

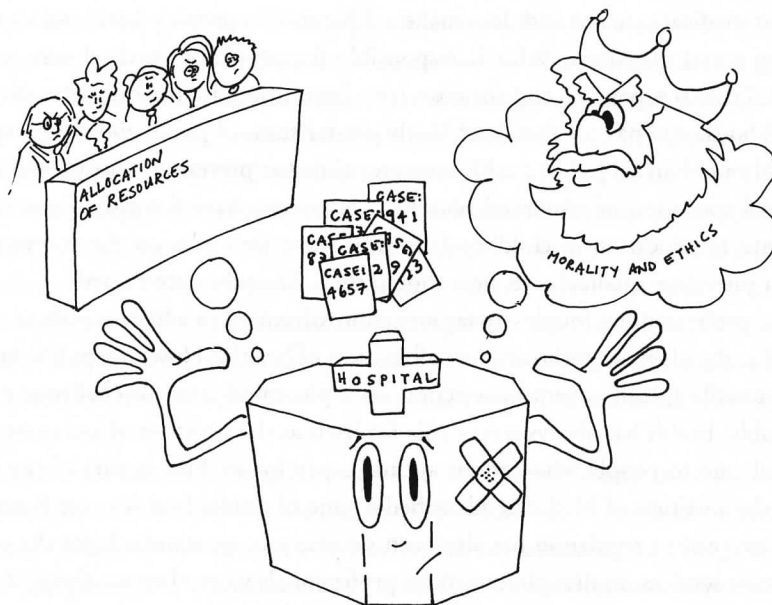
INTRODUCTION TO Public Health

Third Edition



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Is the Medical Care System a Public Health Issue?



Public Health Issues?

Even in an ideal world, where public health functioned perfectly, there would be a need for medicine. The medical system provides preventive care: immunizations against infectious diseases, monitoring of pregnancies and provision of “well-baby care” to ensure that children develop normally, testing of adults for risk factors (such as high cholesterol and blood pressure) that lead to cardiovascular disease, and secondary prevention measures—screening for early detection of diabetes and cancer, for example, and early interventions to correct problems. Even people with the healthiest lifestyles get sick or injured. Medical care saves lives and prevents suffering and disability and, therefore, must be considered necessary for public health.

Medical care is even more necessary when public health is not functioning perfectly. There are many gaps in the public health system because of a lack of resources, lack of political will, and the emergence of new health threats. Also, competing values in society lead people to behave in unhealthy ways. The medical system is called upon to deal with the consequences of failures in public health. Doctors are asked to repair the damage when an unvaccinated child contracts an infectious disease, when a community is sickened by water or food contaminated because of deficiencies in sanitary practices, when someone is injured in a motor vehicle accident caused by a drunk driver, or when a smoker develops cancer after years of exposure to tobacco smoke.

The fact that medical care can and does make a difference in people's health raises a number of fundamental social questions. Who is responsible for providing medical care when it is needed? Medical care is expensive, and the costs have been rising dramatically over the past several decades. Who should pay for that care? Vastly greater sums of public money are spent each year on medical care than on public health measures aimed at preventing disease and disability. Is that a rational allocation of resources? Should U.S. citizens have the same right to medical care as they have to education in childhood? And, if there are limits on the community's responsibility for providing medical care, how should those limits be determined?

The medical profession has fought governmental involvement in addressing these questions, regarding itself as the ultimate authority over all matters of health.¹ However, public health concerns have repeatedly forced government action on a piecemeal basis to challenge medicine's sovereignty. Public health has always seen a role for itself as the provider of last resort, offering needed medical care to people who cannot afford to pay for it. This is part of the assurance function that the Institute of Medicine identified as one of public health's core functions (see Chapter 1). Government regulation has also been necessary to set standards for the practice of various healthcare services, to discipline medical professionals when they are thought to be acting unethically or incompetently, and to set policy when ethical dilemmas have arisen that transcend the individual sickroom.

