
Book Review

The heart of power: Health and politics in the oval office

David Blumenthal and James A. Morone

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The opening paragraph of *The Heart of Power* by David Blumenthal and James Morone describes a conversation that Blumenthal, then an undergraduate at Harvard College, had with Richard Neustadt, the noted presidential historian and one time member of John F. Kennedy's White House staff. Blumenthal credits Neustadt, his course on the American presidency, and their subsequent long friendship with the inspiration for his and Morone's new book.

I'm certain that professor Neustadt would be proud of the product he inspired. In this readable, well-documented, and comprehensive study, the authors lucidly explore how presidential personalities, priorities, political philosophy, and personal health experience have influenced their approaches to health policy. They analyze legislative and policy successes and failures in 11 US presidential administrations, ranging from Franklin D. Roosevelt to George W. Bush. (They omit only the brief presidency of Gerald Ford.)

From FDR's *New Deal* to George W. Bush's *Ownership Society*, Blumenthal and Morone explain how each president, cognizant of the unique history, political opportunities, and risks they faced, learned (or didn't) from their predecessors and built on what had gone before. Their source material includes presidential library archives plus interviews with former presidential staff, and staff of the libraries.

Despite my lifelong involvement in and study of American health-care policy, I learned a great deal from this book. I was not fully appreciative, for example, of the depth and passion of Truman's commitment to a social insurance model of national health insurance, nor was I aware of the level of detailed involvement by Lyndon Johnson in the birth of Medicare, the federal insurance

program for the elderly. It was part of a conscious strategy on Lyndon Baines Johnson's (LBJ) part to give Representative Wilbur Mills most of the credit for passing that landmark legislation in 1965. Flattery, it turns out, is an important policy tool. There are many other examples. The final chapter called 'Eight Rules For The Heart of Power' is thoughtful and thought-provoking. I won't spoil the ending by listing them here.

Most important, the authors drew on their own experiences as political scientist and physician, as scholars, researchers, and participants in our chaotic and bewildering policy process. Together, they have created a fascinating story of health policy development over a period of more than 75 years. This book is well worth reading by anyone interested in the role of US presidents and the presidency in the development of American health policy.

Still, after reading the book, I was left with the feeling that an important set of issues – legitimately beyond the scope of *The Heart of Power* – were left unaddressed. As this book makes clear, in the health field strong presidential leadership is critical to enacting major legislation. Yet, even the most skillful, determined, and powerful president is limited by the political environment of the day. Contrary to the rhetoric, politicians are usually followers, not leaders of popular sentiment. There is only so much any leader can do before he runs up against the barriers to change inherent in the political environment of the day.

What are the barriers to reform of the American health-care system? Why has it been so difficult for American politicians to create a statutory right to health care for Americans – a right that every other affluent democracy created years ago?

First and most basic, the concept of health care as a right remains a polarizing concept in the United States. As Lewis Carroll once said, 'If you don't know where you're going, any road will get you there'. The wisdom of that observation is clear to anybody watching Congress struggle with the issues raised by the most recent health-care reform effort.

Second, Americans are inherently suspicious of central authority – secular or religious. Thomas Paine's concept of government as 'a necessary evil' is alive and well. Establishing a right to health care requires a stiff dose of that necessary evil. Our political institutions are designed to decentralize power.



Third, the idea that America is exceptional and not governed by the rules most other countries follow is still widely held in the United States, however misguided. That makes it difficult for Americans to learn from experience in other nations, or even to be told that there are lessons to be learned from others.

Fourth, only in America has corporatism engulfed so much of medical care and come so close to dominating the doctor–patient relationship. Publicly traded, profit-driven entities now dominate the financing and delivery of medical care in the United States to an extent seen nowhere else in the world. This may be the single most distinguishing characteristic of the modern American health-care system, and the one that has had the most profound impact on it since the early 1980s. The theology of the market and the strongly held belief that the problems of American health care can be solved if only the market could be perfected have most effectively obstructed the development of a rational, efficient, and humane national health-care policy.

Special interest lobbying has, for a long time, played an important role in the development of such a policy in the United States. But its influence has dramatically increased during the past 30 years.

