

Health Care

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THE health of the populace has always been particularly important in Vermont. The long, cold winters and rural isolation stressed the early settlers, and fever, "ague," tuberculosis, and epidemics of infectious disease plagued early inhabitants. While the rate of population growth was high from 1790 to 1820, from 1820 until the modern era the rate of population increase was smaller here than in other states. Indeed, the health of Vermonters was problematical well into the middle of the twentieth century. During the Second World War, for example, half of the Selective Service System draftees in Vermont were rejected for physical or mental defects.

In 1886 the General Assembly established the first State Board of Health and charged it with providing for the public health of the residents. In 1923 the General Assembly reorganized the executive branch of government and in the process created the Department of Health. This body made some progress, but in the wake of World War II, Governors Proctor, Gibson, and Emerson roiled state politics with debates over the parlous state of Vermonters' health.

The Health Department settled into organizational stability with the broad-based revision of the health statutes in 1951. By that time, diseases such as smallpox, diphtheria, and typhoid had been virtually eradicated. The targets in the 1950s were tuberculosis, polio, infectious hepatitis, and bacterial infections. The department was also concerned with cancer control and research, maternal and child health, nursing services, mental health, dental care, health education, and sanitary engineering.

By 1965, the time at which we commence our current review, the health of Vermonters had clearly improved markedly when contrasted with the eighteenth and nineteenth centuries, but serious problems remained. Vermont experienced a decrease in population over the early and midportions of the twentieth century, and there was a shortage of physicians in the state. From 1930 to 1960, the number of doctors decreased, and the number of towns without physicians

increased from 121 to 169, out of a total of 251. (A handful of those towns were uninhabited.) The impact of the shortfall was exacerbated by the fact that so many of the state's physicians lived and practiced in or near Burlington, many of them associated with the College of Medicine of the University of Vermont (UVM).

By happenstance, the year 1965 marks not only the divide between the Nuquist's book and this one, but the great fault line in American health care, as well. It was just one year later that the U.S. Congress set in place the Medicare and Medicaid programs—the promise that the federal government would pay for health care insurance benefits to the over-sixty-five population and to the poor.

This legislation, along with an enormous increase in the flow of federal money into medical research, hospital construction, and the training of new doctors, reworked the face of health care in the United States and in Vermont. In the mid-1960s, the United States spent roughly 5 percent of its gross national product on health care; by 1996 health care spending consumed more than 14 percent.

In 1965 the center of the health care delivery system in Vermont was the local hospital, or hospitals. Burlington alone had two, the Mary Fletcher Hospital and DeGoesbriand Hospital, just a block away, operated by the Roman Catholic Diocese. In neighboring Winooski, the Fanny Allen Hospital, run by the Religious Hospitalers of St. Joseph, a Montreal-based order of nuns, also served the Catholic community in Chittenden County. Many smaller communities had two hospitals, including Newport, St. Johnsbury, and the Barre-Montpelier area. Most doctors worked extensively in these facilities. Patients might be admitted simply because they needed a rest, and the costs were low. The most sophisticated care was delivered at Mary Fletcher Hospital, the home institution of the faculty of the University of Vermont's College of Medicine.

THE VERMONT HEALTH DEPARTMENT

The Vermont Health Department underwent a significant shift in posture in the modern era. The department retained its traditional roles in the control of epidemics, such as the outbreaks of Legionnaires' disease in 1977 and 1980, and the management of environmental influences on public health, such as monitoring private water supplies, inspecting restaurants, enforcing regulations on occupational health and safety, and issuing advisories to the public about such questions as how much locally caught fish it is safe to eat. Many of these oversight responsibilities were shared with other state agencies, particularly the Agency of Natural Resources.

Increasingly, however, the department assumed a central role in the prevention of health problems through programs to alter destructive lifestyles on the part of Vermonters. These prevention responsibilities came in three basic areas: social, environmental, and clinical.

In the social arena, the department operates programs to persuade people to stop smoking and to drink responsibly, to exercise and adopt a more healthful

diet, and to refrain from suicidal and violent behavior. In the environmental area, the department monitors federal and state workplace health and safety requirements and works to reduce the introduction of carcinogenic materials into the landscape and atmosphere. In the clinical area, the department runs programs to make sure Vermonters seek the care they need and that they have the necessary resources available to deal with cancer, AIDS, infectious diseases, maternal and child health, heart disease, and immunizations.

"We work very hard on prevention," said Health Commissioner Dr. Jan Carney. "Changing behavior is much harder than efforts to cure disease and to immunize. . . . You're telling them they have to change today in order to avoid what's going to kill them in thirty years."

In addition to shifting to an emphasis on prevention, Carney said, the department has significantly extended the reach of traditional public health by focusing on specific outcomes and by engaging the community at large in the effort to improve the health status of the state's population.

The establishment of outcome targets is contained in the 1992 department publication, *Healthy Vermonters 2000*, which calls for quantitative changes in a range of parameters from increasing the percentage of pregnant women who receive prenatal care to reducing such destructive behaviors as smoking, abusive drinking, and violence. Establishing outcome targets is a critical factor in the success of the programs, she said.

Enlisting the help of community groups, the public at large, and the legislature in these efforts has also been critical in achieving broad-based improvements, Carney said.

LEGIONNAIRES' DISEASE

The Health Department's infectious disease procedures were tested in 1977 and 1980 by outbreaks of Legionnaires' disease, an atypical pneumonia caused by the bacterium *Legionella pneumophila*. This disease, which is marked by high fever, coughing, and lung congestion, was first identified in 1972 when large numbers of veterans got sick after an American Legion meeting in Philadelphia. The pneumonia was unusually virulent, particularly for those whose immune systems were weak. Twenty-nine of the 182 victims of the Philadelphia outbreak died. (While the disease itself was widely remarked in the wake of the Philadelphia convention, the bacterium itself was not identified until 1977.)⁴

In 1977 forty-nine cases of the disease were diagnosed at the Medical Center Hospital of Vermont in Burlington. Nineteen of those cases were fatal. No source for the outbreak could be found.

A second, more serious outbreak occurred in the spring of 1980. In the wake of the 1977 outbreak, the medical center had established a protocol to

Jan K. Carney, M.D., M.P.H., interview by author, 16 January 1996.

⁴D. N. Klaucke et al., "Legionnaires' Disease: The Epidemiology of Two Outbreaks in Burlington, Vermont, 1980," *American Journal of Epidemiology* 119, no. 3 (1984): 382-91.

monitor pneumonia cases. The first cases showed up in May 1980, and eighty-five were diagnosed by the end of the summer. Sixteen of those cases were fatal. The department launched a major demographic study to determine the patterns and cause of the disease. Some of the victims appeared to have contracted the disease while in the hospital; others came to the hospital after infection. Investigators checked residential and work-location patterns of people who had the disease and found that many lived or worked on the hospital and medical school grounds or to the north and northwest of the campus.

The investigators also analyzed the elements of the water system in the area, including cooling towers on top of the Given Building of the medical college, behind the Bailey/Howe Library, and outside of the engineering building on the UVM campus. They also collected samples from the municipal supply and from several locations inside the hospital itself. And they found that the prevailing winds during the period of the outbreak were from the south.

Twenty-four cases occurred in the first cluster, sixty-one in the second. All the cases occurred in Burlington; there were none at Fanny Allen in Colchester, and none at other hospitals in Vermont. (There were a few other cases subsequently in Vermont; one case was diagnosed at Mt. Ascutney Hospital in 1982, and a Vermonter was diagnosed with the disease at Mary Litchcock Hospital in New Hampshire.) Twenty-nine were found to have contracted the disease while in the hospital, forty-two others were not infected as inpatients, and there were fourteen possible cases of inpatient infection.

The combination of southerly winds and the fact that most victims had been hospital patients or had lived or worked on the campus or just to the north and northwest of it focused attention on the cooling tower on the roof of the Given Building at the UVM College of Medicine, which is just to the south of the patient wards of the hospital. Moreover, the outbreak pattern showed two major spikes just prior to chlorination periods at the Given tower. Tests of the other possible sources—other cooling towers, the municipal water system, and sites inside the hospital—showed no patterns.

The department epidemiologists concluded that the Given tower was the source of the bacteria, which was blown north and northwest, first to the patient wards of the hospital and then to the places where people worked on the campus or lived in adjacent neighborhoods.

