CHAPTER ONE

The Mirage of Reform

WHOEVER provides medical care or pays the costs of illness stands to gain the gratitude and good will of the sick and their families. The prospect of these good-will returns to investment in health care creates a powerful motive for governments and other institutions to intervene in the economics of medicine. Political leaders since Bismarck seeking to strengthen the state or to advance their own or their party's interests have used insurance against the costs of sickness as a means of turning benevolence to power. Similarly, employers often furnish medical care to recruit new workers and instill loyalty to the firm. Unions and fraternal societies have used the same means to strengthen solidarity. On more narrowly commercial grounds, insurance companies also gain advantage from serving as middlemen. To be the intermediary in the costs of sickness is a strategic role that confers social and political as well as strictly economic gains.

From the viewpoint of physicians, all such intermediaries, whether governmental or private, represent an intrusion and potential danger. Prior to the rise of third parties, doctors stood in direct relation to their patients as healers and benefactors. According to traditional ideals, which are not entirely fictitious, doctors gave care according to the needs of the sick and regulated fees according to the patients' ability

to pay, which was, in effect, the doctors' ability to charge. This system did not always provide economic security for the physician, much less for the patient, but it meant that doctors did not face any larger and more powerful organization that could dictate their income and conditions of practice. And many physicians valued this freedom from hierarchical control more than the stable income that an organized system of payment or health insurance might have arguably provided.

The changing organization of economic life upset these simple arrangements. The demand for health insurance originated in the breakdown of a household economy, as families came to depend on the labor of their chief wage earner for income and on the services of doctors and hospitals for medical treatment. In individual households, sickness now interrupted the flow of income as well as the normal routine of domestic life, and it imposed unforeseen expenses for medical care. These were not merely private problems. In the economy as a whole, illness had an indirect cost in diminished production as well as a direct cost in medical expenditures. The politics of health insurance revolve around these four sorts of cost: (1) individual losses of income; (2) individual medical costs; (3) the indirect costs of illness to society; and (4) the social costs of medical care. In the last century, these have given rise successively to different interests in reform. Initially, insurance advocates emphasized the importance of spreading the risks of lost income to working-class families and reducing the loss of productive efficiency to society. After the 1920s, the rising individual risks of high medical costs created difficulties even for middle-class families and generated a new basis of interest in health insurance. And, most recently, reform has been preoccupied by the burden that rising medical costs impose on the society as a whole.

In America health insurance first became a political issue on the eve of the First World War, after nearly all the major European countries had adopted some sort of program. The rapid progress that workmen's compensation laws made in the United States between 1910 and 1913 encouraged reformers to believe that if Americans could be persuaded to adopt compulsory insurance against industrial accidents, they could also be persuaded to adopt compulsory insurance against sickness, which caused poverty and distress among many more families. The enactment of health insurance legislation in other Western capitalist countries suggested there was no fundamental reason that America could not do the same. Reformers believed as well that health insurance would not only benefit American workers; it would yield handsome returns for employers by creating a healthier and more productive labor force. So when they launched a national effort to enact compulsory

health insurance, they anticipated broad support and believed it would, most likely, be the "next great step in social legislation." As would happen repeatedly in the next several decades, advocates of reform had the impression that victory was close at hand, only to see it vanish like a mirage.

This chapter explores why a government health insurance program eluded reformers—why there is, to this day, no national health insurance in America. The next chapter examines the system of financing and organization that appeared in its place.

A COMPARATIVE PERSPECTIVE

The Origins of Social Insurance

Financial protection against the costs of sickness, long a concern of voluntary associations, became a concern of politics in the late nineteenth century. In 1883 Germany established the first national system of compulsory sickness insurance. Organized through independent sickness funds, the program originally applied only to wage earners in some industries and trades. Besides medical attendance, it provided a cash benefit to make up for lost wages during sickness. Similar systems were set up in Austria in 1888 and in Hungary in 1891. Then in a second wave of reform, Norway adopted compulsory sickness insurance in 1909, Serbia in 1910, Britain in 1911, Russia in 1912, and the Netherlands in 1913.

Other European countries subsidized the mutual benefit societies that workers formed among themselves. France and Italy, which required sickness insurance only in a few industries such as railroads and shipping, gave relatively small subsidies, though the French expanded their program in 1910. On the other hand, Sweden, beginning in 1891, Denmark in 1892, and Switzerland in 1912 gave extensive state aid to voluntary funds and provided other strong incentives for membership. By 1907 the proportion of the population covered by sickness insurance in Denmark actually exceeded the proportion in Germany (27 compared with 21 percent).[1]

But in the United States during this period, the government took no action to subsidize voluntary funds nor to make sickness insurance compulsory. In the years between the adoption of compulsory insurance by Germany in 1883 and by England in 1911, the issue was hardly discussed

in America. This long neglect and indifference require some explanation: Why did the Europeans adopt health insurance while Americans ignored it?

The European countries that instituted compulsory sickness insurance did so as part of a general program of social insurance against the chief risks that interrupted continuity of income: industrial accidents, sickness and disability, old age, and unemployment. We associate health insurance with the financing of medical care, but its original function was primarily income stabilization. Many early voluntary funds and some governmental programs included only a sickness benefit, or "sick pay," to compensate for lost wages; paying for medical care came later, or was distinctly secondary. The governmental programs were not universal because they were originally conceived as a means of maintaining the incomes, productive effort, and political allegiance of the working class. Participation was limited to wage earners below a given income and usually did not include their dependents, agricultural workers, the self-employed, or the middle and upper classes. These groups were considered either too difficult to cover (because of high administrative costs) or not in need of income protection.

Social insurance represented a new stage in the management of destitution in capitalist societies. From the rise of national economies to the emergence of industrial capitalism—that is, between the sixteenth and late eighteenth/early nineteenth centuries—the poor received assistance in their own parishes. Industrialization, however, generated growing complaints about the effects of local poor relief on the free circulation of labor and incentives for work. In what Gaston Rimlinger calls the "liberal break" with paternalism, governments abolished the traditional system of poor relief, restricted public assistance to almshouses where it would be available only under the most demeaning conditions, and forced the able-bodied poor to work or to emigrate. While the older forms of social protection survived in the mutual societies of artisans and skilled workers, liberalism reduced the government's role as the guardian of welfare.[2]

