

Chronic Disease in the Twentieth Century

A HISTORY

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Introduction

This work has its origins in confusion. In December 2005 I had the good fortune to be invited to a workshop in London devoted to “chronic disease,” a term I thought I understood. I left the meeting without the faintest idea what it meant (my own paper was on premenstrual syndrome [PMS], which gives some idea of just how confused I was) and with a simple but nagging question. What holds together a concept that includes a cancer that may kill you within months, diabetes that requires lifelong management, and senility in old age (not to mention PMS, which the meeting organizers at least accepted more or less as a chronic disease)? After an initial period of research I found, somewhat to my surprise, that while a large literature builds on the premise that chronic disease is hugely significant, no one had examined the historical development of the concept in the twentieth century, with the exception of several articles and one policy-oriented book by the historian and former president of the Milbank Trust Daniel Fox.¹

While several related but distinct categories like incurability, handicap, and disability have been analyzed as evolving constructs,² chronic disease has been dealt with as a more or less natural category originating in “epidemiologic transition” and whose existence thus requires little explanation. The sociologist David Armstrong, it is true, has questioned the “natural” status of the concept and has called for a “genealogy” of chronic disease, presumably along Foucaultian lines. But the overwhelming consensus seems to be that contemporary concern with chronic disease is simply the logical consequence of changing disease patterns, notably the apparent conquest of infectious disease that has led to new causes of morbidity and death. Even if this explanation seems plausible from the perspective of the early twenty-first century, I do not believe that it is sufficient. Far too much remains unexplained, as I try to demonstrate throughout this book. Rather

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than “genealogy” that starts from the present and looks backward, I conceive of this work as “natural history” that starts from the past and works its way forward, which is in fact how I researched and wrote this book.

Because I have been asked so many times what diseases I am examining, I must emphasize that this is a book not about specific diseases, but about a meta-concept that has been exceptionally elastic and fluid. The term *chronic disease* has covered different diseases and conditions depending on the time, place, and goals of those utilizing it. The emotional valence surrounding it and the uses to which it has been put are equally varied. Individual diseases are discussed in this book only to the extent that they intersected with and helped shape the meta-concept or competed with it for funds and public attention. Thus, cancer and diseases of older persons are more prominent herein than is mental illness, which followed an independent trajectory that intersected only sporadically with that of “chronic disease.” But just as we have learned to understand many disease concepts to be constructed from a mixture of elements—symptom patterns, biological theories, scientific artifacts like statistical correlations or histological slides, and, occasionally, entrepreneurial ambitions and sociocultural assumptions—“chronic disease” must also be treated as a complex conceptual construction that allowed the world to be organized in particular ways and that was mobilized in varied ways depending on time and place. In other words, the concept has done diverse kinds of work for those using it. The aim of this book is to understand its use or nonuse in different times and places.

Chronic disease is not a new notion. It has been a significant category for understanding illness since the Greeks and Romans. To fully appreciate how its meaning and connotations changed in the twentieth century, we must first understand what it meant and how it was used in earlier periods.

Chronic Disease before the Twentieth Century

Chronic disease has traditionally been understood in contrast to acute disease. Beginning in the Greco-Roman period, it was common for comprehensive medical treatises to divide diseases into categories of acute and chronic. While the former run their course quickly, either killing you or going away (either naturally or due to the physician’s intervention), chronic diseases linger. They, too, have a course to run, but one that is much slowed down. If lengthy temporality was the main definer of chronic disease, there was little consensus about what length of time constituted chronicity. Was it forty days or more, an indeterminate lengthy period, or the fact that, over time, a condition never improved or wors-

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ened? For some authors of medical works, chronic diseases were more intense and painful ~~were~~ than short, acute illnesses. Aretaeus the Cappadocian (second century AD), for instance, began his discussion of chronic disease as follows:

Of chronic diseases the pain is great, the period of wasting long, and the recovery uncertain; for they are not dispelled at all, or the diseases relapse upon any slight error; for neither have the patients resolution to persevere to the end; or, if they do persevere, they commit blunders in a prolonged regimen. And if there also be the suffering from a painful system of cure, —of thirst, of hunger, of bitter and harsh medicines, of cutting or burning, —of all which there is sometimes need in protracted diseases, the patients resile as truly preferring even death itself.³

For others, in contrast, these diseases were milder and less intense.⁴ Some medical thinkers minimized the differences between the two terms because of the arbitrariness of declaring a disease chronic after a certain period of time, and because acute diseases could become chronic and vice versa. The great Paris clinician A. F. Chomel wrote in 1822 that, useful as it undoubtedly was, the distinction should not be granted too much importance.⁵ But while the fluidity of categories was generally recognized, many medical authors did in fact view chronicity as a real category. Before the mid-nineteenth century, it was common to think of illnesses as imbalances or derangements of individual constitutions. So it is not surprising that many of the books and articles on chronic disease proposed a single cause for many different chronic conditions. Some of these were very simple indeed. William Cadogan, in his often-reprinted book of the eighteenth century, found that gout and all chronic diseases were the results of the same causes: “indolence, intemperance and vexation.” Since individuals brought about such illness through their behavior, the solution was not medicine but “it must be gently calling forth the powers of the body to act for themselves, introducing gradually a little more and more activity, chosen diet, and, above all peace of mind, changing intirely [sic] that course of life which first brought on the disease.”⁶ A century later, John King attributed most chronic illnesses to “temperament” and poor hygienic practices. Consequently, “although there are many maladies in which medicines and medicinal treatment can not be dispensed with, yet I am fully convinced that nearly, if not quite, one-half of the sicknesses which come under the care of medical men, could and ought to be cured solely by a recourse to hygiene.”⁷

Samuel Hahnemann, the founder of homeopathy, had a more complex view of chronic diseases. Most chronic diseases, he thought, were, like acute diseases, the

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result of original miasms, dynamic noxious influences of which there were three, including one that was the source of syphilis. He called the most important and oldest of the three “Psora,” which originated in leprosy, then evolved into less dramatic skin itches and eruptions, and had over time become internalized within the body, causing literally thousands of different illnesses. It had in the last three hundred years become “the most universal mother of chronic diseases.” Medical mistreatment had exacerbated the situation by destroying the itch eruptions on the skin that mitigated internal conditions. The only possible cures were one or more of the homeopathic remedies that acted directly on the Psora.⁸

If purportedly common causes could hold together the category of chronicity, so could therapies. Mineral waters were probably the single therapy most closely identified with chronic diseases.⁹ Mineral waters had some degree of scientific status in nineteenth-century France (although not in the United States), but other therapeutic solutions for chronic illnesses got less respect. A British review of 1851 had great fun ridiculing a book that saw exercise as the remedy for all chronic diseases.¹⁰ More successful was electricity, often proposed as a therapy for sufferers of many conditions.¹¹ At the end of the eighteenth century, the British physician Thomas Beddoes collaborated with Humphry Davy to establish a pneumatic institution in Bristol to treat patients with “airs,” or gases, produced through chemical reactions. Treatment was initially aimed at tuberculosis and other respiratory conditions, but the opening announcement in the *Bristol Gazette* also welcomed sufferers of “Palsy, Dropsy, Obstinate Venereal Complaints, Scrophula or King’s Evil, and other Diseases, which ordinary means have failed to remove.”¹² Specific climatic zones and even the blue color of the sky might also have a healing effect on human and animal diseases.¹³