Based on doubts about whether bacteria in the Given tower could be controlled chemically, the structure was removed and replaced by a closed cooling system.

The department maintains constant vigilance over potential threats to the public health such as the emergence of new pathogens. Working with the federal Centers for Disease Control and Prevention, for example, the department monitors the appearance of such modern menaces as Group A *streptococcus*, Lyme disease, new forms of *E. coli*, and new forms of *salmonella*.

PREVENTION

SMOKING

By a wide margin, the most important lifestyle problem that Vermonters faced was the use of tobacco. Health Department figures showed that, in the 1970s through the 1990s, about 880 state residents were dying from tobacco-related illnesses each year. That number was higher than the number of deaths from car accidents, AIDS, alcohol, homicides, illegal drugs, and fires combined. It was no coincidence that public health officials believed this behavioral pattern was the most difficult to alter:

There was some progress on the issue. In the decade from 1985 to 1995, the percentage of adult Vermonters who smoked dropped from 30 to 21, according to Health Department figures. During the last half of that period, however, the number of teenagers who reported taking up smoking rose steadily. Moreover, the drop in adult smoking appeared to have slowed or halted.

The nationwide push to reduce tobacco use got its greatest impetus from the 1964 report by the U.S. surgeon general that smoking causes cancer. The report generated a broad-based educational effort to encourage cessation of smoking, and the drop in usage in Vermont was a reflection of that effort. Programmatic efforts in Vermont to persuade people did not have much impact, according to Deborah Dameron, the Health Department specialist assigned to that task. "Nicotine is so addictive that when the whole focus was to persuade people to quit, we didn't see much [of an effect]," she said.³

So the Health Department shifted its focus to two other areas: efforts to prevent stores and vendors from selling cigarettes and tobacco products to children, and efforts to establish smoke-free public areas—stores, restaurants, public buildings, and the like. The focus on sales to children was considered by public health officials to be the key to success over the long term. Most smokers start as youngsters under the age of eighteen, and once addicted, they have great difficulty breaking free. At any given time, for example, about 70 percent of adult smokers were trying to quit, but only 2 or 3 percent of those would succeed. Moreover, public health officials believed that children were the intended target of tobacco company advertising, an argument the companies rejected.

A troubling aspect of the problem for public health officials was the extent to which it appeared to be class-based: low-income individuals with relatively little education smoked much more than well-educated people with higher incomes. In the federally sponsored Women, Infants and Children Program, for instance, 40 percent of pregnant mothers smoked, more than double the level in the nonpoor population.

Vermont efforts from the mid-1980s to the mid-1990s achieved considerable success, although the numbers of smokers continued to be disappointingly

³Deborah Dameron, interview by author, 13 June 1996.

high. The most striking accomplishment was the enactment of an array of state legislation to bar sales to minors and to establish smoke-free zones. One of the most important factors, according to Dameron, was the work of a very broad antismoking coalition made up of parents, legislators, volunteers, and members of numerous organizations, including the American Cancer Society, the American Heart Association, the American Lung Association, Community Health Plan (CHP), Fletcher Allen Health Care, the Vermont State Medical Society, the Vermont State Nurses Association, and others.

The effort in the Vermont legislature, beginning in the mid-1980s, was focused in the House of Representatives. A bipartisan group of legislators fought a series of bitter, pitched battles against tobacco company lobbyists to put an array of protections in place. Leaders in this effort included House Representatives Helen Richle, R-Burlington; Viola Luginbuhl, R-South Burlington; Ann Seibert, D-Norwich; Margaret Martin, D-Middlebury; and Ruth Stokes, R-Williston. The result was one of the earliest and broadest antitobacco programs in the United States.

The key pieces of legislation were the following:

Smoking in the Workplace: a law requiring every employer to establish a smoking policy for his or her workers. An employer could choose to ban smoking entirely or restrict it to certain areas [1987, No. 69 (Bien. Sess.), codified as 18 V.S.A. ch. 28].

Youth Access to Tobacco Products: a law requiring purchasers of tobacco to be eighteen years of age or older and penalizing vendors for selling to minors and minors for misrepresenting their age to buy tobacco products; the law also limited placement of cigarette vending machines and required vendors to be licensed [1991, No. 70 (Bien. Sess.), codified as 7 V.S.A. ch. 40].

Smoking in Public Places: a law prohibiting smoking in common areas of public buildings, enclosed spaces, and offices. The only exception was for holders of a cabaret license, a cabaret being an establishment that serves more alcoholic beverages than food. Cabarets could designate smoking areas [1993, No. 46 (Bien. Sess.), codified as 18 V.S.A. ch. 37].

Tobacco Use on Public School Grounds: a law prohibiting smoking on the grounds of public schools [1995, No. 52 (Bien. Sess.), codified as 16 V.S.A. § 140].

Health Care Financing Law: a law increasing the tax on cigarettes from twenty-four cents to forty-four cents per pack and the wholesale tax on tobacco products from 20 to 41 percent. The money was earmarked for a state program to finance health care insurance for uninsured Vermonters [1991, No. 14 (Bien. Sess.), codified as 32 V.S.A. §§ 7771, 7811, 7823, 7814; 33 V.S.A. ch. 19, subch. 3 (1995)].

The legislative efforts continued in the 1996 session. A bill banning certain types of cigarette advertising—the so-called *Joc Camel* bill—passed in the House

but not in the Senate. The prime sponsor, Representative Karen Kitzmiller, D-Montpelier, said she would try again in the 1997-98 biennium.

A major factor in the success of such efforts is the intensity of enforcement. In 1995 a survey showed that 64 percent of cigarette vendors were flouting the law against sale of tobacco products to minors.¹ A well-publicized crackdown by the state Liquor Control Board reduced that number to 26 percent. Vermont was one of the most aggressive states in the country in pursuing antitobacco policies. It was, for example, one of the earliest to comply with federal regulations requiring the establishment of an antitobacco program.

Continuous educational work with young people was the focal point of the public health community. The Health Department, for example, established a program in 1995 to get kids teaching kids about the dangers of smoking. The department sponsored a program in which high school students went into the elementary schools to talk about the issues. It is very effective to have high school sophomores tell fourth graders it is not "cool" to smoke, Dameron said.²

Despite the central nature of the problem, little money was devoted to smoking cessation. From 1993 to 1997, the Vermont Department of Health relied mainly on \$200,000 in grants from the federal Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation, as well as many voluntary contributions. Community Health Plan, for example, contributed \$10,000 per year, and the television stations in the state matched each purchased advertising spot with a free one. The department broadcast about \$100,000 worth of such advertising per year. However, relatively little general fund money was available.

ALCOHOL AND DRUG ABUSE

In 1990 a survey covering forty-five states showed that Vermonters ranked second in binge drinking, fourth in drunk driving, and tenth in chronic drinking. There were six thousand admissions to state-funded substance abuse treatment programs in 1991. In a 1991 survey, the Health Department reported that 56 percent of high school seniors reported using alcohol once a month and 34 percent reported drinking before driving.

"Vermont has a drinking problem," said Thomas E. Perras, director of the Office of Alcohol and Drug Abuse Programs of the Health Department, who assumed his post in 1994. "About 22 percent of the adult population needs some form of intervention for use of alcohol or drugs." The problem extends down into the tenth grade, despite an intensive effort to educate children about the dangers of drug and alcohol use. And the large numbers that showed up in the surveys indicated that the problem cuts across all social and economic backgrounds.³

As of 1997, the Health Department was spending about \$8 million per year on the drug and alcohol program; the money came from the state general fund,

¹Vermont, Department of Liquor Control, press release, 30 January 1995.

²Dameron, interview.

³Thomas E. Perras, interview by author, 15 October 1996.

federal block grants, Medicaid funding, and private insurance. According to Ferras, the state's program ran on three tracks.

The first, prevention, consisted primarily of state technical and financial assistance to schools and community providers to carry out programs to educate kids in both elementary and high school levels to avoid drugs and to use alcohol wisely, once they were old enough. The department also helped in the establishment of the First Night programs in the state in which communities ran alcohol-free New Year's Eve entertainment efforts.

The second track was intervention. The state operated the CRASH (Countermeasures Relating to Alcohol Safety on the Highways) Program for motorists convicted of driving while intoxicated. The department also supported a public inebriate program in which local police officers could have persons found drunk evaluated for treatment.