The advent of social insurance at the end of the nineteenth century signified a return to social protection. Social insurance departed from the earlier paternalism, however, by providing a right to benefits instead of charity. In this sense, it constituted an extension to social welfare of liberal principles of civil and political rights. On the other hand, social insurance departed from liberalism by expanding the role of the state and demanding compulsory contributions. Consequently, it represented an extension of obligations as well as freedom.[3] In this regard, it was no different from many other modern reforms. The right to a

primary education, for example, typically entails an obligation to attend school, at least until some minimum age. The right to benefits under sickness insurance, while not requiring the sick to see a physician, typically has limited the insured to use of licensed practitioners and hence has extended social control of medical practice. Social insurance, moreover, required contributions from employers as well as workers. Hence, it represented an intrusion by the state into the prerogatives of businessmen in setting wages. Where liberalism had its greatest hold and where private interests were strong relative to the state, social insurance made the slowest headway. So, contrary to the modern view of the welfare state as a "liberal" reform (in the current American sense), social insurance was generally introduced first in authoritarian and paternalistic regimes, like Germany, and only later in the more liberal and democratic societies, like England, France, and the United States.[4] Partly because Germany industrialized later and faster, its traditional forms of social protection had partly survived when it faced the challenge of socialism. Perhaps as a result, it made a more direct transition to the social protection of the welfare state.

Political discontent precipitated the introduction of social insurance in both Germany and England. The German monarchy in the 1880s faced a growing challenge from the German Social Democratic Party. In 1875 the Socialists had been strengthened by a coalition between the followers of Marx and Lassalle. After outlawing the Social Democratic Party, Bismarck was still convinced that repression was insufficient and sought a "welfare monarchy" to assure workers' loyalty.[5]

In England labor unrest also preceded the introduction of social insurance in the early 1900s, but the political conditions were somewhat different. England was a parliamentary democracy in which the Liberals were attempting to hold on to their working-class support by championing social reform. In Germany, Bismarck introduced social rights to avoid granting wider political rights; in Britain, Lloyd George sought social rights within the context of existing rights to political participation. But both were basically defensive efforts to stabilize the political order by integrating the workers into an expanded welfare system. The proponents of social insurance also expected that it would increase industrial productivity and military power by diminishing class antagonism and creating a healthier labor force and army. As Lloyd George later put it in a memorable phrase, "You can not maintain an A-1 empire with a C-3 population."[6]

Germany and England may also have been predisposed toward social insurance programs by strong preexisting mutual benefit funds, which were notably active in providing sickness benefits. In Germany, various

guilds, trades, industries, and mutual societies operated *Krankenkassen* ("sickness funds"). In England, even before 1911, nearly half the adult males—generally the conservative artisans and respectable, self-supporting workers rather than the very poor—belonged to friendly societies, which were powerful national organizations; voluntary sickness insurance covered about 13 percent of the population.[7] Although these preexisting funds represented obstacles to state control of social insurance, they also reflected a widespread awareness among workers of the value of insuring against the costs of sickness.

Why America Lagged

In the United States, the political conditions and preexisting institutions were altogether different. America was the country where classical liberalism had most thoroughly shaped the relations between state and society. As of 1900, American government was highly decentralized, engaged in little direct regulation of the economy or social welfare, and had a small and unprofessional civil service. Strengthening government became one of the central concerns of Progressive reform at the turn of the century, but its impact was limited. At the national level, government had little to do with social welfare, and in health its activities were minor. Congress had set up a system of compulsory hospital insurance for merchant seamen as far back as 1798 (following European precedents), but this was an altogether exceptional measure to deal with a group that was commercially and epidemiologically strategic because of its role in foreign commerce. Congress approved aid to mental hospitals in 1854, only to see the bill vetoed by President Pierce. It created a National Board of Health in 1879 but abolished it in 1883. In two stages in 1902 and 1912, it expanded the Marine Hospital Service into the U.S. Public Health Service but gave it few functions and little authority. The federal government continued to leave such matters to state and local government, and the general rule at those levels was to leave as much to private and voluntary action as possible. Although general hospitals in Europe became primarily governmental and tax supported, in America they remained mainly private. A system of government that followed such principles was not likely to be an early convert to compulsory health insurance.

Nor was there a challenge to political stability in America comparable to the challenge in Europe. In the 1890s, America experienced depression and unrest, but much of the unrest was agrarian and populist, and social insurance would not have responded to farmers' concerns. Socialism emerged as a political force only after the turn of the century, and

even then the Socialist Party was nowhere near the political threat its counterparts were in Europe. At its height, in the elections of 1912 and 1916, the party attracted only 6 percent of the vote; this was, as it happens, precisely the time the health insurance campaign began. After a shaky start, American unions had begun to grow—membership, less than half a million in 1897, was up to 2 million by 1910 and 5 million by 1920—but this growth occurred under a conservative labor leadership suspicious of political reformers. The breach between the conservative trade unions and the Socialist Party prevented the emergence of powerful working-class support for social insurance.

Finally, voluntary sickness funds were less developed in the United States than in Europe, reflecting less interest in health insurance and less familiarity with it. At the turn of the century, European immigrants established numerous small benevolent societies in American cities offering sickness benefits to their members, but the more established fraternal orders, composed of older ethnic stock, mainly provided life insurance. Some local lodges of national orders gave assistance in sickness, but it was more fragmentary than in Europe.[8] Similarly, when unions provided sickness benefits, the locals generally did so, not the national organizations.

American unions oscillated in their attitude toward benefit programs. The first trade unions in the early nineteenth century had been as concerned with mutual aid as with jobs and wages. By the Civil War, however, they turned more toward bargaining with employers and discouraged benefits, since high dues might deter workers from membership. But after the war they began to adopt the theory that benefits promoted membership. In 1877 the Granite Cutters adopted the first national sick benefit plan. Still, unions had to weigh the gains in solidarity from benefits against the deterrent effects of high dues, and this limited their capacity to provide protection against the costs of sickness.[9]

Commercial health insurance was as yet little developed. Around 1850 several health insurance companies were established, but they quickly went bankrupt. However, a related form of insurance, protection against losses from accidental injury and death, did gain a firm footing in the second half of the nineteenth century. Beginning about 1896, firms engaged in this business started offering insurance against specific diseases and gradually broadened their policies to cover all disability from sickness or accident. Such policies were expensive because of administrative costs and were carried mainly by the middle class. There was also a small amount of health and accident insurance sold to workers, but because of overhead and profits, only about 30 to 35 percent of premium income was returned in benefits to subscribers. Frauds

were common, and the larger, more respectable firms stayed away from the business.[10] John F. Dryden, who briefly experimented with sickness benefits when he founded the Prudential Insurance Company in 1875, commented in 1909 that conservative business practice dictated that an industrial insurance company had to limit itself to benefits payable at death. "[T]he assurance of a stipulated sum during sickness," he wrote, "can only safely be transacted, and then only in a limited way, by fraternal organizations having a perfect knowledge of and complete supervision over the individual members."[11] But while fraternal groups could remedy some difficulties that insurance companies encountered, they had problems of their own. Often they were improperly managed and too small to be actuarially sound; as their membership aged, their reserves frequently proved insufficient.