Although much discussion of chronic disease was at this simple level, some medical writers of the early nineteenth century, particularly in France, tried hard to do justice to the variety of conditions represented by the term. They distinguished between functional, localized, and multi-organ chronicity; between those conditions caused by active illnesses and those resulting from organic lesions that remained after the illness had passed; between illnesses caused by a constitutional predisposition (diathesis) and those caused by an external cause; between simple forms and complex forms caused by coexistence of factors or by factors interacting dynamically; between those that were incurable and those that responded to treatment, however slowly.¹⁴ These were not just theoretical questions but ones on which treatment, whether active or palliative, could be based. In 1854 the Paris Academy of Medicine, which tried to resolve controversial medi-

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cal issues through debate, devoted its longest discussion of the nineteenth century to the question of whether microscopic analysis of cells could identify them as either curable or incurable. If it was a true cancer cell, the microscopists claimed it was incurable, whereas surgeons asserted that some cases of cancer were in fact curable.¹⁵

Hundreds of books on chronic disease were published in the eighteenth and nineteenth centuries, suggesting that it was far more common than official mortality statistics or historians' focus on infectious disease would suggest. William Osler wrote in his *Principles and Practice of Medicine* that many of those who died of infectious diseases were already gravely ill: "There is truth in the paradoxical statement that persons rarely die of the disease with which they suffer. Secondary terminal infections carry off many patients with incurable disease."¹⁶ Nonetheless, determining the extent of the problem was almost impossible. The historian Gerald Grob has suggested that Americans before 1900 were mainly preoccupied with acute infectious disease although many in fact suffered from chronic ailments.¹⁷ This situation was less a result of lack of interest than of the difficulty of getting doctors or families to talk about such matters. The reason offered in 1925 for the secrecy surrounding cancer was applicable to many chronic diseases during the previous century: "the implication of hereditary taint or wrongdoing or both."¹⁸ In 1880 John Shaw Billings tried to include in the census information about the nature of diseases and disabilities that people suffered; his attempt provoked little controversy but also garnered little useful information. When ten years later he pursued the matter in greater detail, including questions like "whether suffering from acute or chronic disease, with name of disease and length of time afflicted; whether defective in mind, sight, hearing, or speech, or whether crippled, maimed, or deformed, with name of defect,"¹⁹ and then sent a circular to doctors asking that they provide information about the chronic diseases of individual patients, a firestorm of controversy erupted. Lawyers and politicians became involved and doctors refused to participate. (Other questions, notably one asking about mortgages, were equally controversial.)²⁰ The questions did not reappear on the 1900 census, but a 1905 census in Massachusetts asked about acute and chronic diseases (defined by length regardless of type) and found that 1.12 per 1,000 responders had an acute illness and 7.9 per 1,000 a chronic illness.²¹

While chronic diseases were certainly significant realities for sick people, their doctors, and some compilers of statistics, they were not in the nineteenth century a major category for public health. Even lingering diseases like tuberculosis,

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the leading cause of mortality, did not become objects of public health activity until the latter decades of the nineteenth century. In part, this resulted from lack of accurate knowledge about their causal mechanisms or prevalence and in part from their endemic nature. They were not, like cholera, plague, and yellow fever, sporadically imported from abroad, dramatically killing large numbers of people in a short space of time. And there were no relatively simple *public* actions—like vaccination, quarantine, or sanitary reform—that were widely believed to be effective. One of the consequences of the bacteriological revolution was to gradually transform tuberculosis from a “reputedly” incurable chronic disease and syphilis from a treatable (using mercury) though shameful chronic disease into potentially curable infectious diseases susceptible to large-scale public health interventions. A recent debate among historians about whether infectious diseases were the dominant health problem of the nineteenth century can be largely explained by the fact that those arguing that infectious disease have been over-emphasized are historians of disease while the defender of infectious disease predominance is an historian of public health.²²