The third track was drug and alcohol abuse treatment. A network of outpatient clinics operated across the state, usually in conjunction with a community mental health facility. The clinics were staffed by trained alcohol and drug abuse counselors. In addition, there were three residential treatment facilities - Maple Leaf Farm in Underhill and Serenity House in Wallingford for adults, and Mountain View in Huntington for adolescents.

AIDS

The first AIDS cases in Vermont began to appear about 1983. The pace of the epidemic lagged behind the national trends by five to ten years, and the numbers were very small: one before 1983, none in that year, two in 1984 and 1985, eight in 1986. The number peaked at fifty-two in 1993 and dropped to twenty-nine in 1995. The numbers continued to fall in 1996.

In the early years, according to Deborah Kutzko, a nurse practitioner who has worked with AIDS patients for more than a decade, many people refused to believe that AIDS could be a problem in Vermont. It was seen as a "big city" disease, she said, and there was lots of denial. After the movie *Idol* Rock Hudson died of AIDS in 1985, there was a much greater willingness on the part of vulnerable people to be tested and to confront the issue.

The incidence of disease in Vermont was heavily concentrated in gay men and intravenous drug users; Health Department figures showed that more than 80 percent of people with AIDS fell into one of these categories. Just 6 percent of the cases were contracted by heterosexual people who had a partner at risk.²

The first grant funds came to Vermont in 1985, and the state Health Department set up a program to address the problem. It established seventeen testing stations around the state, located in local doctors' offices so as to avoid the small-town stigma that would attach to a freestanding AIDS office. A person

²Deborah Kutzko, interview by author, 20 June 1996.

³Vermont HIV Prevention Community Planning Group, *Comprehensive Plan for HIV Prevention in Vermont* (1994), 20, 21.

worried about AIDS could go to such an office, get his or her blood drawn, and receive a code number. Health Department AIDS counselors would then meet the person to give him or her the results of the test. They always delivered the news face to face, whether or not the results were positive. "You had to see the counselor personally," Kutzko said. "It was a wonderful teaching opportunity," she added, "and luckily there were few positives."

Meanwhile, the medical community and social organizations set up a comprehensive program to deal with the problem. One such organization was Vermont CARES (Committee for AIDS Resources, Education and Services), which set up branches in Chittenden, Washington, Addison, Rutland, Grand Isle, Lamoille, and Orleans counties. This nonprofit group included consultants, volunteers, and support groups who operated risk education programs. For example, the group regularly sent teams out to make presentations to small groups and high schools. The Health Department established an AIDS hot line, and Fletcher Allen Health Care and Dartmouth-Hitchcock Medical Center set up fully staffed AIDS clinics.

One of the most striking—and at the time controversial—public education efforts was the "Don't Forget Your Rubbers" project. Initiated in 1985 and designed by a public relations firm, this project included such elements as huge posters on city buses showing a young man holding an umbrella in the rain under the slogan "Don't Forget Your Rubbers." The Vermont exhortation to vulnerable populations to practice safe sex generated enormous interest and public comment. The campaign, which was the Vermont component of a federal program, came at a time when there was considerable political pressure nationally against such efforts. North Carolina Republican Senator Jesse Helms, for example, had sponsored federal legislation requiring that recipients of federal grants establish citizens committees to screen public education projects.

The citizens committee in Vermont, which included a Roman Catholic priest, approved the rubbers project as did state government officials at the time, including Governor Madeleine Kunin, Commissioner of Health Dr. Roberta Coffin, and Secretary of Human Services Gretchen Morse. They also insisted that a parallel abstinence campaign be carried out.

Until about 1990, according to Kutzko, most cases of AIDS were contracted out of state. After that, many were contracted locally. "I'm now seeing people twenty to thirty years old sharing needles on the streets of Burlington," Kutzko said. "It scares me. I don't want any more patients."

As of the mid-1990s, the disease did not seem quite so devastating. Medical practitioners could keep people alive for fifteen to twenty years. Most avoided hospital stays. "It's more like a chronic [as opposed to fatally acute] disease," Kutzko said.

Moreover, new drugs became available in the mid-1990s that promised to add years of life to AIDS sufferers. Nevertheless, problems persisted, mainly because of intravenous drug use and the reluctance of gay men to use safe sex

techniques. "You're asking for a complete shift in intimate behavior. That takes a generation and we're not there yet," Kutzko said.⁹

BREAST CANCER

Vermont women died from breast cancer much more frequently than residents of most other states. From 1960 to 1991, Vermont's breast cancer mortality rate consistently ranked in the highest quartile when compared to the rest of the United States.¹⁰ Beginning in the mid-1980s, Vermont public health officials targeted that problem.

In 1988 the Vermont Health Department established the Vermont Coalition on Cancer Prevention and Control, functioning as the umbrella for forty public, private, and voluntary organizations. The following year, the organization produced a plan to deal with cancer in the state. Breast cancer was one of its major concerns; another was cervical cancer. The plan established five areas for action—smoking cessation, diet, better screening, state-of-the-art treatment, and the reduction of environmental threats.

A central finding of surveys on breast cancer was that lack of awareness was the principal reason women had not obtained breast exams and mammograms.¹¹ Health officials had assumed that cost was the primary problem, but surveys showed that just 9 percent of respondents cited cost as the reason for not getting exams. By contrast, 30 percent of women who had not had a mammogram said they were not aware of the need for it.

The Health Department ran a public awareness campaign for two years, from 1991 to 1993. The campaign included media advertising, posters and brochures, news coverage, community meetings, letters to physicians, worksite presentations, and reduced-cost mammography programs. More than five hundred women attended the worksite presentations.

In 1992 the Vermont legislature passed a law requiring that medical insurance carriers in Vermont pay for mammograms for all women enrollees over fifty and for women under fifty if their physicians deemed it necessary.

MATERNAL AND CHILD HEALTH

A major concern of public health officials in the late 1980s was maternal and child health. Considerable attention had been paid nationally to the relatively high level of infant mortality in the United States compared to the rest of the developed world. There was also considerable pressure from advocates for children in Vermont to address the issue.

⁹Kutzko, interview.

¹⁰Vermont, Department of Health, *Healthy Vermonters 2000* (Montpelier, Vt.: Department of Health, 1992), 6.

¹¹Carney, interview.

The key index is infant mortality per one thousand live births; a second outcome indicator is low-birth-weight babies. Public health officials believe that a factor in these outcomes is the percentage of pregnant women who receive prenatal care in the first trimester.

In 1987 the Health Department, which up until then had focused on programs to help children in early childhood, shifted its efforts in the direction of helping pregnant women and infants. The program called for early identification and follow-up through home visits. Public health nurses from the twelve state offices fanned out across the state, seeking out pregnant women, especially teenagers, who were not getting prenatal care. In 1988 the Agency of Human Services set up a program to ensure that these efforts were well coordinated. And in 1989 the Department of Social Welfare increased the reimbursement to obstetricians caring for Medicaid patients and raised the eligibility level of pregnant women to 200 percent of the federal poverty level. This effort continued in 1989 when the Vermont General Assembly passed the Dr. Dynasaur Program, which was the outcome of the early health care reform effort.¹²

While it is not possible to determine a cause-and-effect relationship, the fact was that the statistics describing the health of Vermont mothers and infants improved significantly over the period of this effort. Infant mortality dropped from 9.1 per 1,000 live births to 6.6. The number of women who received late prenatal care or no prenatal care dropped from 4.0 percent of pregnant women to 3.4 percent. The percentage of women obtaining prenatal care in the first trimester increased from 79.1 to 81.4 percent. There was no statistically significant decline in the number of low-birth-weight babies. Nonetheless, the Vermont birth statistics were gratifying to state health officials. A report by a national children's health monitoring group showed that, based on a range of factors including prenatal care and low-birth-weight percentages, Vermont ranked fourth in the United States in children's health, trailing only New Hampshire, Maine, and North Dakota.¹³

THE TOOTH FAIRY PROGRAM

In 1973 the Vermont legislature, long considered one of the more conservative such bodies in the United States, undertook one of the earliest and most striking efforts to address directly the health of a state's population when it established a program to provide dental care to low- and middle-income residents.¹⁴ The program addressed one of the state's most pressing health problems: the catastrophic levels of tooth decay and other types of dental disease in the state, particularly in rural areas.