For most of the twentieth century, the medical profession (mainly through the American Medical Association) has opposed the creation by the government of a statutory right to medical care, fearing government controls on medical practice and doctors' incomes. But as Paul Starr pointed out more than 30 years ago, while American physicians were resisting a 'takeover' of medicine by the government, they were gradually being taken over by private corporations.¹ That takeover is now almost complete. Each year, fewer truly independent medical practitioners remain in the US. Most now work for profit-making and non-profit corporate entities. Many American physicians have agreed to a Faustian bargain, exchanging their autonomy as independent professionals for higher incomes. More than a few are now beginning to regret that bargain. Nowhere in the world are doctors' decisions subject to more scrutiny, second-guessing, and micromanagement by unaccountable private entities than in the United States.

During the more than 75 years covered by this book, massive changes in the nature of medical care have occurred. During the Roosevelt administration (1933–1945) medical care in America was

a cottage industry, comprised of individual doctor-entrepreneurs who were focused on treating and, they hoped, healing individual patients. The tools at their disposal were primitive by present standards. Hospitals were far less important than today. The pharmaceutical and medical device industries were poorly developed. Most medical enterprises were privately owned and not-for-profit. And most importantly, their dominant focus was their mission of curing patients.

The financing of medical care in America was once the exclusive domain of public and non-profit entities. Beginning in the mid-1980s, through a process of consolidation and acquisition that accelerated during the 1990s, health care financing became dominated by publicly traded corporations. These corporations are not health-care companies, as they would like to portray themselves, but rather financial services companies that happen to concentrate on the health-care business. Their primary focus is not the provision of appropriate medical care, but rather the endless pursuit of increased shareholder value.

The direct delivery of health-care services has also become corporatized. Beginning in the mid-1970s with the founding of the Hospital Corporation of America, for-profit entities began, in a major way, to enter into the direct provision of medical services.² Again, the main focus of these investor-owned for-profit entities (and the only one legally required of them) is increased shareholder wealth. In other words, money, not health care, is their mission. The behavior of this sector of the hospital industry, although a small proportion of the total, has infected even the most prestigious academic hospitals. Even these not-for-profit institutions emulate their proprietary brethren.

The pharmaceutical industry has undergone a similar transformation. When George Merck founded his company in 1891, his philosophy was, 'If we develop medicine that cures human disease, the money will take care of itself'.³ The pharmaceutical and medical device industries have exploded since then. More important, they have shifted their focus from Merck's ideal of discovering and marketing curative medicine to becoming huge marketing machines, publicly traded, and obsessed with shareholder value. They aggressively seek ways to develop and market wildly profitable 'blockbuster' drugs that control signs or symptoms or treat lab tests.



Ideally, patients must take them for the duration of their lives. Statins, beta-blockers, and other anti-hypertensive drugs and many drugs used for the treatment of psychiatric patients are examples.³ Curing disease may be good for the patient, but from the point of view of the drug company, it effectively kills the customer. Curing has become a poor business strategy.

America now has this powerful block of special interests, together called the medical-industrial complex – powerful and wealthy enough to mold public policy to its wishes. Only in America have for-profit corporations come to exert so much influence on health-care politics and on the development of government health-care policy. It is no coincidence that only in America is the profitability of health-care companies (such as drug and device manufacturers) unrestrained by price controls or other regulation.

But the most disturbing effect of out-of-control corporatism in health care is not corruption of our policy-making process. The most damaging effect is corruption of the seed corn of professionalism, the integrity of the medical literature itself.⁴

Pharmaceutical and medical device companies have successfully created a widespread ‘rent-an-expert’ industry, persuading opinion leaders among medical academicians to rent their credibility in exchange for outsized consulting fees and lavish resort-based conferences. Prestigious medical opinion leaders routinely give industry-produced, canned lectures that are designed to influence their colleagues’ prescribing patterns. Highly regarded and visible academicians outsource the production of scholarly articles to industry-funded marketing firms. These articles have appeared in some of the best-known and widely read American medical journals. These corrupt activities are funded out of enormous corporate marketing budgets.⁴

Even the most independent and well-meaning doctors no longer fully trust the medical literature.⁴ Where are doctors to obtain objective, unbiased information about how best to treat their patients? The ubiquity of industry money in academic medical centers, continuing medical education programs, and even the National Institutes of Health⁵ has now attracted the attention of Congress and has been widely dissected in the lay media.⁶ Perhaps more than anything I have seen, these developments destroy the basis of the public’s trust in their doctors.