Because most sickness benefits were provided by small immigrant benefit societies and local chapters of fraternal orders and unions, early researchers found it hard to assemble accurate statistics regarding sickness insurance. But it seems likely that such insurance was less extensive in America than in England and Germany before governmental programs were introduced in those countries. In Illinois, Ohio, and California, where state commissions studied the problem around 1918, the proportion of industrial workers enjoying some form of sickness benefit—usually very minimal—was estimated at one third. The percentage would have been much lower if computed over the entire population. In the country as a whole, only a small fraction of the population can have had any protection against loss of earnings, and even fewer received any medical care or coverage of medical expenses through insurance.[12]

Yet American workers did spend a great deal of money for insurance to protect themselves against one related hazard. In the early twentieth century, commercial insurance companies enjoyed enormous success selling "industrial" life insurance policies to working-class families. The lump-sum payments provided by these policies generally paid for funerals and the expenses of a final illness. This business was the backbone of two companies, Metropolitan Life and Prudential, that had risen to the top of the insurance industry by collecting 10, 15, and 25 cents a week from millions of American working-class households. But because the premiums were paid on a weekly basis and lapses were frequent, these policies had to be marketed by an army of insurance agents, who visited their clients as soon after payday as possible. The administrative costs of industrial insurance were staggering; subscribers received in benefits only about 40 percent of what they paid in premiums. The rest went to the agents and the companies. Yet the fear of a pauper burial

was so great that Americans bought $183 million of such insurance in 1911—about as much as Germany spent on its entire social insurance system.[13]

GRAND ILLUSIONS, 1915–1920

The Democratization of Efficiency

In America, reformers outside government, rather than political leaders, took the initiative in advocating health insurance. The idea did not enter political debate under antisocialist sponsorship, as it often did in Europe. Indeed, the Socialists in 1904 were the first American political party to endorse health insurance. At the center of the movement, however, was the American Association for Labor Legislation (AALL), founded in 1906, a group of "social progressives" who sought to reform capitalism rather than abolish it. The association's membership was small and primarily academic, and it included such notable figures as the Progressive economists John R. Commons and Richard Ely of the University of Wisconsin and Henry R. Seager of Columbia. The AALL's chief initial concern was occupational disease, and its first major success came in the campaign against "phossy jaw," a disease common among workers in match factories that could be prevented by eliminating phosphorous from the production process. The association was prominent in the drive for workmen's compensation. It sought the prohibition of child labor and also supported unemployment relief through public works, state employment agencies, and unemployment insurance. Officially, it took no position on unions, but many of its members supported unions and the association originally included several prominent labor leaders.[14]

The AALL's campaign for health insurance had the misfortune of getting under way just as Progressivism began to recede. As a political force, Progressivism reached its peak in the election of 1912, when the Progressives bolted from the Republican Party and nominated former President Theodore Roosevelt as their candidate. Much like Lloyd George and Winston Churchill, Roosevelt supported social insurance, including health insurance, in the belief that no country could be strong whose people were sick and poor. But his defeat in 1912 by Woodrow Wilson postponed for another two decades the kind of leadership that might have involved the national government more extensively in the

management of social welfare. In America compulsory health insurance would not have the kind of national political sponsor it enjoyed in Germany and England.

In the December after the 1912 election, the AALL voted to create a committee on social insurance, and in June 1913 it organized the first national conference on the subject. Despite its broad mandate, the committee decided to concentrate on health insurance, and the following summer it drew up a model bill, the first draft of which was published in 1915.

The AALL's bill followed European precedent in limiting participation to the working class, though it gave medical coverage not just to workers but also to their dependents. Its program applied to all manual workers and to others earning less that $1,200 a year, except for domestic and casual employees. Benefits were of four kinds: (1) medical aid, including all physicians', nurses', and hospital services; (2) sick pay (at two thirds of wages for up to twenty-six weeks; at one third of wages during hospitalization); (3) maternity benefits for the wives of insured men as well as insured women; and (4) a death benefit of $50 to pay for funeral expenses. The costs, estimated at 4 percent of wages, were to be divided among employers and workers, each to pay two fifths, and the state, which would contribute the fifth remaining. The employers' share increased for the lowest-income workers. A worker earning $600 a year, the AALL estimated, would pay 80 cents out of a monthly premium of $2.[15]

The reformers formulated the case for health insurance in terms of two objectives. They argued it would relieve poverty caused by sickness by distributing the uneven wage losses and medical costs that individual families experienced. And, second, they maintained it would reduce the total costs of illness and insurance to society by providing effective medical care, creating monetary incentives for disease prevention, and eliminating wasteful expenditures on industrial insurance. This mixture of concerns was typical of the social Progressives. On the one hand, in emphasizing the relief of poverty, they made an appeal to moral compassion; on the other, in emphasizing prevention and increased national efficiency, they made an appeal to economic rationality.[16] Combining social meliorism with the ideal of efficiency fitted perfectly into Progressive ideology. It also reflected the political conditions of a democratic capitalist society, which made it incumbent upon reformers to gain the support of both the public and powerful business interests. Progressive health insurance was shaped by these political realities as well as by the economics of sickness and health care of the time.

Relieving poverty caused by sickness, as the reformers saw it, involved both compensating lost earnings and paying medical costs. The Progressives considered these equally important. Data from the period suggest that for individual workers wage losses were two to four times greater than health care costs, but for families as a whole, total losses of income and medical costs were roughly the same because of the additional health care expenses of dependents.[17] A study of 4,474 workers in a Chicago neighborhood showed that in the course of a year about one in four was sick for a week or longer and, from such sicknesses, lost an average of $119 or 13.7 percent of annual wages. The proportion of families that could not "make ends meet" increased to 16.6 percent among those with serious illness, compared to 4.7 percent among those without.[18] Advocates of health insurance also cited data from charities indicating that sickness was the leading immediate cause of poverty; a conservative estimate by the Illinois commission found it to be the chief factor in a quarter to a third of the charity cases in the state.[19]

I. M. Rubinow, a leading authority on social insurance who was both a physician and an actuary as well as a Socialist, saw health insurance as the means to cut the "vicious circle" of disease and poverty. It would prevent the families of the sick from becoming destitute and thereby prevent further sickness. Such a program had to be compulsory, Rubinow argued, to make it universal (that is, among low-income wage earners) and to secure contributions from employers and the public, who shared responsibility for the conditions that caused sickness. American workers, he wrote, "must learn to see that they have a right to force at least part of the cost and waste of sickness back upon the industry and society at large, and they can do it only when they demand that the state use its power and authority to help them, indirectly at least, with as much vigor as it has come to the assistance of the business interests . . . ."[20]

Yet, in advocating health insurance, most Progressive reformers spoke of stabilizing rather than redistributing incomes, and on behalf of a public interest in preventing poverty and disease rather than a special grievance of labor. Though their program had redistributive implications, they generally appealed for support on the grounds that all interests, including those of business, favored insurance.