During the course of the nineteenth century, specific disease entities superseded general constitutional disturbances as the chief focus of medical thought. The revival of constitutional medicine in elite circles early in the twentieth century gave new life to comprehensive views of chronic disease. For instance, the well-known Boston orthopedist J. E. Goldthwait wrote numerous articles in eminently respectable medical journals arguing for a mechanistic conception of chronic diseases. In his view, poor posture displaced the internal organs of the body, impeding their function and causing any number of chronic conditions, depending on which organs were affected.²³ Nonetheless, on the whole, a general notion like “chronic disease” became less useful within elite mainstream medicine and became increasingly associated with alternative medicines and new gadgets. Although academic medical writers never abandoned the idea that some diseases were essentially chronic, they more frequently used the words *chronic* and *acute* as adjectives, either of which might be applied to conditions like gastric ulcers, abscesses, communicable diseases, or isolated joints and body parts.²⁴

But if the term *chronic disease* lost much of its specific character in the world of medical science, it retained and even increased in importance as a term of administration and welfare, often serving as popular shorthand for more regulatory formulas like “incurable, infirm, or elderly.” Assignment to one of these categories might give paupers access to certain types of institutions like hospices as well as meager welfare benefits and/or charity. But such labeling also had serious

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restrictive effects; as general hospitals gradually lost their welfare function and became more medicalized, they frequently denied admission to “chronics” on the grounds that there was nothing medicine could do in such cases and that hospital beds, always in short supply, should be reserved for those who might benefit from medical treatment. Certainly regulations to this effect were often breached, but they nonetheless caused considerable suffering for many. That “chronics” were taking up space in hospitals was a frequent complaint and how to get rid of them was a constant theme during the nineteenth and early twentieth centuries. But there did exist genuine concern in certain quarters about the best way to care for people suffering from such conditions and this concern stimulated charitable works and welfare initiatives. Such concern, however, spread only sporadically and briefly into the wider political and social arenas.²⁵

That rules were frequently not enforced in general hospitals helps explain how physicians could witness and write about diseases like cancer and neurological conditions. J. M. Charcot was able to write *Lessons on Chronic Disease*, the single most famous nineteenth-century medical work on this subject,²⁶ because the ethos of research and teaching that had begun to sweep European hospitals since early in the nineteenth century had spread to the two huge hospices of Paris. Charcot became senior physician at the Salpêtrière in 1862. This hospice had both a psychiatric service and one for elderly and chronically ill patients. The first provided Charcot with the medical cases that made him a pioneer of modern psychiatry; the second made possible much of his work on chronic diseases, principally neurological diseases like multiple sclerosis and cerebral hemorrhages but also conditions like gout and chronic rheumatism.

Chronic Disease in the Twentieth Century

In the twentieth century, although the term remained imprecise and elastic,²⁷ *chronic disease* acquired new meaning as one of most serious problems facing national healthcare systems. One has merely to do a Google Scholar Search for “Chronic Disease Care” or read the web pages of national Ministries of Health to see that it has become ubiquitous. The process was of course gradual. Appearing in odd years as a category in *Index Medicus* during most of the 1920s, “Diseases, chronic” became a category that appeared annually from 1927 on. In 1935 the US Public Health Service (PHS) undertook the National Health Survey (NHS) of 1935–36, an unprecedented large-scale survey to determine the incidence of chronic disease and disability. In 1955 a new periodical, the *Journal of Chronic Disease*, made its appearance. The term *chronic disease* was joined by other terms

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like *chronic illness*, which had rarely been used during the previous century but which became increasingly popular.²⁸ Although *chronic illness* came to refer to the subjective experience of sickness, at least in social science circles from the 1970s on, initially it was largely synonymous with *chronic disease* but conveyed a softer and more hopeful message, one with fewer associations with poverty and incurability and thus more appropriate for a growing social movement. Another new term used somewhat less frequently was *degenerative disease*, which conveyed the sense that aging led to a natural deterioration of organs. In some usages, it also conveyed a sense of collective and debilitating national decline due to social change and “civilization.”