¹²Vermont, *Acts and Resolves Passed by the General Assembly of the State of Vermont* (spine title: *Laws of Vermont*) (Montpelier, VT: Secretary of State, 1812-), 1989, No. 94.

¹³Vermont Children's Forum, *The State of Our Children: Kids Count in Vermont, 1997 Data Book* (Montpelier, VT: Forum, 1997), 125.

¹⁴*Children's Comprehensive Dental Care Program*, 33 V.S.A. § 3301.

A report published in 1972 framed the problem: 40 percent of the state's schoolchildren had an urgent need for dental care. Fifty thousand Vermonters had no teeth at all, and another forty thousand had only half of their teeth; the total represented a fifth of the population. Half the children in the state had not seen a dentist by their fifteenth birthday. There were two million unfilled tooth cavities in the state.¹⁵

The author of the report was Jay Breines, a researcher for the Vermont Public Interest Research Group (VPIRG), an advocacy organization inspired by consumer activist Ralph Nader. Breines and the VPIRG director, Scott Skinner, drafted legislation for a \$3 million program to provide dental care to those with low incomes who did not qualify for Medicaid benefits. The bill was strongly supported by Dr. John Long, the director of the Dental Health Division of the state Health Department.

Representative Brian Burns, D-Burlington, sponsored the bill in the legislature and, despite intense conservative opposition, guided it to passage. The measure came to be called the "Tooth Fairy Bill," and Burns, the "Chief Tooth Fairy." Breines, Long, Skinner, and Burns were dubbed the "Four Musketeers."

The program produced by their joint effort had a major impact on the dental health of the population in Vermont over the two decades, following its implementation in 1974. The cost of the program had been trimmed from the original amount to about \$300,000, and the cost to the state never reached much beyond that, but the benefits were significant. The number of children in Vermont with untreated tooth decay dropped from 45.4 percent in 1972-73 to 11.9 percent in 1984-85.¹⁶ Moreover, the number of dentists working in the state rose markedly, from 180 in 1970 to 265 in 1975, and owing apparently to increased awareness about dental problems, the utilization of dental services by the Medicaid population increased significantly, as well.

Despite its early successes, the utilization rate of the program trended steadily down in the 1980s. One reason was that the legislature was reluctant to increase the eligibility levels to keep up with the rapidly rising income levels in the state. In 1976, for example, 63,000 schoolchildren in the state were income-eligible; by the 1980s, that number had dropped to 38,000. By 1989 enrollment was just over 5,000 students.

In 1992 the program was subsumed into the Dr. Dinosaur Program, which covered the same population for all their health care needs but without the requirement for a co-payment that had been a part of the Tooth Fairy Program.

By the mid-1990s, the Health Department's dental section (the previous Dental Health Division had been folded into the Division of Health Improvement by 1996) had adopted the posture of much of the remainder of the Health Department in that it was aiming its effort at education and prevention.

¹⁵Jay Breines, *Nothing to Smile About* (Montpelier: Vermont Public Interest Research Group, 1972), 1-5.

¹⁶Thomas Ivey, director of Dental Health Services, interview by author, 2 December 1996.

According to Dr. Thomas Ivey, the director of Dental Health Services, who assumed his post in 1992, the group was carrying out the following initiatives:

providing a fluoride rinse program for elementary schools in Vermont (the presence of fluoride in the water is a major factor in controlling dental disease; 154 schools in the state had a program in which pupils rinsed their mouths with a fluoride solution once a week; about eighteen thousand Vermont youngsters were getting the rinse in 1995, and the number was increasing gradually);
acting as a consultant for the Medicaid division by checking on claims for payment of dental services to recipients;
helping water systems in the state monitor and control the amount of fluoride in those systems.

As of 1997, according to Ivey, the department was planning to establish a program to address the problem of dental disease in babies, arising out of the practice of giving bedtime bottles. In 1995 some 500 babies in Vermont had dental disease because of this practice; of those, 280 had undergone treatment under general anesthesia in a hospital. The problem was costing Vermonters \$1 million per year, Ivey said.

The program planning included the establishment of a coalition of doctors, dentists, and other health care providers to urge mothers not to put their babies to bed with bottles. They had also produced a video to be shown to mothers, stressing that point.

According to Ivey, in 1996 there were still unmet dental needs in the state, but the situation was nothing like it had been in the early 1970s when Vermont state government first confronted the problem. "Compared to the past, there is vast improvement," Ivey said. "There is just half as much tooth decay in Vermont as there was in 1973."¹⁷

HEALTH SYSTEM REFORM

The history of health care system reform efforts in the late 1980s and 1990s needs to be considered in the light of its early history, for the wave that crested in 1994-95 began to gather more than fifty years earlier. World War II marked the watershed between the early and modern eras in American medicine.

The late nineteenth and early twentieth centuries were dominated by concerns we now think of as the domain of public health. The protection of public water supplies and mass inoculations drove back such scourges as typhoid fever and smallpox, and great improvements in nutrition and the environment generally helped to suppress tuberculosis. Once a disease had a foothold, however, it pretty much ran its course, despite the efforts of physicians. Simple wound infections, pneumonias, difficulties in childbirth—all could be, and often

¹⁷Ibid.

were fatal. The most important benefit, if one could call it that, of private-sector medicine was that it did not cost much.

Around World War II, and possibly because of it, the medical profession vastly increased its ability to intervene directly in the disease process. Major improvements came in the form of new drugs such as penicillin and in improved surgical techniques. As a direct consequence of the war, health care insurance was extended broadly to the American populace. With wages frozen, employers often resorted to company-financed insurance to attract and retain workers.

In the postwar period, the federal government began to increase its investment in medical infrastructure, pouring vast sums into medical research, hospital construction, medical college expansions, and the training of physicians. This process reached a culmination of sorts in the mid-1960s with the passage by Congress of Medicare and Medicaid. The combination of extensive coverage of employer-based health insurance and federal responsibility for the elderly and the poor made the enormously enhanced benefits of private-sector medicine available to most Americans. There were no significant constraints on cost: If you were covered, by private insurance or by Medicaid or Medicare, someone else paid your bills. As of the mid-1960s, the U.S. was spending 5 or 6 percent of its gross national product on health care; that number would rise sharply.

It is important to understand that this largesse flowed into a system that had only the most primitive sort of corporate organizational structure. American medicine was a cottage industry. Physicians, the key decision makers and definers of service, operated as individual entrepreneurs. Hospitals had corporate structures, but few hospitals were connected with one another, and for the most part, they had no corporate ties to the physicians who practiced within their walls.

The convergence of virtually unlimited purchasing power and ever increasing technological capability in the delivery system resulted in a decades-long upward cost spiral. Cost in the private-sector health care system routinely exceeded the underlying rate of inflation in the economy by two or three times, and the total resources far eclipsed levels paid out for public health functions. By the late 1980s, there was strenuous and growing resistance to further cost increases. In addition, the cost levels were threatening the availability of care as employers began to reduce the scope of coverage to reduce the pain of increasingly expensive premiums. And the number of completely uninsured working people—the working poor—became a serious public policy problem.

THE VERMONT EXPERIENCE

The first major effort by Vermont state government to influence the modern health care structure came in October 1973, when Governor Thomas Salmon appointed a nineteen-member commission to explore the need for regulatory authority over the health care delivery system in the state. The first chairman was Daniel J. O'Brien, a realtor; he served until June 1974, when he resigned and was

replaced by Robert V. Daniels, a Democratic state senator from Chittenden County. The group became known as the Daniels commission.

The group looked first at the regulatory tools available in state government and then at the structure of the system, including its facilities, human resources, and costs. The commission submitted its report to the governor on 6 January 1975.¹⁸ Its findings included the first public notice of a broad array of problems that continued to bedevil policy makers two decades later. These findings included the following:

There were too many specialists and not enough generalists in Vermont.

The structure of health insurance was enormously complex, administrative costs of the system were very high, and lots of money flowed out of the state in the form of insurance company profits.

Widespread variation existed in the utilization patterns of health care resources and costs.

Malpractice costs were rising and leading to defensive medicine.

There was a large and growing demand by the public for all sorts of health care resources, without regard to costs.