This orientation was abundantly evident in the second half of the social Progressives' case for health insurance. As the AALL put it, health insurance had as one of its aims the "conservation of human resources," seen as analogous to the conservation of natural resources. Irving Fisher, then one of the country's most eminent economists, argued in a pres-

idential address to the AALL in 1916 that health insurance would have its greatest value in stimulating preventive measures and hence was needed not just "to tide workers over the grave emergencies incident to illness," but also "to reduce illness itself, lengthen life, abate poverty, improve working power, raise the wage level, and diminish the causes of industrial discontent."[21] B. S. Warren and Edgar Sydenstricker of the U.S. Public Health Service maintained that because a compulsory insurance scheme would require financial contributions from industry, workers, and the community, it would encourage them to support public health measures in order to prevent disease and save money.[22]

In addition, compulsory health insurance, by including a funeral benefit, would eliminate the huge cost of marketing industrial insurance policies, not to mention the profits. Hence, reformers claimed they could finance much of the cost of health insurance out of the money wasted on industrial insurance policies. Warren and Sydenstricker cited a 1901 Bureau of Labor study showing that 65.8 percent of 2,567 families had expenditures for industrial insurance averaging $29.55 per family, while 76.7 percent had expenditures for sickness and death averaging $26.78 per family.[23] In effect, instead of paying insurance agents to visit them weekly to make collections, wage-earning families could pay for doctors and nurses to visit them when they were sick. So the inclusion of funeral benefits was not an idiosyncratic choice of Progressive reformers; it was part of their general program for increased social efficiency.

The arguments for health insurance reflected a great confidence among Progressive reformers in the capacity of public health and medical care to prevent and cure disease. The achievements of medicine, Rubinow said in a defense of health insurance, exceeded the wildest dreams of a half century earlier. "If there was a rational basis for a certain medical nihilism so popular then, it has vanished long ago. No reasonable being will doubt the tremendous efficiency of competent medical aid."[24] The democratic view, instead of demanding that every man be his own physician, now insisted that the services of physicians be available to all. After reviewing the evidence that from a quarter to two fifths of the sick were not receiving any medical care, a commission in Ohio observed that all facts pointed to the need for a "democratization of medical service," which meant wider distribution, not lay control.[25]

As ardent believers in the value of medical care and the legitimate basis of professional authority, Progressive reformers had no basic quarrel with physicians. Consequently, the AALL in 1914 sought to involve the leaders of the medical profession in formulating the model health insurance bill. Anticipating some resistance by private practitioners, they

tried to be flexible about provisions that would affect doctors. To their pleasant surprise, they found that prominent physicians not only were sympathetic but wanted actively to help in securing legislation.[26] Among these cooperative physicians were some of the leaders of the AMA, including George H. Simmons, the editor of its *Journal*, and Frederick R. Green, secretary of its newly created Council on Health and Public Instruction, who wrote to the AALL's secretary, John Andrews, "Your plans are so entirely in line with our own that I want to be of every possible assistance."[27] He proposed setting up a three-man committee to work with the AALL. In February 1916, the AMA board approved the committee, and the Socialist I. M. Rubinow was hired as its executive secretary. The committee was located in the same building in New York City as the AALL, and its chairman, Alexander Lambert, Theodore Roosevelt's personal physician, was the AALL's medical advisor. At this point, the AMA and the AALL formed a united front on behalf of health insurance.

Yet there were points of tension between the reformers and the physicians, especially where the Progressive search for efficiency conflicted with the doctors' defense of their income and autonomy. Some reformers saw health insurance as an opportunity to subordinate medical practice to public health, to encourage the growth of group practice, and to change the method of payment from fee-for-service to salary or capitation (that is, per patient per year). These changes the doctors would not accept.

The relation of health insurance to public health was one issue on which the AALL was prepared to give way to the doctors. Public health officers, arguing that preventive medicine ought to be the overriding concern, wanted to make health departments the administrative agencies for health insurance. But Lambert, speaking for both the AALL and the AMA at a conference in 1916, noted that the physicians would be unwilling to submit to "absolute control" by public health authorities, and the doctors' preferences had to be respected.[28]

Other reformers like Rubinow wanted to use health insurance to promote a shift from individual general practice to specialized group practice under governmental control. The initially positive response of AMA leaders in 1915 encouraged Michael M. Davis, Jr., then director of the Boston Dispensary, to hope that America might be able to "improve on" Britain and Germany in the organization of services. In a letter to the AALL's John Andrews, Davis wrote that they ought to be careful not to tie health insurance "to a system of individualized private practice without creating a definite opening for . . . cooperative medical work in diagnosis and treatment." Davis added that he had "a good

many ideas on organization" since visiting the Mayo Clinic.[29] But most physicians were unlikely to be enthusiastic about such ideas, which threatened to subordinate them in a bureaucratic hierarchy, and the most the AALL could do was to include a provision allowing local insurance committees to contract with group practices as well as with individual doctors.

Undoubtedly, the most serious point of tension was the method of paying physicians under health insurance. Reformers were reluctant to adopt any method that would cause serious financial problems for the insurance system, and European experience had clearly indicated that paying doctors for each service they performed was more likely to cause budgetary problems than if they were paid per capita, that is, according to the number of patients who signed up on their list for the year. Consequently, reformers recommended that doctors be paid on a capitation basis rather than by visit. Physicians, however, strongly objected to any form of contract practice as a result of their experience with fraternal lodges and industrial firms that forced them to bid against each other for group business. Trying to mediate the conflict, Lambert proposed paying doctors by visit out of a budget for physicians' services determined by the number of people insured in a local area.[30]

The AMA's initial cooperation with the AALL did not necessarily reflect any widespread enthusiasm among its membership. Two state medical societies, Wisconsin and Pennsylvania, had quickly endorsed the principle of compulsory health insurance, but others were apathetic. A survey of secretaries of state medical societies in late 1916 showed that the vast majority had not yet discussed health insurance.[31] At the AALL's annual meeting in late 1916, several physicians commented that the great majority of practitioners were probably opposed to health insurance, but expressed confidence that this was primarily because of ignorance. No doctor who had given it careful study was against it, commented Frederick Green of the AMA, but it would not be long before Green himself denied he had ever favored the measure.[32]

Although the Progressive Party broke up in the 1916 election after endorsing the Republican nominee, reformers could take some satisfaction in the early response that year to the proposal for health insurance. The Commission on Industrial Relations, created by President Wilson in the wake of labor violence, recommended health insurance in its final report. The labor committee of the U.S. House of Representatives held hearings on a resolution introduced by its sole Socialist member to create a national social insurance commission. Though the proposal failed to gain approval, several states established investigative commissions. Organizations of public health officers and nurses endorsed the measure. In short, health insurance seemed to be gaining support and moving toward public approval.