The shift in focus from mission to money has also led to a deterioration of the curing and healing elements of modern American medicine.⁷ More and more doctors are encouraged by their own economic aspirations, and by those of their corporate employers to make medical decisions intended to maximize revenue rather than to provide appropriate care to patients.⁷⁻¹²

Doctors are under mounting pressure to meet revenue targets as a condition of continued employment. That, together with the rising costs of medical education and consequent indebtedness of medical graduates may explain the decline (and I think, probable future disappearance) of primary care practitioners in America. There's just not enough money in it.

This transition from a healing mission to a money mission is a dominant (if not the dominant) factor driving the explosion of health-care expenditures. Combining sophisticated direct-to-consumer marketing of pharmaceuticals and 'gee-whiz' medical technology with the open-ended nature of third-party financing has led to the rapid and recession-resistant increases in medical care expenditures we are now witnessing.

As a result, the lack of affordability, not just of insurance, but also of the underlying medical care is fueling growth in the number of un- and under-insured Americans. This growth has accelerated as a result of the economic downturn, creating enormous suffering and growing pent-up demand for medical care.¹³

This increasing commercialization of medicine also undermines patient confidence. They sense the role money plays in influencing physicians' clinical decisions and become disenchanted with their medical care. As a result, many are seeking alternatives to our expensive, fragmented, and impersonal medical industry.

The frustration doesn't end with patients. Doctors are caught between demands to produce more billable events (visits, procedures, lab tests and so on) and barriers to payment thrown up by insurance companies. Both demands to earn more and controls to restrain payments conflict with their medical training and ethics. Both contribute in a big way to physicians' dissatisfaction with medical practice. They have led to a growing and premature exodus of senior physicians from the workforce.

The current debate about health-care reform in the United States represents a fork in the road for the American health-care system.

If we have enough national solidarity, we will take the left-hand fork. In doing so, we will embark on a path to strengthen our public sector system of financing and delivering health care. We will do this by embracing either a social insurance model similar to those in Taiwan and Canada, or a highly regulated not-for-profit public utility model similar to those in Germany, The Netherlands, Switzerland, and other European countries. Either way, we will join the rest of the industrialized world in creating a statutory right to health care for all people.

Only then will we be able to begin the long, difficult process of driving the profit motive out of the direct provision of medical care and recovering the lost art of healing. It goes without saying that members of the medical-industrial complex are determined to thwart any legislation that moves in that direction.

If we take the right-hand fork, we will reinforce the notion of health care as a privilege, boost the role of and encourage the further expansion of the corporatization of American medicine that Paul Starr predicted. Stratification of access to medical care according to income will grow even more rapidly. That will signal a retreat from the ideal of health care as a right.

Everybody seems to agree that we can't fail to act. If we continue ahead with no change in course, we will drive into a ditch as costs continue to explode and access to care further deteriorates.

Whatever the outcome, the story of the evolution of the health-care system in the United States holds important – and cautionary – lessons for other nations, as they too struggle to strike the suitable balance between expenditure, quality, and access to health care compatible with their own cultures.

The Heart of Power is a valuable contribution to better understanding that story. But it is not the entire story. Perhaps Blumenthal and Morone could apply their considerable talents to writing a sequel to *The Heart of Power* that examines the issues raised by the relentless corporatization of medical care in the United States. Maybe they could call it *The Heart of Darkness*, had Joseph Conrad not used the title already.

I have a recurrent dream, and not a pleasant one. I wander the temple of medicine seeking Asclepius, but find instead only Mammon.

It doesn't have to be that way, even in exceptionalist America. Stay tuned.



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