The health care system was fragile in rural areas.

The state lacked the necessary data to plan and monitor the system.

After two years of work, the commission issued a long list of recommendations, including suggestions to the Vermont congressional delegation, the private sector, and providers, especially hospitals. The most significant recommendations, however, comprised a three-pronged cost-containment and planning structure: (1) a health care cost commission to regulate hospital costs; (2) a health policy council to draft a state health plan for the state; and (3) a certificate of need panel, made up of members of the first two bodies, empowered to authorize any capital investment or new service costing more than \$150,000.

Just weeks after the submission of the Daniels commission's report, Congress enacted Public Law 93-641.¹⁹ This landmark legislation launched the country on a path toward planning and regulation that petered out only with the failure of the Bill and Hillary Clinton health care initiative of 1994.

In 1976 and 1977, the Vermont General Assembly put in place the health planning apparatus recommended by the Daniels commission. The first entity was the Health Policy Council. This did not meet federal regulations, so a revised body, the Health Policy Corporation, with essentially the same functions, was established in 1977. The body had twenty-two members, including legislators, insurers, providers, and representatives of consumers.

In 1979 the General Assembly put in place the first piece of significant health care regulation: the Certificate of Need law,²⁰ which gave the state the

¹⁸Vermont, Governor's Commission on Medical Care, report, Montpelier, 23 December 1974.

¹⁹*National Health Planning and Resources Development Act of 1974*, Pub. L. 93-641, 93d Cong., 2d sess., 4 January 1975.

²⁰*Health Facility Planning*, 18 V.S.A. ch. 55 (1979).

authority to approve or disapprove expenditures in excess of \$150,000 for any hospital expansion project or new health care service. This statute made the Health Policy Corporation the arena for many battles over health care costs, including hospital expansion projects in Burlington, Rutland, and Springfield in the 1980s. The largest such project was the \$80 million expansion project at the Medical Center Hospital of Vermont, which was approved by the Health Policy Corporation in 1981—by just one vote.

The actual operating costs of hospitals remained outside regulation, however, and that became a major issue in the early 1980s. In 1982 Governor Richard Snelling appointed a cost-containment commission, chaired by Douglas Kitchell, a prominent businessman. That group recommended that the state adopt cost controls along the lines of those in Rhode Island. The device to regulate hospital budgets, known as MAXICAP, touched off one of the epic political battles of the modern era.

Governor Snelling, a moderate-to-conservative Republican, wanted strict cost controls. Stephan Morse, the Republican Speaker of the House of Representatives, wanted action also, but he was not sure he wanted it dictated by the governor. At the outset of the 1983 legislative session, Morse had appointed a young Republican representative from Shelburne, Gretchen Morse (no relation), to the chairmanship of the House Health and Welfare Committee. Gretchen Morse had moved quickly to the forefront in the previous session through her leadership on education financing.

Gretchen Morse pushed the MAXICAP bill through the House, with bipartisan support. No one opposed the information and data gathering elements of the bill, but significant controversy arose over the actual spending regulation. The Vermont Hospital Association strongly opposed that aspect of the bill.

"We didn't think public education was enough," Gretchen Morse said later. "We wanted a global budget. We wanted to say—this is how much money is in the picture for health care, and with the various players around the table, we could negotiate budgets for all the hospitals under that amount."²²

Supporters of the bill believed that Blue Cross and Blue Shield, by virtue of its dominant position as the state's largest insurer, could help enforce the spending limitations. Governor Snelling also believed that the Department of Banking and Insurance could help through its control of insurance premium rates.

The bill passed the House on a close vote, but the Hospital Association carried the battle into the Senate, which passed a watered-down version—without MAXICAP. The conference committee to reconcile the two bills was nightmarish, according to Gretchen Morse. Governor Snelling strongly urged her to insist on the cap, but there simply were not enough votes for it. Eventually the conference dropped the cap and set up in its place the Vermont Hospital Data Council. That body would have five members: two representing consumers, the

²²Gretchen Morse, interview by author, 17 January 1996.

secretary of the Agency of Human Services, and representatives of Blue Cross and Blue Shield and the Vermont Hospital Association.²²

The Data Council's task was to put hospital budgeting on a common basis, assemble data about those budgets, and make recommendations to hospitals about how the budgets might be changed. But the council could not compel those changes. Governor Snelling appointed Duncan Brown, a South Burlington businessman, to head the organization. The council functioned under its initial guidelines for twelve years until it got the power in the mid-1990s to cap hospital revenues.²³

VERMONT HEALTH INSURANCE PLAN

By the late 1980s, two decades of medical inflation that exceeded the annual increases in the consumer price index by two or three times had generated a new, extremely knotty policy problem: many people could no longer afford health insurance. Health care insurance premiums rose and rose again. More and more people who purchased health insurance privately were finding they no longer could afford to do so. Employers who paid for insurance for their employees began trying to shed part of the burden, reducing coverage levels and requiring workers to pay more of the health care costs through such devices as premium sharing, co-payments, and deductibles. Moreover, Congress began simply refusing to pay the full cost of health care for Medicare and Medicaid patients, thereby generating a cost shift that exacerbated the load on the private payers.

In the face of this trend, the Vermont General Assembly in its 1988 session established the Vermont Health Insurance Plan (VHIP), with the goal of ensuring that all Vermonters had health insurance coverage.²⁴ The program was to be designed by a board made up of all the health care interests in the state. The law went into effect in July. In August Governor Madeleine Kunin endorsed the underlying concept, pledging in her reelection announcement speech to ensure that all Vermonters had health care insurance.²⁵

The financial situation in Vermont, however, was deteriorating rapidly. Throughout most of the 1980s, Vermont state government enjoyed revenue surpluses from tax receipts, and each legislative session was rife with debate over how to spend them. Kunin was reelected in November 1988, but as her department heads began to bring in their spending requests and her financial chiefs began to shape the budget that would take effect the following July, they realized that the surpluses were rapidly dwindling.

None of these considerations troubled the deliberations of the VHIP board, however. The board had carried out a detailed survey of the number of

²²*Hospital Data Council*, 18 V.S.A. ch. 44 (1983) (amends 18 V.S.A. § 1906).

²³*Health Care Authority*, 18 V.S.A. pt. 9, ch. 225 (1992).

²⁴*Vermont Health Insurance Plan*, 18 V.S.A. ch. 110 (1988).

²⁵Governor Madeleine M. Kunin, reelection campaign speech, Burlington, Vt., August 1988.

uninsured. That study turned up some surprising data. For example, the number of uninsured was much smaller than estimated. Based on national trends, the board expected to find 60,000 people uninsured. The actual number turned out to be just over 31,000. Moreover, the survey found that this group of people was actually getting as much health care, measured by visits to a physician and days in the hospital, as the insured population. The medical community was delivering care without insurance.

A strong consensus held, nonetheless, that the state needed to guarantee coverage, and the board drafted a program to do that. It had several elements, but the cost was significant—\$94 million a year at full operation, which was scheduled for 1994. The governor balked at that figure and reversed course. She would not support the program, and she would not build it into the budget she would submit to the General Assembly in January 1989. She would consider something less.

The problem was not just the absolute cost. Kunin's health care advisors told her that the way the program was drawn there was nothing to prevent employers from dropping health insurance for their employees on the assumption they could enter the state program. Such an eventuality could cause state costs to explode well beyond the projected number. The program designers tried to solve this by building in a six-month delay in the granting of benefits if an applicant left an insurance program, but that did not eliminate the concern.

The governor was not the only one who was skeptical. Key legislators were also. For example, Representative Oreste Valsangiacomo, D-Barre, the influential chair of the House Ways and Means Committee, the body that would have to approve the financing package for the plan, absolutely refused to consider it. He suggested to the governor's staff that they bring in something smaller, a lot smaller, perhaps costing only a million or two.

The governor's staff thereupon picked two elements out of the VHIP board's plan and developed them into an administration proposal. The proposal called for guaranteeing that every pregnant woman in Vermont would be covered for her pregnancy and that young children would be covered also. The vehicle was the Medicaid Program. Pregnant women with incomes up to 200 percent of the federal poverty level would be covered; children to age seven in families with incomes to 225 percent of the poverty level would be covered. The program went into effect in mid-1989; it was called Dr. Dynasaur.