Labor and Capital Versus Reform

Yet there were also signs of trouble. To the chagrin of reformers, the American Federation of Labor (though not all its member unions or state federations) opposed the program. Samuel Gompers, president of the AF of L, repeatedly denounced compulsory health insurance as an unnecessary, paternalistic reform that would create a system of state supervision of the people's health. In an acrimonious debate with Rubinow at the 1916 congressional hearings on a national commission, Gompers assailed the Socialist's belief that government had to be called in to ensure workers' welfare and gave a ringing defense of the success of trade unions in raising workers' standard of living.[33]

This view was characteristic of Gompers and the AF of L, which at that time opposed legislation to establish a minimum wage, unemployment insurance, old-age pensions, or even an eight-hour day. Gompers insisted that workers could rely only on their own economic power, not the state, to obtain higher wages and benefits. He worried that a government insurance system would weaken unions by usurping their role in providing social benefits.[34]

Gompers' central concern was maintaining the strength of the unions. As Selig Perlman writes in his classic *Theory of the Labor Movement*, the "overshadowing problem" of American unions was "staying organized" because of the "lack of class cohesiveness in American labor."[35] All previous attempts in the United States to build unions had been wrecked during economic depressions. Early in his career, Gompers wrote that the most intelligent workers would remain members of a union in times of adversity, but the others, who had "no inclination or ability or time" to see its advantages, should find their interests made "so inseparable from the union as to make it a direct and decided loss to them to sever their connection. . . . I know of no better means than to make our unions beneficial and benevolent as well as protective."[36] As a young leader of the cigarmakers in New York, he had proposed in 1879 that the union provide sickness and death benefits. The measure was adopted, and in one year his local increased its membership from 300 to 3,000. "Gompers," writes a biographer, "believed that the phenomenal increase in the membership of Local 144 was due to the introduction of those benefits."[37] Explaining the AF of L's rejection in 1902 of a proposal for federal old-age pensions, Gompers wrote that "the unions desired to develop their own system of protection against all the

vicissitudes of life as a means of gaining recruits. Social security would deprive them of that function."[38]

But, in fact, American trade unions had not much developed their own systems of welfare protection. They were increasingly gaining a stable membership, not by offering welfare benefits, but by controlling job opportunities. Gompers' views were based on the expectation that benefits would prove useful rather than any extensive use of them. Although his views prevailed in the national organization, other AF of L leaders, including Vice President William Green, saw less of a threat to labor solidarity from a governmental program and favored health insurance. Ten of the largest state federations within the AF of L, including California, New York, Massachusetts, Pennsylvania, and Wisconsin, supported health insurance proposals in their states. Only in New York, however, was organized labor a leading force in the campaign.[39]

Employers generally saw compulsory health insurance as contrary to their interests, despite some early business reaction that was tentatively sympathetic. A committee of the National Association of Manufacturers (NAM), a hard-line antiunion organization, reported in 1916 that voluntary insurance would be the "higher and better method," but it recognized that compulsory insurance might be necessary and, if so, all occupations ought to be included. This report was only accepted, not adopted, by the NAM, and like other business groups it soon joined the opposition to compulsory health insurance.[40]

Spokesmen for American business typically rejected the argument that health insurance would add to productive efficiency. The National Industrial Conference Board, a research organization established by major industrial trade associations, agreed that sickness was a serious handicap to the "social well-being and productive efficiency of the nation," but argued that direct investment in public health would have a higher return than cash benefits for the sick. Compulsory health insurance would not "materially reduce the amount of sickness"; the incentives for prevention would not work because the responsibility for most sickness could not be fixed. Indeed, days lost from work might increase because sick pay encouraged malingering; the conference board cited statistics indicating that days lost from work on account of sickness had increased in Germany after insurance was enacted. Nor would health insurance greatly reduce poverty. The figures suggesting sickness caused poverty ignored other causes. Also, many of those seeking charity would not have had health insurance because they were casual workers, self-employed, or unemployed. The large sums spent on health insurance, therefore, would benefit only part of the population;

in New York, the board calculated, the insurance bill would cover only one third of the population.[41]

Even the most liberal elements of business, represented in the National Civic Federation (NCF), generally opposed compulsory health insurance. The civic federation, founded in 1901 by journalist Ralph Easley to bring together the leaders of capital, labor, and the public in the interest of social harmony, included the more moderate big businessmen who were willing to recognize organized labor as a legitimate partner in American capitalism, at least outside of their own factories.[42] The NCF had been an ally of the American Association for Labor Legislation in the campaign for workmen's compensation, and it had some overlapping members, including Gompers, who served as a vice president of both groups. But even though the two organizations sought peaceful labor reform within the framework of capitalism, they grew increasingly estranged as the health insurance conflict unfolded. The AALL was composed mainly of academic reformers who saw themselves as pursuing the interests of the public rather than those of any class, while the civic federation sought a mutual accommodation between the interests of organized labor and those of big business. The social Progressives in the AALL were inclined to rely upon the judgment of professionals and the power of government, whereas organized labor and big business favored private bargaining outside the purview of the state. Gompers resigned from the AALL in 1915 in part over the association's frequent call for impartial experts and high-minded commissions to resolve social problems. Such experts Gompers distrusted as a distinct class with interests of their own. On the other hand, he remained in the National Civic Federation despite repeated attacks by left-wing labor leaders for collaborating with big business. The leaders of the AF of L, unlike many of the Progressives, accepted big business as inevitable and viewed unions as the necessary counterweight to protect the interests of workers. As has often been pointed out, American labor leaders resembled American businessmen in priding themselves on being practical, cynical about politics, and distrustful of intellectuals and their abstract schemes.[43] Furthermore, in regard to social insurance, neither unions nor big business at that time wanted any competition from government in social welfare programs that could potentially increase workers' loyalty to either of them.[44] Thus health insurance, rather than pitting labor unions against capital, pitted both of them against the reformers.