When Medical Care Is a Public Health Responsibility

Some forms of medical care are more important to the health of the community than others. Medical treatment of communicable diseases is particularly important because of the possibility that one sick individual could infect many others. Consequently, public health has taken a major interest in all aspects of infectious disease control, from the early days when quarantines were the only effective way of controlling epidemics, to immunization programs, to the provi-

sion of free medical treatment for those who do not have health insurance and cannot afford to pay for care. City and county health departments have traditionally operated clinics for diagnosis and treatment of infectious diseases. Today, the threat of re-emerging tuberculosis is taken seriously enough that, for example, the New York City Department of Health provides a program of directly observed therapy (see Chapter 10) in which public health nurses are sent to track down patients and make sure they take their medicine. The fact that AIDS is a communicable disease accounts, at least in part, for the major investment that the federal and some state governments have made not only in research, but also in providing treatment for patients.

A second area in which communities have an undisputed interest in the universal availability of medical care is the provision of emergency services. Emergencies are by definition unpredictable and can strike individuals at any time and in any place. In an increasingly mobile society, heart attacks and motor vehicle crashes may occur when people are far from home, with no family or friends present to provide first aid or call the doctor. It is in the interest of everyone to save lives first and ask questions later. Beginning with the Highway Safety Act of 1966, the federal government began to pressure states and localities to develop procedures for providing quick access to emergency care. Since then, in accordance with federal standards, communities have developed 911 phone-response networks, trained emergency medical technicians, dispatched ambulances using a centralized system, regulated the availability of hospital emergency rooms, identified trauma centers, and provided evacuation helicopters in rural areas. Still, the quality and the effectiveness of emergency response systems vary considerably in different parts of the country.²

A number of federal and state laws require that emergency rooms provide treatment to any patient that arrives with a life-threatening condition until he or she is stabilized, regardless of ability to pay. When the emergency situation has passed, however, many hospitals transfer poor and uninsured patients to public or charity hospitals. Some states have laws that prohibit hospitals from denying admission based solely on inability to pay, but in many parts of the country hospitals can and do turn away patients for financial reasons. Once medical treatment is under way, however, a patient's rights are greatly enhanced. There are laws against "abandonment," and hospitals cannot simply discharge patients because they are poor and uninsured.

Although most U.S. citizens do not have a general right to medical care, there are several exceptions, including veterans and prisoners. The hospitals and clinics of the Department of Veterans Affairs (VA) were designed to treat war-related injuries, but they also serve as a safety net for low-income veterans who do not have other sources of medical care. Funding for the VA system is chronically inadequate, however, and the agency has tightened its criteria for eligibility; except for those with combat injuries, only the poorest veterans can be served. Many veterans suffer from psychiatric disabilities or have substance abuse problems—conditions that the

VA has special expertise to treat.³ Prisoners are entitled to medical care because, as wards of the state, they are unable to seek care on their own. The courts have ruled that to deny them care would be the cruel and unusual punishment forbidden by the Constitution.⁴ The medical care provided in prisons, however, is often substandard.

The Conflict Between Public Health and the Medical Profession

Most Americans get health insurance as part of an employee benefit package. The insurance covers the worker and his or her family. This approach to paying medical bills became dominant after World War II, when unions bargained actively to obtain health benefits for workers. The arrangement satisfied most groups over the next three or four decades. Workers and their families could receive necessary medical care without worrying about cost; doctors and hospitals were happy because they could provide care as they saw fit and not worry about getting paid; unions took credit for forcing employers to provide the benefits; employers did not object because the cost at first was modest and the benefits inspired loyalty in their workers.