GOVERNOR'S BLUE RIBBON COMMISSION

The Dr. Dynasaur Program did little, however, to reduce the political pressures for structural reform of the health care system. Costs continued to rise: Hospital budgets increased by nearly 12 percent a year between 1987 and 1991, and charges increased nearly 20 percent, owing to the cost shift. The 31,000 uninsured in 1988 had risen to 45,000. The access and cost problems, in short, were growing apace. In the 1991 legislative session, the House passed a bill authorizing the Hospital Data Council to set budgets for hospitals—the original

core of the 1983 MAXICAP bill. The Senate modified the bill significantly, however, and the two chambers never came to agreement.

In light of these continuing pressures, Governor Richard Snelling, who had been returned to office in 1990, established a Blue Ribbon Commission on Health Care in the spring of 1991. The commission completed its work in the fall of 1991 and submitted it to newly installed Governor Howard Dean, a medical doctor, who took office after Snelling died unexpectedly. The Dean administration submitted a bill based on the commission's recommendations, and the 1992 session of the legislature took it up. The process was extremely intense and culminated in the passage of Act 160.²⁶

The essence of the administration's bill was the establishment of a health care authority, a semi-independent body whose job would be to design a full-blown health care-delivery system in Vermont that would guarantee health care coverage to everyone, ensure high quality, and rigorously contain costs. There was considerable debate over how long the design might take, but it soon became clear that, if the bill were to take effect 1 July 1992, the job could not be done by the beginning of the 1993 session, and that waiting until the 1995 session would be too long. The obvious target was the late fall of 1993, with submission to the legislative session opening in January 1994.

The Dean bill came into the House and was taken up by two committees, House Health and Welfare, chaired by Margaret Martin, D-Middlebury, and the House Commerce Committee, chaired by Paul Harrington, R-Middlesex. (The author was a member of House Health and Welfare.) Over a period of six weeks, the two committees extensively rewrote the bill. The issue was intense in the House mainly because the committee members were grappling for the first time with the enormous complexity of the modern health care system. There were major debates about the structure of the health care authority and about how to bring the existing regulatory apparatus under its control. The lack of good data about the system was a major concern. A key decision was to give the authority power as of 1995 to control hospital budgets, an issue first raised in the 1975 Daniels report and turned aside in the MAXICAP debate of 1983. A vigorous debate took place over whether to establish an administrative resolution structure for malpractice cases, and contentious discussions ensued about the benefit package that should be available to everyone.

The Senate, meanwhile, was on a completely different track. In the previous session, Cheryl Rivers, a former advocate for low-income Vermonters and then a Democratic senator from Windsor County, had sponsored a bill establishing a Canadian-style single-payer system. She had enlisted the support of several liberal groups, including the teachers' union in the state as well as the state's radical congressman, Bernie Sanders. Her most important supporter, however, was Senator Sally Conrad, D-Chittenden, the chair of the Health and Welfare Committee. Conrad committed her committee to the single-payer concept, and that body spent two years working on the measure.

²⁶Health Care Authority (1992).

By the late winter of 1992, however, it was becoming clear that, while the single-payer idea was generating much attention in the press and in policy discussions, it had no chance of actually passing. In fact, Conrad and Rivers could not get the bill out of their own committee; the other three members of Health and Welfare, two Republicans and one Democrat, would not vote for it.

So Conrad and Rivers approached Speaker Ralph Wright and suggested a deal. They would not oppose the House bill when it got to the Senate if Wright would see that the new authority designed not only a multiple-payer system but a single-payer system, as well. Wright agreed on the spot. The bill went forward in essentially that form.

In July 1992, Governor Dean appointed the three members of the new Vermont Health Care Authority—chair Richard Brandenburg, dean of the University of Vermont School of Business Administration, and members Paul Harrington, the chair of House Commerce, who resigned his House seat, and Veronica Celani, welfare commissioner in the Agency of Human Services, who resigned her post. The staff was cobbled together from the staffs of the Health Department, the Agency of Human Services, the Data Council, and the Health Policy Council. The new authority had less than eighteen months to design the two reform structures. In addition, the members had to operate the Certificate of Need process for capital investments and the hospital budget procedures of the Data Council, with the understanding that the latter would likely change significantly with the new power to control hospital budgets as of 1995. They also had to begin trying to solve the problem of a lack of data about the system.

The authority set to work. It received a Robert Wood Johnson Foundation grant to hire several consultants to help with the work and set up a working group of more than twenty people from all the health care interests in the state to advise in the process.

The assumption in all of this was that the state would play a very large role in the operation of the delivery system. There was considerable disagreement about details, but the assumption of a powerful state role was pervasive not only in Vermont but also in other states moving toward reform—and not only in states but also nationally. Much of the theory driving this policy consensus was coming out of the Jackson Hole Group, an ad hoc collection of university-based scholars and national business leaders who gathered at a private home in the Wyoming resort to talk about health care problems.

The authority made its deadline, delivering the two proposed plans on the afternoon of 1 November. This material went to the legislature in the opening days of the 1994 session. Two decades of health care reform pressures would come to culmination in an eight-week period, the do-or-die window in Vermont's legislative process. A major factor was the accident of timing by which action had to begin in the second year of the biennium. Major bills starting in the first year of the biennium often have a better chance of passage since they have a full, two-year run. Unless passed quickly, the health care reform bill would die with the adjournment of the 1994 session; a new legislature would be elected in the fall of that year.

When the legislature took up the issue, opinion was virtually unanimous that some kind of major reform measure would pass. At the outset, the author took an informal survey of the most knowledgeable and cynical veterans of the State House, and without exception, they judged that something major would pass; a second consensus was that it would not be a single-payer system.

By this time, Speaker Wright had become a strong supporter of the bill. That was something of a departure for him. He was a liberal, but his focus had always been the processes of the House, not the outcome of specific bills. Wright had become a believer, however. In order to drive the bill forward, he returned to a structure that he had used in the passage of key environmental legislation during the Kunin years—the establishment of a joint House committee to consider the bill. The chair of this group was Sean Campbell, D-Saxtons River, a member of the Democratic House leadership in previous sessions. The other members were chosen to represent all the interested committees—Health and Welfare, Commerce, Judiciary, Ways and Means, Government Operations, Appropriations. Getting a huge bill through those committees in serial fashion would have been impossible in a single session. The other form of balance was partisan—key Republicans were members also. These included Richard Westman of Cambridge, the minority leader; Barbara Wood of Bethel; and Thomas Little of Shelburne.

The special committee actually began deliberations in the fall of 1993, before the 1994 session formally convened, in order to begin educating its members about health care. Most members did not know the arcane language of the field, to say nothing of the myriad twists and turns of the policy issue. The bill itself was a monster, replete with new structures and processes. There would be "integrated systems of care," incorporating big blocks of patients and organized groups of doctors and hospitals; there would be new rules for insurance companies and community forms of governance. Patients would have to go to primary care physicians first, and their access to specialists would be limited. Providers would negotiate with alliances, some public and some private. There would be new cost controls, state subsidies for the uninsured, and new taxes.

The issues were dense to the point of impenetrability. They defeated the press, which was never able to follow the complexities of the debate, which meant that neither could nonexpert and noninvolved legislators (the great majority). Even professional policy analysts had trouble keeping everything straight.

There were also failures of technical analysis. There was continual uncertainty about the benefit package and about how the state subsidy pool would function. Most important, it was never fully clear what the program would cost. The governor said at the outset that his plan had a price tag of \$37 million, but this figure did not hold up long. If you subsidize the young working family, how about the elderly who pay a sizeable portion of their own health care bills? Subsidizing the elderly would have driven the program cost over \$100 million, far outside the feasibility zone.

Moreover, there were doubts that the central beneficiary, the young working family, could afford the program. Even with an employer picking up half the cost and the state providing a subsidy, it appeared that the out-of-pocket cost might be a thousand dollars. Speaker Wright and others thought that was too high. In any event, support for the program steadily drained away.