In 1914 the civic federation sent a committee to England to study recent social insurance legislation, and two years later it set up a social insurance department. At first, the federation criticized specific provi-

sions of American insurance proposals. By 1917, however, it was spearheading the opposition, charging that health insurance was a failure in Europe that impractical reformers wanted to foist upon workers in the United States even though labor—witness Gompers and the AF of L—had no desire for it.[45]

One segment of business, well represented in the civic federation, played a particularly active role in fighting compulsory health insurance—the insurance industry. Other commercial interests in health care, such as pharmaceutical companies, assailed health insurance, but none so relentlessly as the insurance firms. Where reformers mounted campaigns for health insurance, the insurance industry aroused the opposition. Particularly active were representatives of the two firms, Prudential and Metropolitan Life, whose industrial life insurance business was directly threatened by the reformers' inclusion of a funeral benefit. As of 1915 Prudential held 38 percent and Metropolitan 34 percent of industrial business.[46] Nor were their interests alone at stake; both firms were closely linked through their investments and boards of directors with other large corporations. The reformers, in their innocent enthusiasm for efficiency, were threatening to eliminate an important source of profit for the insurance industry and of investment capital for American business. As a result, they unwittingly brought down upon themselves the concerted opposition of big business. The chief spokesman for the insurance industry was Frederick L. Hoffman, a respected actuary who was vice president of Prudential and a member of the AALL until 1917, when he resigned over the health insurance issue and became the reformers' most indefatigable critic. Nearly all the propaganda against compulsory health insurance, John R. Commons later suggested, could be traced back to Hoffman, and this was only a slight exaggeration.[47] Another insurance company vice president, Lee K. Frankel of Metropolitan, chaired the National Civic Federation's social insurance committee and prepared its response to health insurance.[48] Yet a third key critic was P. Tecumseh Sherman, a lawyer for insurance interests also active in the civic federation. These ties helped solidify the opposition of insurance companies and employers to health insurance. On the other hand, the unions were divided among themselves and at odds with the political organizations advocating reform.

Defeat Comes to the Progressives

In 1917 two developments changed the entire complexion of the health insurance debate. The first was growing opposition from physicians. Though the AMA House of Delegates in June 1917 approved a final report from its social insurance committee favoring health insurance, this action did not reflect sentiment in state medical societies. In New York, the state council of the medical society had endorsed the model health insurance bill in December 1916, but meetings in county societies in January and February saw a groundswell of opposition. In March the state council met again and withdrew its earlier approval. The source of this opposition, according to Ronald L. Numbers, was "almost entirely economic in nature."[49] When legislative hearings were held in March, the doctors who testified were nearly all opposed to health insurance. In Illinois a committee of the state society reported in May that an insurance bill it had been prepared to fight in the legislature had never materialized: "We feel that the active opposition of the medical profession prevented its introduction."[50]

The second key development of 1917, the entry of America into the war in April, proved a major turning point in the insurance movement. Many physicians went into the service; the AMA closed down its committee on social insurance and I. M. Rubinow took another job. In Massachusetts, debate was suspended on a bill that had the support of prominent Boston physicians and progressive social and political leaders. Anti-German feeling rose to a fever, the government's propaganda bureau commissioned articles denouncing German social insurance, and opponents of health insurance now assailed it as a Prussian menace inconsistent with American values.[51]

The one public referendum on health insurance took place in this climate of wartime hysteria. In early 1917 the California social insurance commission recommended health insurance, and as a first and necessary step it proposed an enabling amendment to the state constitution. Some leaders of the state medical society favored the plan and kept the society neutral, but a large group of doctors formed an independent League for the Conservation of Public Health to oppose the measure. "What is Compulsory Social Health Insurance?" asked one of the league's pamphlets. "It is a dangerous device, invented in Germany, announced by the German Emperor from the throne the same year he started plotting and preparing to conquer the world." To doctors the league wrote that the state commission was "wholesaling medical services at bargain counter prices" and that two thirds of the population would be divided up among panel doctors "whose compensation would be fixed, and whose services would be supervised by political appointees."[52] Also prominent in the opposition were Christian Scientists, who operated through an agency financed by the insurance industry. In November 1918 the health insurance referendum went down to a thunderous defeat—358,324 to 133,858.[53]

Another promising effort failed in New York, where the State Federation of Labor and the AALL jointly sponsored a health insurance bill

with the support of Governor Alfred E. Smith and a coalition of Democrats and Progressive Republicans. In 1919 the Senate passed the bill by a vote of thirty to twenty, but it died in the House, which was dominated by conservatives. In Ohio that year the insurance commission reported in favor of compulsory health insurance, but no action was taken; in Pennsylvania, the health insurance commission made no recommendation; and in Illinois, where the state commission had conducted the most thorough investigation, it voted seven to two against any health insurance proposal.[54]

The war, though only eighteen months long for Americans, proved to be the graveyard of an already faltering Progressive movement. It diverted attention from social reform, channeled the enthusiasm for doing good into a crusade abroad, and divided the old nationalist Progressives like Roosevelt from the more pacifist and isolationist elements of the movement. In the red scare immediately after the war, when the government attempted to root out the last vestiges of radicalism, opponents of compulsory health insurance associated it with Bolshevism and buried it in an avalanche of anticommunist rhetoric. Then, along with most other Progressive causes, health insurance vanished in the complacency of the 1920s.

Why did Progressive proposals for health insurance fail? Clearly the war cannot provide the whole explanation. The opposition was growing even beforehand. The early optimism may have been an illusion caused partly by the time it took opponents to organize a concerted response. Reformers themselves, conceding their own political naiveté, later looked back on their defeat as the work of special interests, mainly the doctors and the insurance companies. Writing in 1931, Rubinow recalled that reformers had been "intoxicated" by their success with workmen's compensation and failed to appreciate the opposition that employers, insurers, and others would raise. "Nothing can be more damaging in a military campaign than the failure to appreciate the strength of the enemy," Rubinow wrote, "except it be the failure to recognize the allies the enemy might acquire." Workmen's compensation had proved to be more expensive than reformers had anticipated, and health insurance would have cost employers, Rubinow admitted, "many times as much."* Businessmen could see on which side of the balance sheet such costs would go; they could not see the gains, which were indirect. The