Traditional health insurance, the kind of insurance provided by most employers until quite recently, is like car insurance. Regular premiums are paid to the insurance company to cover the worker and his or her family. When covered individuals get sick, they go to the doctor or other medical provider of their choice, and that provider then sends them bills for services rendered. The patients pay the bills and are reimbursed by the insurance company. Sometimes the policy, like many car insurance policies, calls for a deductible that the patient must pay first before the insurance kicks in. Sometimes the patients must also pay a flat fee or a fixed percentage of the remainder of the bill, called a copayment. This way of paying for medical care is called "fee-for-service." The fee-for-service approach permits doctors to make decisions about a patient's care with no consideration of cost. As discussed in Chapter 26, this freedom has led to escalating medical costs and increasing numbers of uninsured citizens whose access to care is limited.

The medical profession has strongly resisted efforts to be included in the domain of public services. Since the end of the 19th century, with the discovery of bacterial causes of diseases, public health has claimed the prevention and treatment of infectious disease as its responsibility, and doctors have resisted that claim. While tolerant of public health's efforts at cleaning up the environment, private practitioners regarded diagnosing and curing sick people as their domain. Early in the 20th century, they fought reporting requirements for cases of tuberculosis and venereal disease, and they opposed the creation of public health clinics and centers, which they

perceived as an attack on their economic interests. This struggle continued throughout the century, and although public health has had some victories, the medical establishment has been able to prevent the United States from providing for its citizens the public assurance of needed medical care.¹

Still, there is a long history of providing charity care for the nation's poor. Often, treatment was provided by part-time volunteer physicians who combined their services with research and the teaching of medical students. This practice began in the late 18th century, with the establishment of free dispensaries in eastern cities, many of them connected with medical schools. These services were controversial. Private practitioners were suspicious that free care was being provided to those who could afford to pay for it, and there was great concern about "dispensary abuse." The poor, on the other hand, were distrustful of the dispensaries, where they were forced to wait hours for hasty and superficial attention.¹

In the early 20th century, city health departments began setting up clinics for the control of infectious diseases and the prevention of infant mortality. Baby clinics emphasized the teaching of hygienic practices and promotion of improvements in child care, diet, and living patterns. Clinics for tuberculosis and venereal disease provided diagnosis and advice about hygiene and diet but left treatment to private physicians, who objected strongly when they felt that the clinics were trespassing on their territory. The New York City Department of Health ran into trouble when its diagnostic bacteriologic laboratory began producing diphtheria antitoxin, selling it to drugstores, and making it available to poor patients for free, prompting complaints of socialism and unfair competition that forced it to cease all sale of the antitoxin. Despite the early opposition of the medical profession, however, an uneasy truce has evolved that allows city and county health departments to provide treatment for the poor, often under the uncomfortable conditions that prevailed in the old dispensaries.¹

Community health centers provide another source of basic medical care for the poor. These centers are supported by federal grants as well as by payments by public and private health insurance for services provided. There are about 1200 community health centers in the United States. They are located in inner cities and isolated rural areas where there are shortages of medical and social services. Community health centers provide primary and preventive care to people who might otherwise not be able to afford it. Services may be paid for by government programs (see the next section), or patients may pay a fee based on a sliding scale according to income. Community health centers serve as an important safety net for low-income families; the numbers served have been increasing, and in 2008 they served about 21 percent of low-income uninsured persons.⁵

The health of schoolchildren has been a public health concern since the late 19th century. To control the spread of communicable diseases, cities began to employ medical inspectors to examine children who showed signs of illness and exclude them from school if they had a communicable disease. School doctors and nurses also began testing children for eye problems and other physical impairments that might interfere with learning. Because of the opposition of the medical establishment, they were not allowed to provide medical treatments. With the development of effective vaccines, the law began requiring that children be immunized—by their private physicians or in public clinics—before they started school, and the threat of epidemics in the schools has receded. In some cities, school health programs treat minor problems; sometimes they merely send notes recommending treatment home to parents. It is a source of frustration to public health practitioners that there is no integration of school health programs with medical services, leaving many children with health problems that are repeatedly diagnosed but untreated.¹