For most historians and sociologists the rising interest in chronic disease throughout the century simply reflects changes in disease patterns in the Western world that took place as a result of the growing capacity in Europe and North America to prevent and cure infectious diseases. Infants who would have died in the nineteenth century lived on into adulthood in the twentieth century. Adults who would have previously died from infectious diseases were saved by sulphonamides and postwar antibiotics and thus moved on to the diseases of middle and old age. By the second half of the twentieth century, many of those suffering from serious noninfectious diseases that could not be cured could survive for increasingly prolonged periods with proper management; and by the end of the century, more and more people were living long enough to deal with multiple health problems of extreme old age. The issue was not just growing numbers of chronically ill people; it was more fundamentally the costs of their care. High-tech acute care is very expensive but time-limited. Long-term care has no such time limits and may be punctuated by costly acute episodes. All this is certainly part of the story of chronic disease in the twentieth century.

Two other approaches add to our understanding. There is a Foucaultian approach that is used by relatively few analysts but that deals directly with the rising concern with chronic illness. It works on a very different analytical level from the epidemiological argument. Whereas D. M. Fox and others see efforts to adapt medical institutions to a new disease reality as largely failing, these writers view concern with chronicity as part of a profound structural change that has in fact been remarkably successful. W. R. Arney and B. J. Bergen perceive developing concern with chronicity as part of a wide-ranging transformation that allowed medicine to organize itself around the concept of prevention and to take over problems that had previously been managed by social welfare institutions providing assistance or charity to certain kinds of indigent people (whom they refer to as “anomalies”).²⁹

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David Armstrong has associated the spread of the notion of chronic disease with the rise of a new kind of medicine he calls “surveillance medicine,” replacing the “hospital medicine” that predominated for nearly two centuries; this new regime takes patients out of hospitals and focuses on prevention of a growing number of conditions through ever-more pervasive and sophisticated forms of monitoring and screening, including self-monitoring.³⁰ One can of course take issue with many aspects of such interpretations. Surveillance and preventive medicine began with infectious diseases like tuberculosis and syphilis, and there is no reason to think they would not have spread as states took a more active role in healthcare, no matter what kinds of diseases were targeted. This reading, moreover, ignores the specific historical mechanisms that link chronic disease and surveillance. And reports about the death of hospital medicine have, to paraphrase Mark Twain, been greatly exaggerated. What we have seen rather is enormous economic pressures to do what hospitals do more quickly and cheaply and sometimes in alternative settings. Still, with all these caveats in mind, something like “surveillance” was very much part of the effort to confront chronic disease. Most recently, Armstrong has argued that emphasis on chronic disease has largely been about pathologizing the process of aging, implying both the possibility and the necessity of treatment under medical control.³¹ While this argument neglects the quite different motives of many groups advancing a chronic disease agenda and underestimates the difficulties that aging posed for this agenda, Armstrong correctly points to a major cultural shift: emphasis on chronic disease has been about rejecting attitudes of hopelessness, inevitability, and neglect applied to a variety of conditions, including those of old people, and transforming them into targets of intervention and amelioration.

In making his latest arguments, Armstrong exemplifies a third approach that analyzes the “medicalization” process through which more and more conditions are defined as diseases. If it rarely focuses on the broad category *chronic disease*, this approach may center attention on particularly susceptible population groups like women or older people. Most often, however, the units of analysis are the new conditions that, according to successive waves of interpretation, were promoted by physicians or medical scientists, then by pharmaceutical companies, and, in more recent work, by patient groups;³² these are frequently long-term conditions like attention deficit hyperactivity disorder (ADHD) or fibromyalgia. Not only do new chronic diseases appear with considerable regularity, but older conditions also expand. Historians like Robert Aronowitz and Ilana Löwy have described the bracket creep that defines diseases like cancer at earlier and earlier stages.³³ Simi-

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larly, criteria for defining hypertension (a risk factor that has become a disease), autism, or depression tend to become more and more inclusive. Much of this literature is highly critical of this process. But there is little question that such developments inflate the number of people defined as chronically ill and requiring treatment.