*The AALL had estimated the cost of its program, including sick pay, medical aid, and maternity and funeral benefits at only 4 percent of wages, but in its Chicago survey, the Illinois commission found it would cost 7.5 percent of payroll just to cover lost wages and medical care.[55]

insurance companies "suddenly realized the tremendous possibilities of the field for themselves"; the inclusion of the funeral benefit was "a grave, tactical error because of the implied threat to the gigantic structure of industrial life insurance." The doctors got "panicky." Minor but vocal groups, such as Christian Scientists, entered the opposition out of fear that a government program would limit religious and medical freedom. "All these fears, some justified, some exaggerated, and some altogether fanciful, produced such a confusion of group conflicts that only a clear recognition of the need by the millions of American workmen might have overcome it, and that clear recognition was lacking."[56]

But the view that interest groups killed health insurance—true enough as a description of what happened—neglects the prior question of why these and other groups interpreted their interests as they did. Some historians treat these interests as if they were self-evident.[57] But the three main opponents—the medical profession, labor, and business—all had conflicting and ambiguous interests that made them initially uncertain and divided about what position they ought to take. That the AMA could have initially approved health insurance, while the AF of L opposed it, suggests how complex the identification of group interests may be. Some doctors believed health insurance would increase their incomes, and some labor leaders believed it would inhibit working-class organization. While these interpretations of their groups' interests were ultimately rejected, they were not self-evidently mistaken. Moreover, in European countries the interest groups analogous to the opponents in America often turned out to benefit materially from government health insurance programs. For example, the insurance industry in England ended up profiting from a health insurance system that permitted private firms to play a major role in carrying cash benefits.[58] Employers benefited from the greater political stability and diminished labor turnover that health insurance helped bring about. It is not difficult to imagine how American state legislators might have passed a health insurance program that would have enriched both insurance companies and doctors and, in the long run, strengthened the economic system. So it is not at all clear why doctors, insurance companies, and employers interpreted their interests as requiring the defeat of health insurance, when by its modification they might have satisfied those same interests.

Ideology, historical experience, and the overall political context played a key role in shaping how groups identified and expressed their interests. These factors are readily apparent if we compare the failure of health insurance in America with its earlier successes in Europe.

In neither Germany nor even Britain was the idea of compulsory health insurance fundamentally contested when it was originally proposed. The opposition did not suggest, as in America, that health insurance would subvert individual initiative and self-reliance. Many of the same groups as in America criticized the plans, but they concentrated on amending provisions that threatened to alter established relations of power. In Germany, the opposition, including conservatives and businessmen as well as socialists, resisted Bismarck's efforts to use social insurance to enhance the power of the state; and in its final form, health insurance was operated by decentralized sickness funds, rather than the imperial insurance office.[59]

The establishment of compulsory insurance in Britain also required compromise with private interests. The insurance companies and the doctors objected to the privileged role that Lloyd George's original plan gave the friendly societies. The insurance firms were worried that the friendly societies would gain an edge in selling life insurance, and the doctors had long chafed under the power the friendly societies exercised in the provision of medical service. So, splitting the program in two, Lloyd George satisfied the objections of the insurance companies by allowing them to carry cash benefits, and he met the objections of the doctors by placing control of medical benefits in the public sector under local committees on which the physicians were given representation. Thus the shift of medical care into the public sector in Britain arose partly because of the doctors' desire to liberate themselves from a form of client control. Dealing with educated civil servants may have been more palatable than dealing with the working-class officers of friendly societies. Moreover, as an incentive for cooperation, Lloyd George gave the doctors a large boost in income by increasing their rates of compensation. Even so, the British Medical Association, out of touch with its membership, called a last minute strike against the government. But the revolt fizzled as long-impoverished general practitioners found they could increase their incomes an average of 50 percent by signing up on panels to care for the insured.[60]

American doctors faced no dominating purchaser, like the friendly societies, from whom a government program might offer escape. The doctors' experience with contract practice and workmen's compensation was sufficient, however, to persuade them that any financial intermediary would like nothing better than to pay them as little as possible. So their own past strongly biased them against any extension of organized financing. "My own experience in speaking to physicians," wrote the chairman of the California commission in a private letter in 1918, "is that the only questions they ask are questions of detail . . . how much money they would get, whether they would have to get up nights at the demand of whoever called them . . ."[61] Progressive proposals, furthermore, caught the physicians in transition to more secure economic status; during the war, their incomes rose significantly.[62] Any positive economic incentive they might have had for favoring health insurance was diminishing.

The structure of government and the demands of politics, however, were of overriding importance in shaping the strategy of the opposition. In America, there was no comparable unification of political authority to compare with the power of Lloyd George or Bismarck. Even if an American president had wanted health insurance, he would not have had the leverage to force the opposition to compromise. Only a more serious threat to political stability in America could have so changed the terms of debate as to force interest groups to work within the framework of reform instead of against it. In the absence of such a threat, employers saw the immediate costs but not the distant and less certain gains, and their opposition, particularly through the National Civic Federation, was probably decisive. Workmen's compensation had won approval only after employers had found the liability system too erratic and unpredictable in its costs to serve their interests.[63] Had there been more of a socialist challenge, employers might have revised their views of the possible benefits of other social insurance programs, including health insurance. The physicians would have understood that some reform was unavoidable and worked to secure as favorable a plan as they could. Indeed, this was their initial reaction, but the more uncertain the passage of health insurance became, the more categorical became their opposition. Defeating health insurance in toto by opening up the ideological issues left uncontested in England and Germany was a safer strategy for the opponents than working within the framework of reform in the hope of turning it to their advantage.

EVOLUTION IN DEFEAT, 1920–1932

While the movement for compulsory health insurance slept through the 1920s, major changes were taking place in the economics of medical care as well as in American society and politics. So when the movement reawakened in the next decade, the reformers became engaged in a new and different struggle. The lessons of controversy and defeat, the

growing costs of medical care, and the now formidable political influence and cultural authority of the medical profession brought about a subtle shift in the objectives of health insurance and the strategy of its advocates.

Though the broad objective of health insurance continued to be relieving the economic problems of sickness, the focus of reform shifted from stabilizing income and increasing efficiency to financing and expanding access to medical care. By the thirties, most of the leading figures in the movement regarded medical costs as a more serious problem than the wage loss of sickness. The reformers still favored cash benefits in sickness, but relegated them to subordinate importance and suggested their administration be entirely separate from coverage of medical expenses. In another change that narrowed the focus to medical care, they dropped the funeral benefit as politically impractical. The pursuit of social efficiency was now tempered by a greater willingness to accommodate likely interest-group opposition. By this time, reformers also did not rest their case on the dubious claim that by providing incentives for public health, health insurance would reduce the net costs of illness to society and actually increase profits and wages. They were now more prepared to grant that under an insurance program the social costs of medical care would be unlikely to diminish. Instead, they justified health insurance on the grounds that it would make more predictable and manageable the uncertain and sometimes devastating costs of medical care to individuals. It would also, they said, give Americans the means to provide for their "unmet medical needs." Furthermore, whereas the Progressives had limited health insurance to wage earners and their families, reformers now extended the proposal to the middle class as well. These changes, especially the last, signified a basic departure from the traditional European conception of health insurance as a form of income maintenance and stimulus to productivity for the industrial working class. And in Europe, too, health insurance, beginning as a program for wage earners, was gradually becoming a system of financing medical care for the entire population.