Throughout the 20th century, there have been repeated attempts in the United States to provide some kind of national health insurance plan to ensure that everyone would have access to needed medical care. During this period, most industrialized countries were setting up such programs, some of them run by the national government, others more loosely organized. Germany established the first national system of compulsory sickness insurance in 1883. Over the next thirty years, Austria, Hungary, Norway, Serbia, Britain, Russia, and the Netherlands followed Germany's example. Canada implemented a national health insurance plan in the 1970s.¹

In the United States, efforts to establish a national health program were made before World War I but were derailed by the war. Another attempt was made during the 1930s as part of President Franklin D. Roosevelt's New Deal, but health insurance was not included in the Social Security Act. After World War II, President Harry S. Truman proposed a single health insurance system that would apply to everyone; again the attempt failed. Each time, the medical profession opposed governmental involvement in medical care as "socialized medicine," and various other political interests joined to defeat the proposals.¹

In 1965, a significant victory over the medical establishment's opposition was achieved under President Lyndon Johnson: legislation for Medicare, which provides insurance for the elderly, and Medicaid, a welfare-type program for the poor, were passed. These programs were designed to remedy what people considered the main problems with employer-based insurance: it stopped when a worker retired, and it left the poor and unemployed out of the system.¹

Medicare, created in 1965 as a mandatory insurance program for people over the age of 65, is part of the Social Security system. (Younger people who are entitled to Social Security because of disability are also eligible for Medicare.) Workers pay into the system through deductions from their paychecks; employers pay a tax on their payroll; and workers are entitled to benefits

when they reach retirement age. The Medicare program has two parts: Part A, which covers hospital insurance, and Part B, which pays doctor bills and other outpatient costs. Virtually all people are automatically enrolled in Medicare Part A when they reach age 65. Part B is voluntary and requires participants to pay a monthly premium. Medicare is much like traditional health insurance, in that most doctors and other providers are paid on a fee-for-service basis. Like private insurance, the patient is required to pay deductibles and copayments. In 2003, legislation was passed that created a new Medicare prescription drug plan. The new benefit, which became effective in 2006, is optional and requires an additional monthly premium. Medicare is discussed further in Chapter 28.

Medicaid was created, also in 1965, as a welfare program for the poor, with costs shared by the federal government and the states. Eligibility is determined by income and varies from one state to another. Medical bills are paid directly by the state or local government to the provider, usually at a low, fixed rate for each service. Alternatively, states may fund managed care companies to cover Medicaid patients, as discussed in Chapter 26.

In the early 1970s, President Richard Nixon tried to expand these programs, proposing a national plan to cover everyone, but his efforts were derailed by the Watergate scandal. No further efforts were made until President Bill Clinton was elected in 1992, promising to provide health insurance for all; his proposal was also defeated. However, because of increasing concern about the problem of children without access to medical care, President Clinton and Congress negotiated a program called the Children's Health Insurance Program (CHIP). This is a joint federal-state program, similar to Medicaid, which expands coverage to children in families that earn too much to qualify for Medicaid, usually up to 200 percent of the federal poverty level.⁶ Now, President Obama has vowed to reform the healthcare system to ensure that all Americans will have medical insurance, and Congress is attempting to come up with a plan. Whether this attempt will succeed remains to be seen.

Pending the outcome of the current efforts, the United States remains the only industrialized nation, except South Africa, that does not have a national plan ensuring medical care for all its citizens. In 2008, over 20 percent of the American population ages 18 to 64 had no health insurance.⁷ For many of these people, there is no guaranteed access to health care except for emergency care. While most public health advocates believe that the government should ensure access to basic medical care for anyone who needs it, the American political system has not supported that view. Clinical medicine, always more prestigious and more well financed than public health, has been able to fend off public health's attempts to integrate medical treatment into a rational system that would maximize the health of all Americans. However, in response to increasing evidence that the U.S. healthcare system is dysfunctional, as discussed in Chapter 26, even the American Medical Association has endorsed President Obama's efforts to change the system.⁸