By mid-March, Governor Dean began to cut loose the entire structure of the authority. He installed a temporary chair, Cornelius Hogan, the secretary of the Agency of Human Services and the most capable and respected member of his cabinet. Brandenburg returned to the University of Vermont; Harrington and Celani moved to other assignments in state government. A bill with a few face-saving elements was ultimately passed, but it was clear that major health care reform based on state government was dead. A wave that had been building for twenty years had crested well short of its goal and was rapidly ebbing. The same was true in Washington, D.C., and in the states that had been in the vanguard of reform—Minnesota, Oregon, Florida, and Washington. The authority remained in place, however, under the direction of Theresa Alberghini, a former member of the staff of U.S. Senator Patrick Leahy.

A SMALL FIX

In the 1995 session, Governor Dean came back with a bill to provide some insurance coverage for fifteen thousand people, funded primarily by an increase in the tobacco tax. That bill passed; the tobacco tax was increased from twenty to forty-four cents per pack, but the program got off to a rocky start. The insurance carrier selected in the first round of bidding could not get a state license. And a joint venture between Community Health Plan and Blue Cross and Blue Shield of Vermont came up with too high a bid to interest state officials.

Nonetheless, the state began offering a fee-for-service outpatient benefit in January 1996. CIIP began to enroll patients from the target population in October 1996, and Blue Cross did the same in January 1997. Hospital benefits were scheduled to become available as the recipients moved into managed care systems.

However, legislative disenchantment with the whole process had made Governor Dean fear for the future of the authority itself. So in the 1996 session, he advanced legislation to merge the authority functions with the Department of Banking, Insurance and Securities. The authority apparatus became the Division of Health Care Administration, headed by Alberghini with the title of deputy commissioner. The bill passed; the new governmental entity became the Department of Banking, Insurance, Securities and Health Care Administration. In addition to the merger and installation of the regulatory functions in a more traditional regulatory framework, the measure eliminated the Health Policy Council and the Hospital Data Council and replaced them with a single, nine-member Public Oversight Commission (POC) empowered to make recommendations on both Certificate of Need capital investment decisions and hospital budgets. The authority to rule on those recommendations was vested in

the commissioner of Banking, Insurance, Securities and Health Care Administration, although it was clear that in practice this authority would be delegated to the deputy commissioner running the Division of Health Care Administration. The bill also established a technical panel, composed of individuals with legal, economic, and health industry expertise; the technical panel was to provide advice to the POC and to the division staff.

INSURANCE REFORM

In the 1991 session of the General Assembly, Blue Cross and Blue Shield of Vermont brought forward a major proposal to change the small-group insurance market. The measure proposed to enforce community rating on the small-group market (employers with from one to forty-nine employees) as a way to prevent other insurers from "cherry picking" the state, that is, finding employer groups with the healthiest workers, insuring them at low rates, and refusing to cover firms with high-risk workers who would then be forced to get their insurance from Blue Cross at high rates. This stratagem set up a vicious spiral whereby Blue Cross's rates kept going higher and higher because its enrollees were sicker than the community at large. Forcing insurers to base their rates on their "community" of policyholders would limit cherry picking as an insurer's base of customers grew.

Blue Cross conducted an elaborate campaign. The company hired not just one lobbyist but all the most influential of those available and prosecuted an extensive campaign in the fall of 1990, holding breakfast meetings in different parts of the state to which it invited hundreds of business people, legislators, members of the press, and other interested parties. The theme was that, without relief, Blue Cross would not survive.

Owing to this effort, the bill had enormous momentum by the time it was introduced. Moreover, it had a strong sponsor, Paul Harrington, the Republican chair of the House Commerce Committee. The House in that session was controlled by Democrats, but Harrington was well respected by Democrats, particularly on business issues, and he was close to the powerful Democratic Speaker, Ralph Wright. House Democrats, meanwhile, were strongly inclined to support anything that discomfited insurance companies. The House, therefore, easily deflected the pressure coming from waves of lobbyists sent in by national insurance companies such as Aetna, and the bill passed.²⁷

The process of getting the community rating bill through the legislature was accompanied by some striking political theater. The company considered the most egregious of the cherry pickers was the Golden Rule Insurance Company, which sold very low-cost policies to young, healthy people. When the bill passed, a company spokesperson held a press conference on the front steps of the State House, denouncing the decision. He was flanked by two boxes, each one

²⁷ *Small Group Health Insurance*, 8 V.S.A. § 4089 (1991).

containing a live ferret (since he could not locate weasels). The first box was labeled "Governor"; the second, "Legislature."

THE VERMONT PROGRAM FOR QUALITY IN HEALTH CARE

In 1973 John Wennberg, M.D., and Alan Gittelsohn published an article in *Science* magazine, detailing wide variations in utilization rates of the medical services delivered in Vermont hospitals.²⁸ Wennberg, a physician and epidemiologist based at the University of Vermont, carried out his initial studies under the auspices of the federal regional medical program, one of an array of federal efforts to put a health planning and assessment apparatus in place to accompany its huge investment in medical care. Wennberg found that overall use rates in terms of inpatient days per thousand people in the population differed by as much as four times or more. Residents of Rutland County, for example, used the hospital at twice the rate of residents of Addison County. The authors found the same patterns in a dozen common surgical procedures, as well as dozens of medical procedures—hospitalizations for pediatric pneumonia, gastroenteritis, and the like. Children in the Morrisville area received tonsillectomies at thirteen times the state average.

Wennberg attributed these differences to variations in practice patterns among physicians in local medical communities. Doctors in the Middlebury area practiced differently from doctors in Rutland or Morrisville. He called his method of analyzing data "small area variation," and its application, beginning in Vermont and then spreading across the United States, gave rise to a new issue in the health policy arena—the quality of care. Policy makers inferred from the Wennberg data that high levels of hospitalization represented inappropriate care that drove costs up unnecessarily. The Wennberg data were gathered over several years by the Cooperative Health Information Center of Vermont (CHICV) and subsequently became the state database on hospital care, managed by the Vermont Hospital Association and the state Health Department. From the mid-1980s through the 1990s, the small area variation data formed the principal basis for cost-containment efforts and quality control in Vermont.

The question, of course, was how to remove inappropriate care from the system in order to improve the quality of care and reduce overall costs. The author of this chapter carried out a study in 1983, showing that reducing the levels of usage in the sixteen hospitals in the state to the state average rate would reduce statewide hospital costs by 30 percent.²⁹

Wennberg had argued that simply informing the physicians of the variations would lead to significant changes in practice patterns, and he found incidents of that in several locations in the United States and Canada. One of the most

²⁸John Wennberg, M.D., and Alan Gittelsohn, "Small Area Variations in Health Care Delivery," *Science*, 14 December 1973, 1102-8.

²⁹*The Patterns of Practice*, a twenty-five-part documentary broadcast on WCAX-TV, Burlington, Vt., 1984.

striking examples was the utilization of tonsillectomy in Morrisville. When informed that their rate was inordinately high, the physicians in Morrisville attacked the problem vigorously, setting up groups and procedures to test the appropriateness of care. The original Wennberg data showed that 64 percent of youngsters in the Morrisville area had had their tonsils removed. When the physicians' monitoring program went into effect, that dropped to 2 percent.

In 1987 Governor Madeleine Kunin appointed the author chair of the Vermont Hospital Data Council. The council then embarked on an effort to use the Wennberg variations as a cost-containment and quality-improvement tool. A review of hospitalization for low back pain, for example, showed that 33 percent of this care was medically warranted in the legal sense but "questioned." The name for this category was negotiated between the reviewing agencies and the hospitals and was interpreted by the council to mean a practice pattern that could be safely changed, at least in purely medical terms. The same questionable category for cesarean-section births was 22 percent; the C-section study distinguished between "strongly indicated" and "moderately indicated." These data comported with the findings in manufacturing industries that poor quality care added from 30 to 50 percent to the overall costs of medical care.

In the late 1980s, hospital utilization dropped significantly both in Vermont and nationally, but costs did not. The council, therefore, concluded that small area variation analysis by itself could not solve the cost problem. These data could delineate radically different use rates, but they could not define the "right" rate, and their mere publication could not drive changes in practice patterns widely enough to contain costs. The council felt that it was necessary to develop a tool that could ascertain inappropriate or wasted care on a case-by-case basis and, significantly beyond that, the state needed a system that would identify and shift these inefficient practice patterns.

