The Public Health Service and the Nation's Health Care in the Post-World War II Era

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SINCE THE MID-1940S, the Public Health Service (PHS) has been the lead agency in policy to supply knowledge, facilities, and professionals to the health sector. As a result of this mission, the PHS has frequently disappointed reformers who were eager to use Federal funds and authority to increase entitlement to personal health services. Although celebrating an act of Congress passed 50 years ago should not be confused with current debate, it is an occasion for appreciating the endurance of policies and their advocates.

Our enduring policy has accorded priority in direct public expenditures for improving the nation's health to increasing the supply of services and the information on which they are based. The most visible consequences of this enduring national policy have been the construction of more and more efficient hospitals, the development and dissemination of increasingly effective drugs and devices, the education and training of ever more highly specialized professionals, and the discovery of considerable knowledge about the incidence, prevalence, causes, course, and treatment of disease.

For more than half a century this policy has been implemented by sharing power. The States and tax-exempt organizations have been the partners of the PHS in a reinvention of government that, though written into a statute in 1944, had begun considerably earlier.

The PHS Act of 1944 was a culmination and a precursor. Our celebration today has this in common with more famous anniversaries of recent months. D-Day was not the first evidence that the momentum of the war in Europe had shifted to the Allies. The GI Bill was hardly the first legislation to attract young male voters to the Democratic coalition.

The act of 1944 was, however, part of a significant innovation in national policy. The act was among the cluster of laws, regulations, and budget decisions that transformed scientific research from an incidental or emergency task of government to a major area of priority. Vannevar Bush, who directed the wartime Office of Scientific Research and Development, celebrated this change in the title of a report he presented to the President later in 1944. Science, he said, was an "endless frontier." The director of the Federal budget knew better. Science, Harold Smith commented, was also an "endless appropriation" (*1*).

The act of 1944 gave the Public Health Service its mission and structure as the lead agency in the national policy consensus that medical science was the principal cause of progress in the struggle against disease. This consensus about medical science became one of three governing assumptions of national policy in the second half of this century.

The other two assumptions drove policy for foreign and economic affairs. The fundamental assumption of foreign policy was that the Soviet menace could be contained by prudent alliances and by the deterring effects of nuclear weapons. Policy for economic affairs rested on the assumption that intervention by Federal regulators and the prudent use of the budget could prevent the recurrence of a major depression.

Please do not misread me as saying that any of these three governing assumptions of national policy was wrong 50 years ago or is wrong now. I am simply doing my professional duty, which is to identify powerful concepts that decision makers and voters believed, and continued to be believe, to be true. The analysis of policy, historically as well as contemporaneously, appropriately begins with inquiry about assumptions, about driving ideas that the people who make decisions and those who support them take for granted.

In retrospect then, the significance of the Public Health Service Act of 1944 was that it was the first of several events in health policy that assumed a linear relationship between investment in the supply of knowledge and health services and reduction in the burden of disease. These events included the agreement in 1945 by the Bureau of the Budget and the Congress to fund the extramural grants program of the National Institutes of Health (NIH), the expansion of hospital capacity as a result of the Hill-Burton Act of 1946, the establishment of the Communicable Disease Center the same year, and the creation of

new Institutes of NIH (and the structure of the NIH itself) between 1946 and 1948.

Policy to address demand for health services had a very different history as a result of another set of decisions in the 1940s. In the sequence of events which included the act of 1944, direct Federal expenditures matched by State appropriations and private contributions fueled policy for the supply of services. In contrast, Federal tax policy became the instrument for subsidizing demand for health care. In order to maintain wage controls in wartime, Federal regulations permitted employers to exclude from both taxable wages and corporate income their contributions to their employees' premiums for private health insurance. During the war, moreover, Federal policy encouraged labor unions to bargain with employers for health benefits that were financed by foregone tax collections, what a later generation would call Federal tax appropriations.

The Federal Government thus simultaneously centralized responsibility for the supply of services and knowledge in the Public Health Service and its State and tax-exempt partners and ceded control over personal health services to employers, unions, and nonprofit and investor-owned insurance companies. This uneasy alliance was regulated by the Treasury and Labor Departments and the committees cognizant of them in the Congress. These regulators were convinced, by both ideology and practical politics, that they did not make health policy.

The burst of new health policy during and after the Second World War that I have described established a pattern that persisted for half a century. No other nation has matched, even on a relative basis, our investment in research, in the supply of facilities and professionals, and in capacity for disease surveillance. Similarly, no other nation has relied so heavily on tax and, subsequently, pensions policy to make access to health care affordable and equitable.

The politics of these twin policies created complementary constituencies. The major goal of one set of groups was to increase the supply of health services; of the other, to fuel demand for them at the lowest cost in professional and institutional autonomy. As a result of the politics and policy choices of the mid-1940s, the supply of health services was financed from different sources than the demand for them. Moreover, the major sources of public financing to implement our dual health policy, direct appropriations for supply and tax appropriations for demand, usually did not compete with each other.

