by Starr to tell different aspects of the evolution of medical care. Anyone teaching a class in health policy should consider assigning all three books to give students a complete picture of the dynamics that shaped today's health care at key turning points.

—Jill Quadagno, Florida State University

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Jill Quadagno is a Mildred and Claude Pepper eminent scholar and research associate in the Pepper Institute on Aging and Public Policy at Florida State University. She has published twelve books and more than eighty articles on aging, health, and social policy issues. Her books include *One Nation, Uninsured: Why the US Has No National Health Insurance* and *The Color of Welfare: How Racism Undermined the War on Poverty*. Her areas of specialization include social security reform, health policy, and public attitudes toward social programs. Her research has been featured on NPR, *Harpers Magazine*, *Newsweek* and the *Wall Street Journal*.
jquadagno@fsu.edu

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