Licensing and Regulation

While the medical profession, until recently, has resisted government efforts to ensure and fund medical care for all Americans, it has been willing to submit to some forms of government regulation. Licensure of qualified medical practitioners, including physicians, nurses, and other health professionals, protects the prerogatives of the professionals from encroachment by unlicensed practitioners and also ensures quality of care for patients. Physicians, nurses, and dentists must be licensed to practice in every state. Licensing requirements for other healthcare professionals vary from state to state. States may establish requirements, such as continuing medical education, for physicians and nurses to maintain or update their skills to retain their licenses. States also have the power to discipline medical professionals for incompetence or misconduct with the ultimate threat of revoking their licenses.

States also license and regulate medical facilities such as hospitals and nursing homes. To confirm that they provide high-quality care, healthcare institutions also may seek accreditation by a private organization, generally the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Since Medicare, Medicaid, and many private health insurers usually require institutions to be accredited in order to pay them for patient services, maintaining accreditation is important to them. Schools of medicine, nursing, and public health as well as training programs for advanced medical specialties also seek accreditation as a measure of their quality. As medical care is increasingly being provided by managed care organizations (see Chapter 26) and as methods are developed to evaluate the quality of care provided by these organizations (see Chapter 27), accreditation of managed care organizations is becoming more widespread.

As discussed in Chapter 26, governments have attempted to use regulatory approaches to restrain the growth of medical costs by requiring certificates of need before new facilities can be built or expensive new equipment purchased. These efforts have generally been ineffective and most have been abandoned.

Ethical and Legal Issues in Medical Care

Although the United States has chosen not to establish a broad right to medical care, it has been forced repeatedly to deal with individual cases that attract public attention and demand community response. Consequently, there are many legal requirements and restrictions on medical care that have arisen from specific cases. Usually, such cases have come to the attention of the courts when medical professionals disagreed with each other or with patients' families.

Decisions in these cases have set legal precedents for how medicine can be practiced in certain situations. Many of these situations involve the beginning and end of life, and many of the precedents have profound implications for public health.

Abortion is one of the most controversial medico-legal issues, pitting the "right to life" of the fetus against the right of the pregnant woman to control her own body. Abortion was illegal in most states until 1973, when the Supreme Court decided in *Roe v. Wade* that women have a constitutional right to an abortion, at least in the first trimester of pregnancy. The controversy continues, however, with right-to-life activists trying, with some success in some state legislatures, to place limits on the circumstances under which women can exercise their rights. Abortion coverage has also been a stumbling block in Congress's current efforts to pass health-care reform.

Similar controversy raged in the late 1990s over whether mentally competent, terminally ill patients have the right to physician-assisted suicide. Dr. Jack Kevorkian was making a career of helping to end the lives of people who were suffering or were afraid that they would suffer painful or degrading deaths. While laws were passed outlawing Dr. Kevorkian's activities, juries sympathized with the patients and refused to convict him. However, in 1999, he was convicted of second-degree murder because he went beyond assisting suicide and administered a lethal drug himself to a patient who wished to die. The death of a 52-year-old man with Lou Gehrig's disease was aired on the CBS program *60 Minutes*. Dr. Kevorkian served eight years in prison and was released in 2007. He ran unsuccessfully for Congress in Michigan in 2008.⁹ Meanwhile, two states—Oregon in 1994 and Washington in 2008—have passed ballot measures that allow physicians to assist patients to commit suicide by prescribing lethal doses of drugs. The patients must be mentally competent adults, terminally ill with less than six months to live, and they must be capable of taking the medications by themselves.¹⁰

