BOOK REVIEWS

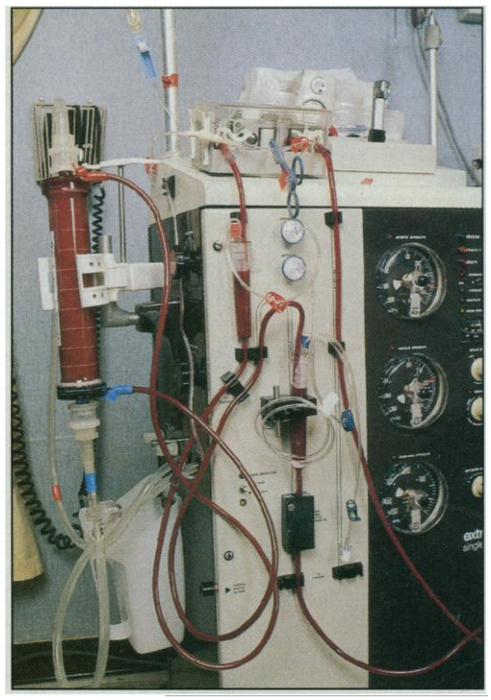
The Machine Age in Medicine

Beginnings Count. The Technological Imperative in American Health Care. DAVID J. ROTHMAN. Oxford University Press, New York, 1997. xiv, 189 pp. $24.95 or §18.95. ISBN 0-19-511118-4. A Twentieth Century Fund Book.

This slim volume is concerned with the "crucial links" between the fact that the United States is the only industrialized nation without a national health insurance system and its singular dependence "on powerful and costly medical technologies." It develops two themes: first, that the American people prefer that health insurance be provided by the private sector, not the government; and second, that the demand for life-saving medical technology is so strong that the American middle class is willing to reject universal health insurance. Successive chapters—three about health insurance and three about the machines of medicine—deal with the origins of Blue Cross, the iron lung, Medicare, the artificial kidney, the respirator, and the defeat of the Clinton health care reform legislation.

The emergence of Blue Cross in the 1930s not only established employer-based, community-rated hospital insurance but, more importantly, defined the provision of such insurance as a private sector function. Rothman emphasizes Blue Cross advertising as a major factor shaping political opposition to "compulsory" health insurance, but says little of opposition by organized medicine to publicly provided health insurance. Nor does he mention the fact that the social insurance agenda in the '30s was dominated by economic security, not health insurance. Medicare, enacted in 1965, did not challenge this basic orientation to the private provision of health insurance; it simply carved out an exception for the elderly. More recently, the failure of the Clinton health reform legislation in 1993–94 reflected the opposition of the general public to government provision of health insurance.

The "technological imperative" argument of this book focuses on the effect of expensive medical technology on limiting access to care, not by denying the poor fewer MRI scans, for example, but by foreclosing the political possibility of universal health insurance. The message of the iron lung, around which Americans initially formed their ideas about allocating scarce medical resources, was "that life-saving technologies had to be available to everyone, that the prospect of benefits, however slim, outweighed the costs, however substantial," and that the private sector, not government, was capable of distributing these medical resources without rationing. Rothman cites a report of 583 patients in the country who were iron-lung–dependent in 1950. One might ask, what can be learned from such small numbers? Not instrumental lessons, surely, but symbolic ones, perhaps. But no mention is made of the Salk and Sabin vaccines, which had the instrumental effect of making the iron lung obsolete and the symbolic effect of medical science displacing clumsy machinery.



Kidney dialysis machine. Since 1972, access to kidney dialysis has been a right rather than a privilege in the United States. Current economic conditions are changing this situation. [Photograph: Larry Mulvehill/ Photo Researchers]

As Medicare breached the private domination of health insurance, so dialysis breached the private provision of access to life-saving medical technology. (The 1972 Medicare kidney entitlement actually covers all patients with permanent kidney failure, regardless of age, for treatment by either dialysis or kidney transplantation.) Why was this public financing step taken? The reasons include: a rejection of the rationing of access to dialysis, prevalent in the 1960s; costs per patient beyond individual or family resources; a gross underestimate of the cost impact on Medicare of this entitlement; and the hope that a universal kidney-failure benefit might be the first step toward national health insurance. In fact, there were good reasons to expect legislative action on national health insurance in 1973–74 until Watergate came to dominate political life.

The respirator, the defining technology of intensive care, is less an object of hope and more the source of reflection about the limits of medical technology. Although both the iron lung and the artificial kidney were criticized for their limits, the promise of saving lives overrode reservations about therapeutic use. But the respirator came to symbolize for bioethicists, physicians, and popular writers the view that medical resources were finite, and of limited benefit, and must, at some point, be rationed. Thus, on the eve of President Clinton's arrival in Washington in early 1993, there appeared to be greater realism about medical technology and an apparent willingness to consider some form of national health insurance.

That, of course, was not to be. Now, as we rely on market forces to reduce the costs of care, three views of medical technology and health insurance contend for allegiance. The dominant view holds that medical science and technology are the guarantors of *quality* medical care and provide hope for reducing currently intractable diseases to clinically manageable proportions. A distinctly different view, held by a growing number of health economists, is that innovation in medicine is one of the principal drivers of increasing health care *costs*, accounting for as much as half of the real increase in those costs in recent years. Rothman, however, asks about *access*—whether the nation can continue for the foreseeable future to maintain the contradiction between a commitment to private sector provision of health insurance, the demand for access to all life-saving technology, and the increasing limits on access to care. For this reason alone, *Beginnings Count* deserves to be widely read and its implications vigorously debated.

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