Health care reform in the 1960s complicated but did not fundamentally change this situation. Because Medicare was an extension of pensions policy, paid for from a trust fund financed by social security taxes, its politics occurred outside the struggle for direct appropriations. Medicaid was a different matter; over time its expansion taught States and Federal leaders the cost of separating policies for demand from those for supply.

The political consequences of separating policies that, in other countries, competed for the same funds, are a familiar story. For half a century, State health officials and leaders of academic medicine advocated increased appropriations for the Public Health Service and its agencies without being required to give serious attention to trade-offs between subsidies for supply and those for demand. For the same half century, associations representing physicians, hospitals, and the insurance industry, and their allies in business and labor, endorsed appropriations for the PHS without enormous threat to their own interests.

The consensus about the importance of expanding knowledge, science, technology, and the health care work force had the force of belief as well as of economic interest. But the consensus also facilitated a compartmentalization of health policy that reinforced any tendencies toward arrogance and smugness—and a sense of entitlement to endless appropriations—that were present in groups with interests at stake.

Because of the politics of our enduring health policy, moreover, it was for a long time both prudent and proper for leaders of the Public Health Service to disappoint advocates of direct Federal policy to make health care more accessible and affordable. Just two days after President Roosevelt signed the 1944 act, an editorial in the New York Times, missing entirely the emerging policy consensus, urged the PHS to remedy the defects in "health insurance schemes" which "rely too much on the private practitioner" (*2*).

As a Surgeon General put it around 1950, disagreeing with the American Medical Association in public about national health insurance would be unprofessional (*3*). Similarly, 15 years later, Wilbur Cohen, the architect of Medicare in the executive branch, complained that the Public Health Service was "not interested" in the problems of financing medical care (*4*). I suspect that some contemporary reformers are similarly frustrated with the views of some leaders of the great institution whose achievements we are celebrating.

The Public Health Service should not, however, be criticized for carrying out its assignment. The PHS has been the pre-eminent Federal agency in our nation's enduring health policy, sharing power with States, tax-exempt organizations, and interest groups. The legislation we celebrate today gave the PHS an improved administrative organization, grant-making

authority, and better qualified personnel to carry out its role in that policy.

Our enduring health policy, the separation of the politics of supplying health services from the politics of demand for them, may be changing. Persons who take this view adduce two causes. One cause is growing reluctance among political and business leaders and perhaps consumers to pay the rising costs that have been the result of encouraging consumers to demand what can be supplied. There may be a new consensus emerging about what it is comfortable to pay for with tax appropriations, foregone profits, and disposable income.

The other cause of the apparently diminishing usefulness of the separation of policy for supply from that for demand is uncertainty about how applied biomedical science can improve the management of chronic disease. The causal chain that began with bench science and led to longer life and lower morbidity through an increase in the supply of medical specialists, drugs, equipment, and hospitals is no longer taken for granted.

What has been an enduring policy is most likely changing, though not as thoroughly or as rapidly as many reformers desire. I need not describe to this audience the practical political reasons why change may not be thorough or rapid.

Another reason that key elements of our enduring policy might remain after reform is that the separation of the politics of supply from those of demand has had many positive results. The application of biomedical research has relieved pain and extended lives, as well as creating employment at home and contributing positively to the balance of trade with other countries. The services of health professionals and the facilities they use have satisfied many people. Until recently, our enduring policies for both supply and demand have sustained a large industry that has been relatively safe from recession and reorganization.

The Public Health Service Act of 1944 was, in summary, an early episode in the history of a policy consensus that held for half a century. This statement is, of course, an hypothesis, an interpretation of evidence. Historical science, as it is called in every language except English, employs hypotheses just as any other area of disciplined inquiry does. An hypothesis is a model; that is, it is an abstraction from the messy data of the world that is intended to help us understand more usefully the central tendencies or themes in that data.

This talk has been about an hypothesis. That is the reason I have not mentioned other responsibilities of the PHS since 1944, especially the responsibilities for direct service that have been part of its mandate since 1798. I did not mention these responsibilities simply because they are outside the range of my hypothesis, my model of what was most important in the past half century. I know very well that the PHS since 1944 has had responsibility for much more than the supply of services and useful knowledge. Most important, the PHS provided medical care to members of groups—for example seaman, Native Americans, large numbers of the rural and urban poor, and refugees—who were outside the reach of our consensus national policy for meeting the demand for health care, what I have been calling our enduring policy. My subordinate hypothesis, to be technical, is that the PHS since 1944 has continued to serve its earlier role as the provider of residual services in our nation's health care system.

I suspect that half a century from now, after 246 years, the Public Health Service will still be responsible for its part in an enduring national policy. That policy will surely be very different from the consensus of the half century after 1944. The PHS will also continue to have other responsibilities. In a nation as diverse as ours, any national consensus on policy will leave some people unserved and at serious risk.

References

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