Ironically, while there is no legal requirement to provide medical care to people who want and could benefit from it, many of the most contentious legal cases have concerned the system's insistence on providing expensive, intrusive, and unwanted treatment to patients whose conditions are judged medically hopeless. In the 1976 case of Karen Ann Quinlan, a young woman left permanently unconscious from an overdose of drugs and alcohol, the New Jersey Supreme Court eventually ruled that she could be removed from a ventilator at the request of her parents over the objections of hospital personnel. However, in the fourteen months of the court battle, the young woman had been weaned from the ventilator and was able to breathe on her own, although she remained unconscious. She was transferred to a nursing home where she survived for ten years in a persistent vegetative state.¹¹

In the similar case of Nancy Cruzan, a young Missouri woman in a persistent vegetative state resulting from an automobile crash, the Supreme Court decided in 1990 that states could set the standards for when life support could be removed. Cruzan's father had to move her to an-

other state in order to remove the feeding tube and let her die.¹² Now, after a number of other cases have been tried in the courts, the precedent is well established that competent patients can refuse medical treatment and that life-support measures are not required for an incompetent patient who has specified in advance the conditions under which he or she would not want them. The most reliable way for an individual to ensure that his or her wishes would be followed is to sign a durable power of attorney over to a trusted friend or family member who can make medical decisions if he or she becomes incompetent.

The lack of such an advance directive led to the politically charged battle in early 2005 over removing a feeding tube from Terri Schiavo, a young Florida woman who had been in a persistent vegetative state for fifteen years. Florida law provided that Ms. Schiavo's husband was entitled to decide that the feeding tube should be removed; he contended that she would not have wanted to be kept alive in this condition. However, Ms. Schiavo's parents objected, maintaining that she recognized them and that she might improve with treatment. Inspired by "right-to-life" political pressures, the Florida governor and legislature, the U.S. Congress, and President Bush attempted to block removal of the feeding tube, but the Florida courts, the federal appeals court, and the Supreme Court upheld the husband's right to decide. Ms. Schiavo died thirteen days after the tube was removed. Such family disputes over withdrawing life support, while common, would be easily resolved if the individual had prepared a "living will" that specified her wishes.¹³

But what happens if a patient indicates that he or she wants all possible measures taken to preserve his or her life, even if there is no hope of regaining consciousness? This is what happened in 1991 in the case of Helga Wanglie, an 87-year-old woman in a persistent vegetative state who was being kept on a ventilator and feeding tube in a Minneapolis hospital. Her husband and children refused to allow life support to be removed, stating that they were praying for a miracle. The hospital went to court, claiming that the treatment was futile and merely prolonged death. The court refused to intervene, and the patient remained on life support until she died three days later.^{14,15} In some states, including California and Texas, the law allows health-care institutions to withdraw life support when further treatment is judged futile, even against the wishes of the patient as expressed in an advance directive.¹³ Not often mentioned in the legal arguments is the cost of the care. Most often, the costs of caring for brain-damaged patients are borne by the taxpayer, since few families have the resources to pay for the necessary care.

Similar quandaries occur at the beginning of life, when decisions must be made about treating infants whose prospects are limited. Several notable cases occurred in the 1970s and 1980s involving babies born with Down syndrome, characterized by mental retardation and often accompanied by physical defects that are lethal but correctable by surgery. The difficult question with which parents are confronted, while still reeling from the news that their infant is not normal, is whether to authorize the surgery, allowing the infant a chance to live although his or her

quality of life will be uncertain. In 1982, the Infant Doe case drew public attention to the problem. Infant Doe was a Down syndrome baby born in Bloomington, Indiana, with tracheoesophageal fistula, a hole between the respiratory and digestive tracts. The parents chose not to operate, but hospital administrators and pediatricians went to court to force the surgery. The judge ruled that the parents had the right to make the decision; each level of appeal supported the parents, and the baby died before the case reached the Supreme Court.¹¹