In 1988 the author and others, including Dr. Mildred Reardon, the president of the Vermont State Medical Society, and Dr. Henry Tufo, a University of Vermont physician who had introduced the principles of Continuous Quality Improvement (CQI) techniques into his practice group, established a working group to pursue this goal. The group included every health care interest in the state—the Vermont State Medical Society, state government (the Data Council), the business community, the Vermont Professional Services Review Organization, Blue Cross and Blue Shield of Vermont, representatives of the public, and several key individuals, mostly physicians and hospital administrators. Important principles, in addition to inclusivity, were that the program would be cooperative, not mandatory and punitive; that it would stand alone and not be an arm of state government; and that it would utilize the CQI techniques developed in industry.

Both the administrative structure and the methodologies were major departures. Most quality initiatives in health care had been carried out by outside organizations which were seen as hostile and threatening by practitioners. In the Vermont case, all the players were linked in a single structure; all agreed that real quality improvements had to come from within an organization. Moreover, the CQI techniques, while widespread in manufacturing, particularly the auto

industry, had been used in health care mainly for service-related improvements—the turnaround time for operating suites, for example. The Vermont group proposed to use them to improve clinical quality.

In the fall of 1989, the group incorporated as the Vermont Program for Quality in Health Care, Inc. (VPQHC). It established study groups in the areas of oncology, cardiac care, pulmonary medicine, orthopedics, obstetrics and gynecology, and mental health. These groups prepared practice guidelines for a number of specific conditions that appeared to be common, variable, and expensive. These included colorectal cancer, congestive heart failure, low back pain, C-section for failure to progress, vaginal birth after C-section (VBAC), and others. Reductions in deviations from these guidelines and continuous modification of the guidelines themselves were the raw material of the CQI process.

These efforts generated significant shifts in medical practice patterns. A major effort aimed at reducing the incidence of cesarean sections, mainly by increasing the rate at which women who had had one child by C-section had a subsequent birth normally. For many years, physicians assumed that, if a woman had one birth by C-section, all subsequent births should be by that method. The American College of Obstetricians and Gynecologists changed that standard several years ago.

At least partially owing to this project, the C-section rate dropped steadily in Vermont, from 19.7 percent in 1991 to 17.7 in 1994 to 16.7 in the first three quarters of 1996, this trend was closing rapidly on the federally established goal of 15 percent. The VBAC rate, meanwhile, increased rapidly. In 1990 the rate was 29 percent. By 1996 it was 47.2, twice the national average and well above the federal target of 35 percent.

A second major effort was carried out in the area of control of infection resulting from surgery. The project focused on the percentage of patients who received antibiotics prior to surgery, as recommended by the American College of Surgeons. In 1992, 20 percent of patients did not get preoperative antibiotics; by 1995, after extensive efforts by the project team, the rate had been cut to 13 percent.

A major problem for VPQHC was developing a permanent financing structure. The annual operating budget had risen to about \$500,000 by 1995. Up to that point, financing had come mainly from contributions by hospitals and by a large, three-year grant from the Robert Wood Johnson Foundation. In early 1996, however, with the Robert Wood Johnson grant running out, the board of trustees decided to force the funding issue. In the waning hours of the 1996 session, the Vermont General Assembly assured the funding of the group by establishing a state mandate for the health care providers and insurers in the state to support the group in the amount of \$375,000 per year.³⁰ That action appeared to establish VPQHC as a permanent part of the health care delivery system.

The effective mission of the group, however, had shifted by that point. On the one hand, the increasing integration of health care providers, along with the

³⁰18 V.S.A. § 9416 (1996).

shift in reimbursement to capitation, meant that providers would be driven to develop effective quality tools on their own as a means of bringing their costs down while assuring their patients of high quality care. On the other hand, state government was generating increasing pressure for VPQHC to fill the role of guarantor of the quality of the health care system. All of the reform legislation of the late 1980s and early 1990s had contained language about such a function, but the issue became more pressing as managed care increasingly penetrated the state. Patients, policy makers, and legislators were clearly concerned, along with the public, that the advent of managed care would lead to a decrease in the amount and quality of care for individual patients as a way of preserving profits for insurance companies and health maintenance organizations (HMOs).

The legislature gave the Division of Health Care Administration the responsibility of dealing with this issue,⁴¹ but it also indicated that the division should take advantage of VPQHC's expertise and experience in this arena. In response, the division contracted with VPQHC to select a list of quality indicators, to publish semiannual reports on those indicators, and to carry out follow-up improvement projects where warranted. At the same time, there were indications that the ultimate shape of the regulatory approach to quality would flow out of a collaborative effort between the division, VPQHC, Fletcher Allen Health Care, and Dartmouth-Hitchcock Medical Center. The two medical centers did not receive explicit mandates from the legislature, but both were devoting considerable resources to the quality of care, and it was clear that both the division and VPQHC would need to take advantage of that.

APPROACHING THE MILLENNIUM

As Vermont approaches the year 2000, its health care system faces changes that are as potentially far-reaching as those it experienced at midcentury. While there were some successes during the reform years of the early 1990s, very little of the structural engineering carried out at that time has moved beyond the blueprint stage. No structural guarantee of insurance coverage has been established for those workers whose employers do not provide it (although the Dean administration continues to hope to chip away at the problem with the tobacco tax), nor have any of the big, complex, government-managed, integrated systems envisioned by the health planners been set in place. The failures in Vermont paralleled the collapse of the Clinton health plan in 1994. The outcome of these struggles was a decision, no less critical for being implicit, that the remaking of the health care delivery system would be undertaken in the private sector.

The key elements in this process were already in place in 1995: the shift to capitated reimbursement and the restructuring of the delivery system to make it possible to operate within that new framework. In most of the country, the new structures are large agglomerations of providers, both doctors and hospitals, within health maintenance organization corporate structures. And within

⁴¹18 V.S.A. § 9414 (1996).

HMOs—groups of providers allied with insurers—it is the insurance partner that is dominant.

The picture in Vermont is somewhat different. In early 1996, Kaiser Permanente, a large, West-Coast-based HMO, took over Community Health Plan, the largest HMO in Vermont with about ninety thousand enrollees. Otherwise, however, the in-state providers in Vermont play a stronger role. Both Dartmouth-Hitchcock Medical Center, located in Lebanon, New Hampshire, and Fletcher Allen Health Care in Burlington, have positioned themselves as the centers of two large systems—one covering western New Hampshire and eastern Vermont and the other, western Vermont and northeastern New York State. In both cases, providers dominate the insurers in the mix; moreover, within each of those centers, the dominant role is shifting to physicians and away from hospital administrators.

The most complete integration is in Burlington, where in 1995 the faculty physicians of the University of Vermont's College of Medicine, the Medical Center of Vermont, and Fanny Allen Hospital merged into a single operating company—Fletcher Allen Health Care. The new company has very close contractual ties to the UVM College of Medicine. By 1996 Fletcher Allen was moving to design its systems to offer a capitate rate for blocks of patients in its region. Moreover, Fletcher Allen joined with Blue Cross and Blue Shield of Vermont and Rutland Regional Medical Center to form an HMO, the Vermont Health Plan, which entered the market late in 1996.

Dartmouth-Hitchcock, meanwhile, formed a link between its physicians, the Hitchcock Clinic, and the Leahy Clinic, based in Burlington, Massachusetts. And Mary Hitchcock Hospital, allied but still apart from the clinic, was building a hospital alliance on both sides of the Connecticut River and extending into western Massachusetts. The westernmost outpost of the alliance is the Central Vermont Medical Center in Berlin, Vermont. This geographic configuration has set up an intensely competitive atmosphere between Dartmouth-Hitchcock and Fletcher Allen. Neither company, however, is in thrall to the insurers in its market.

Although a strong consensus has evolved about what health care might look like in 2000, little actual progress toward that vision, beyond the basic corporate structures, had been made as of 1996. Managed care was assumed to be the paradigm of the future, but much of the medical world still runs on discounted fee-for-service. Everyone understands that costs will have to come down by a third or more and that the delivery systems will have to be completely rebuilt in order to accomplish such reductions, but the actual rebuilding has scarcely begun. Everyone understands or at least believes that hospitals will continue to fade in importance and that physicians and ambulatory clinics will be the center of the system in the future, but at mid-decade, hospitals are still the largest single consumers of the health care dollar. (About 38 percent of the health expenditures went to hospitals; the next biggest share was physicians at about 19 percent.) The patients, meanwhile, worry because they have no idea what managed care will be like and whether it will serve their needs.