While there is truth in all of these approaches that together explain a great deal that occurred—in combination with the process of medical specialization early in the twentieth century that created groups of cancer or heart specialists who founded such disease-based associations as the American Cancer Society or the American Heart Association that gave new prominence to the diseases they treated—they nonetheless leave a number of critical questions unanswered.

The first of these has to do with timing. As I demonstrate in the first few chapters, discussion of chronic disease began during World War I and intensified during the 1920s and 1930s. Although infant mortality had significantly decreased and mortality from many infectious diseases was declining, tuberculosis remained one of the great killers. Mortality rates overall were going down so it is hard to understand why the apparent decline of some diseases that killed the young and the rise of others later in life inspired so much passion. Furthermore, there was no unanimity about the reliability of statistics showing a dramatic increase in mortality from cancer and heart disease; in fact, many observers, including the producers of these statistics, were highly skeptical about them on the grounds that disease categories, modes of diagnoses, methods of reporting, and medical fashion had changed drastically. At the very least, one has to look carefully at who took such statistics seriously and why they did so.

Second, even if one accepts some rise in the incidence of diseases of middle and old age—and everyone admitted that declines in infant and child mortality inevitably led to increases—why jump from specific diseases to a general category like “chronic disease”? The statisticians who produced the data certainly did not do this. If one looks at the early statistics produced, one sees classification based on organic systems, not on acuteness versus chronicity. One can certainly understand that claims of a rising incidence of cancer, whether correct or not, might provoke widespread terror. But how does one explain the influence of a fairly abstract meta-concept like “chronic disease”? One answer is that new types of quantification objectified the category by counting such new “facts” as “days of disability” or “risk factors” and later “quality of life.” But one must still ask why and how such categories were created. Another response is that this was part of nascent processes of *medicalization* or surveillance, which in hindsight is undoubt-

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edly true but which does not get us far in understanding why the process was occurring at that particular time and place.

The word *place* leads to the third and most critical point for the purposes of this book: large-scale public and political concern with chronic disease was largely an American phenomenon until roughly 1960, when it began to spread to other nations. The reason for this American interest is that a variety of groups found it a useful category for pursuing their quite distinct goals and eventually for coalescing around a policy of healthcare expansion. In the United Kingdom, chronic disease appeared as a social issue just after World War II, referring to the problem of elderly patients either in grossly inadequate Poor Law hospitals or “blocking” beds in general hospitals. By the 1960s, the broader American understanding of chronic disease came into use in the United Kingdom but was not central to British discussions of healthcare for much of the twentieth century. In France the term was also applied primarily to elderly persons and was used to describe patients whom administrators wished to evict from hospitals. The term in fact disappeared from official discourse after 1970 because it was thought to be stigmatizing and because other terms were more congruent with administrative thinking about the provision of healthcare facilities. Such differences raise several obvious questions that will be explored in this book. What conditions and forces in the United States made “chronic disease” such a potent way of thinking about and organizing the world of healthcare? How did other nations understand and deal with the phenomena that “chronic disease” covered? And finally how does a meta-concept like “chronic disease” move from one environment to another?

To avoid misunderstanding, let me emphasize two points. I am *not* suggesting that other nations were uninterested in diseases like cancer or heart disease. One could in fact make the case that the United Kingdom and France were well in advance of the United States in providing state support for cancer care. Nor am I suggesting that the notion of chronic disease was completely absent from rhetoric and policy in the United Kingdom and France. What I am arguing is that the concept of chronic disease was considerably more central to healthcare and welfare rhetoric, organization, and policy in the United States than elsewhere, at least until the 1960s and probably well beyond. The second point that I wish to stress is that I am not seeking to enter debates about American exceptionalism. If anything, I believe all nations to be exceptional. The French story I tell in chapter 10 is surely as unique as anything that occurred in the United States. If I had chosen another meta-concept like “exclusion” or “handicap,” my narrative would have centered on Europe.