However, the publicity over Infant Doe attracted the attention of the Reagan administration, which firmly supported the right-to-life viewpoint. On the grounds that nontreatment of newborns constituted discrimination against people with disabilities, the Justice Department implemented the so-called Baby Doe rules, which mandated treatment of all newborns with birth defects. Large posters were to be displayed outside all neonatal intensive care units stating that "Discriminatory failure to feed and care for handicapped infants in this facility is prohibited by federal law." A toll-free 800 number, the "Baby Doe hotline," was posted to report abuses, and "Baby Doe squads," composed of lawyers, government administrators, and physicians, investigated complaints. Later court action struck down the Baby Doe rules; but in 1984, Congress passed a law declaring that nontreatment in Baby Doe cases is child abuse except when the child is chronically and irreversibly comatose, is inevitably dying, or when treatment would be "futile and inhumane."¹¹ The ethics of these rules are still being debated.¹⁶

It is not only Down syndrome infants that must be given aggressive medical treatment. Many of the 543,000 infants born preterm every year also must be provided with advanced, high-technology care. Although most of these infants survive to lead normal lives, many others—especially those with very low birthweight (less than 3.4 pounds) die or are left with permanent impairments. Infants with very low birthweight that survive are at increased risk of such long-term disabilities as cerebral palsy, autism, mental retardation, vision and hearing impairments, and other developmental problems.¹⁷

The costs of medical treatment for these infants, like the costs of providing life support for nearly dead adults, are not generally considered when decisions are made about whether aggressive treatment should be given. If these babies survive with major handicaps, medical and care-taking costs will continue throughout their lives. According to the Institute of Medicine, preterm births cost the nation an estimated \$26 billion annually, mostly for medical care, but also for early intervention, special education, and lost productivity.¹⁷ Much of the costs, like those for brain-damaged adults, is borne by taxpayers.

From a public health perspective, the American healthcare system is unfair and unethical. Vast resources are spent on a relatively few desperately ill patients, many of whom have no prospect of a reasonable quality of life, while millions of Americans have no access to the most basic medical services that could relieve pain and prevent long-term disability. Richard Lamm, a former governor of Colorado who has been an outspoken critic of the inequities of the system, laments that

medical ethicists debate agonizingly over the treatment of a few individuals while little attention is paid to social ethics, a neglected and much needed examination of the allocation of resources for the entire system. Lamm argues that "it is axiomatic that public funds should buy the most health for the most people,"^{18(p.14)} a view consistent with that of public health. Chapter 26 discusses further the financing of U.S. medical care and the flaws in the system.

Ethical Issues in Medical Resource Allocation

While public health advocates believe that the inequities in access to care are the most important ethical dilemmas concerning the medical system, numerous other situations call for public participation in medical decisions. Sometimes the issue is access to scarce resources other than money. For example, when hemodialysis (blood-cleansing) was first developed in 1970 to help failing kidneys, there was a shortage of dialysis machines. To choose which patients should be dialyzed, "God Committees" were formed. The committees consisted of laypeople who would select the most worthy candidates for the life-saving treatment. The committees tended to favor those who had jobs, family responsibilities, youth, good general health, and strong motivation. The judgment process made many people uncomfortable.¹¹ After dramatic publicity about the plight of patients with kidney failure who were denied the dialysis treatment, Congress passed the 1972 End-Stage Renal Disease (ESRD) Act, which funded dialysis treatment for all Americans without selection criteria. Subsequently, the program's funding was extended to include kidney transplants, which can end patients' need for dialysis.