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The account I offer is about more than differences among countries. It is about teasing out the various components that make up the notion of “chronic disease.” As elastic as this notion has been with respect to the illnesses that it covers, concern with chronic disease has been of three basic types. The first is medical *treatment* of the sick, which was indeed a problem in the early twentieth century when few facilities for patients who had cancer, heart disease, and other conditions existed. My conception of medical includes research because it was recognized that treatment rested on both biological research to explicate disease mechanisms and clinical research to test therapies. A second element in chronic disease discourse and practice is *prevention*, the mission of public health. From the earliest days of the chronic disease movement, there was concern to prevent conditions that killed, maimed, or disabled. By the middle of the twentieth century, this form of prevention was considered “primary” because a second form of prevention had appeared on the scene: finding and treating existing disease in its early stages in order to prevent deterioration and possible death. Doing so, of course, required medical care and brought the notion of prevention and public health policy more directly into the medical sphere. And finally there is long-term *care*—a term that includes medical care but much more as well. Very ill and infirm people frequently require nonmedical services and facilities. One of the thorniest issues surrounding chronic illness is how to provide such services. The task is complicated by the tendency to place nonmedical support under the jurisdiction of welfare authorities. The division of labor between medical and welfare institutions has frequently been a point of tension and conflict in all three nations under discussion not because of imperialistic ambitions on either side but because both wished to *avoid* responsibility for such services.

Criticism of chronic disease policy usually focuses on how money and resources have been distributed among these three components. Characteristically, it has been charged that too much weight has been placed on treatment (therapeutics and research) and not enough on prevention or care. Alternatively, criticism focuses on particular strategies within one of these elements; that medical care, for instance, focuses too much on acute episodes of chronic illness and not enough on proper disease management to avoid these episodes. Primary prevention is short-changed by emphasis on secondary prevention and may itself be inadequate because of a dominant focus on individual behavior modification that ignores social factors like poverty and unhealthy environments. Long-term care, it is alleged, invests too much on institutionalization and not enough on enabling people to live at home. However justified such criticisms may be, one cannot say

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that chronic disease is not taken seriously. Disagreements are not about the seriousness of the problem but about the best way to deal with it.

Separating the different elements that make up “chronic disease” is not the only analytical distinction that is required. There is first of all the distinction between movements or programs on behalf of specific diseases like cancer or specific populations like older people and those seeking more comprehensive solutions based on the assumption that all such problems have fundamental similarities and require common or at least coordinated solutions. Specific diseases may have strong emotional resonance because people suffer from them directly; the idea of chronic disease functions at a more abstract level. Practical programs based on specific diseases are simpler to manage than comprehensive programs but they may lead to waste and gaps in service. The strength of the cancer movement has been at times a major asset for promoting the comprehensive view of disease (see chapter 2), but like other disease-specific movements has also competed for resources, often successfully, against comprehensive chronic disease strategies. The organization of the National Institutes of Health (NIH) around specific disease categories is perhaps the most striking example of this dynamic.

There is a second distinction that must be raised. Some problems occupy small groups who administer healthcare institutions and who make decisions that provoke relatively little public response outside narrow professional circles. Other issues enter the public arena and generate widespread and passionate debate among many interested groups and actors. The narrative of this book attempts to account for the early move in the United States from the first to the second type of social action and the later, considerably less charged, and differently tilted trajectories followed in the United Kingdom and France. This distinction is particularly significant because it underlies my argument that concern with and responses to chronic disease involved political choices that are not directly addressed by either the epidemiologic transition or medical surveillance arguments. That chronic disease was the major problem of the twentieth century was an idea embraced by many groups for a wide variety of reasons: administering and planning for large populations; improving the quality of the race; attempting to expand the functions and raise the status of organizations or occupational groups; promoting healthcare reform or on the contrary resisting such reform; increasing investment in biomedical research; attempting to control healthcare costs; and, occasionally, alleviating suffering.