The ESRD Act created a new group of citizens with a right to medical care based on their diagnoses. Advocates for patients with other conditions, such as hemophilia and heart and lung disease, tried to persuade Congress to fund their diseases as well; however, the cost of kidney dialysis and transplants skyrocketed due in part to the open-ended funding, and Congress declined to extend the benefit to people other than kidney patients.¹¹

As organ transplantation has become increasingly successful due to improved antirejection drugs, the problem of how to distribute scarce resources has resurfaced, since the number of donor organs is never adequate to fill the need. Livers are in especially short supply, and there is no substitute treatment, like kidney dialysis, for failing livers. More than 6000 patients receive liver transplants each year, but at the end of 2006, there were over 12,000 people on regional waiting lists.¹⁹

The policy on distributing organs has been controversial. The task of matching available organs with waiting patients is handled by a nonprofit organization under contract with the Department of Health and Human Services. The organization, the United Network of Organ Sharing (UNOS), maintains a computerized network of 58 organ recovery centers in eleven

geographic regions of the nation. When an organ becomes available, a suitable recipient is first sought within the same region. If a suitable match is not made within the region, the computer looks at waiting lists in other regions.²⁰

In 2009, the issue of priority for transplants arose when Steve Jobs, the chief executive of Apple, unexpectedly received a liver transplant some time after he had been diagnosed with pancreatic cancer, possibly because the cancer had spread to his liver. Questions were raised about whether he had jumped to the head of the waiting list because of his wealth and celebrity, as had apparently happened when Mickey Mantle had a liver transplant in 1995 after only one day on the list. In a *New York Times* article, transplant specialists were quoted as saying that, although jumping ahead of others would not have been allowed for Mr. Jobs, there were ways of working the system that he could have used. Because waiting times vary at different transplant centers around the country, he could have registered at more than one center and, having access to a jet, could have arrived at a center promptly when an organ became available.²¹ The allocation process is a life-or-death matter because each year over 7000 patients die while waiting for an organ.¹⁹

The acrimony over rationing of organs, which is unavoidable because of obvious shortages, demonstrates how difficult it is politically to make rational decisions in the allocation of medical care. Chapter 26 argues that rationing currently exists throughout the medical system and should be addressed openly, although very few politicians or medical professionals are willing to face this fact.

Conclusion

While public health's focus on prevention of disease aims to minimize the need for medical care, access to medical care is an important part of the assurance function of public health. Medicine has always resisted attempts to include it as part of the public health system, with considerable success. Most Americans have private health insurance provided through their employers. However, public health concerns have overcome the opposition of the medical profession on some issues.

The urgent need to control the spread of communicable diseases has led to significant government involvement at the local level in providing medical care. Governments also coordinate, and often provide, emergency services to ensure prompt response when lives are at stake. Public health clinics that provide care for the poor have been grudgingly accepted by organized medicine, but there is no general right to medical care for Americans, as there is in most other industrialized countries.

There have been repeated attempts throughout the 20th century to enact a universal health insurance system in the United States. All have been defeated. However, in the 1960s, Congress created the Medicare program, which guarantees medical care for the elderly, and the Medicaid program, which provides health care for the poor. In the 1990s, a joint federal–state program called Children's Health Insurance Program (CHIP) was created to provide medical care for poor children. Now, President Obama is making another attempt to reform the system so that all Americans will be covered by insurance.

Public health has a role in monitoring and ensuring the quality of medical care through licensing of physicians, nurses, and other health professionals. Healthcare institutions such as hospitals and nursing homes also must be licensed by states. By requiring institutions to be accredited in order to receive Medicare and Medicaid payment for services, the government can help to ensure that the services provided meet a standard of quality. Government involvement in medical issues also occurs in connection with ethical and legal debates about life and death—issues that impact both medicine and public health. Such questions are especially painful when they concern removal of life support from permanently unconscious patients or nontreatment of severely handicapped newborns, situations that involve the provision of costly and probably futile care, usually at the public's expense.

Public participation in medical decisions is also necessary when scarce resources other than money are distributed. When hemodialysis for kidney failure was developed, there was a shortage of dialysis machines, and committees were formed to decide which patients could have the life-saving treatments. This was such a difficult political issue that Congress decided on the expensive solution of funding treatment for all Americans with kidney failure. Currently, patients with failing livers are in similar life-and-death situations, with liver transplants being their only hope of survival. However, there is a shortage of livers available for transplant, and there is always controversy over how these organs should be distributed.

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