The shift in concern among American reformers from the wage loss of sickness to medical expenses reflected an objective change in the ratio of the two costs, particularly for the middle class. Estimates at the end of the 1920s now showed that medical costs were 20 percent higher than lost earnings due to sickness for families with incomes under $1,200 a year and nearly 85 percent higher for families with incomes between $1,200 and $2,500. The relatively higher cost of medical care, wrote the medical economist I. S. Falk, was "a new condition, different from what

prevailed in other times and in other countries" when they instituted health insurance programs.[64] Writing in 1937, Michael Davis commented, "The development of health insurance has shown a steady but slow change from the economic to the medical emphasis." According to Davis, not only was medical care now a bigger item in family medical budgets than wage losses, but coverage of medical expenses was more important than income protection because medicine had become so effective in relieving suffering and promoting health.[65]

The increasing attention to medical costs preceded the Depression and the revival of the health insurance movement. In 1934 Davis noted the "paradox" that concern about medical costs had emerged during the prosperous twenties and "that most published complaints regarding the cost arose from the middle class."[66] This new development is the key to explaining the new direction of the health insurance movement.

The rise in medical costs had its origins before the conflict over Progressive health insurance plans, but not until the twenties did the middle class feel the impact and reformers appreciate the change. The increase came in the costs of both physicians' services and hospital care. The cost of physicians' services rose because of both improved quality (as a result of scientific advance and greater investment in required education) and increasing monopoly power (as a result of licensing restrictions and other practices that by the 1920s were giving doctors significantly higher returns than their investment in education would have justified).[67]

The rise in hospital costs had its origins in the complete transformation of hospital care at the turn of the century, but hospital charges to patients were still relatively low when the Progressive era insurance plans were formulated. Among 211 families surveyed in 1918 in Columbus, Ohio, by the U.S. Bureau of Labor Statistics, hospital costs averaged only 7.6 percent of a total medical bill averaging $48.41 (of which about half went to physicians).[68] Consequently, the Progressives gave little attention to hospital costs or the problems of hospital reimbursement. By 1929, according to a much larger national study, hospital charges (not including doctors' and private nurses' hospital bills, were 13 percent of a total family medical bill averaging $108.[69] In 1934 Davis estimated hospital charges plus physicians' bills for in-hospital services at 40 percent of total family medical expenditures.[70] Some of the increase over the levels in 1918 may be laid to an increased volume of hospital services and higher unit costs, and some to the increased tendency of hospitals to impose charges for services that previously were given below cost or as charity.

But increasing average costs do not tell the whole story. The key new development was the increasing *variation* in costs, as a result of the infrequent but exceptionally large expense of hospitalized illness. These high bills for hospitalized illnesses were precisely what hit the middle class in the twenties and changed the political complexion of the health insurance issue. As of 1929 only one person in seventeen was hospitalized in the course of a year, but illnesses that required hospitalization accounted for 50 percent of all charges for medical care. In urban families with incomes of between $2,000 and $3,000 a year, medical charges averaged $261 if there was any hospitalized illness, but only $67 if there was none.[71] A small but significant number of families were now faced with bills that amounted to a third or half their annual income. As Davis wrote, "In former years when the range of sickness costs was lower, and few illnesses caused high expenditures, families with middle-class income felt financial pinch due to sickness much less frequently than today. Now people who are economically secure . . . against all ordinary demands, are not secure against the costs of sickness. Thus, the economic problems of medical care now implicate not merely wage-earners but the whole population." As a result, Americans needed a "new approach" to health insurance "because the costs of medical care now involve larger sums of money and affect more people than does wage-loss due to sickness."[72]

The decade of the twenties saw another development, long in the making, come to maturity and change the context of the health insurance debate: the consolidation of professional power. During and after the First World War, as I noted earlier, physicians' incomes grew sharply; and their prestige, aided by the successes of medical science, became securely established in American culture. The twenties were a decade when legislators, district attorneys, AMA publicists, and public health officials took up the war against "quackery" as a great cause of enlightened government and exposed and prosecuted "cultists" and operators of diploma mills.

The growing influence of the medical profession was evident in the fate of one of the few government programs enacted over the AMA's protests. In 1921 women reformers, taking advantage of the new power of the female franchise, persuaded Congress to pass the Shepherd-Towner Act, which provided matching funds to the states for prenatal and child health centers. These centers, staffed mainly by public health nurses and women physicians, sought to reduce rates of maternal and infant mortality by giving pregnant women advice on personal hygiene and infant care. As the historian Sheila Rothman writes, "Advances in health care were to come not from the construction of hospitals, medical research, or the training of medical specialists—or even from new cures for disease. Rather, educated women were to instill in other women a broad knowledge of the rules of bodily hygiene and in this way prevent the onset of disease." But private physicians began to take an increased interest in these functions, and in 1927 the AMA was able to persuade Congress to discontinue the program.[73]

A third development affecting medical care also became clearer in the 1920s, though it, too, had been in progress for more than two decades. This was the gradual depletion of physicians in rural areas as a result of migration to cities and the diminishing output of medical schools. As the importance of hospitals to medical care became more widely recognized, the inadequacy of rural facilities also drew increasing criticism.*

The growing concern in the twenties about the costs and distribution of medical care prompted the formation of a privately funded commission that represents one of the key landmarks in the development of medical policy. Significantly, the group called itself the Committee on the Costs of Medical Care. (In the Progressive era, it would have been the Committee on the Costs of Illness.) An independent body, the CCMC was created by some fifteen economists, physicians, and public health specialists, who met in April 1926 at a conference on medical economics in Washington, D.C. They designated a smaller committee, including Michael Davis, law professor Walton Hamilton, and public health professor C-E. A. Winslow, to formulate a plan of studies. A year later, the group—soon to number almost fifty and to include prominent members of the professions and representatives of major interest groups—agreed to seek financial support from foundations for a five-year program of research. The committee chose as its chairman Ray Lyman Wilbur, a physician who was president of Stanford University and Hoover's secretary of the interior. A prominent figure in the Republican Party as well as a past president of the AMA, Wilbur was ideally suited to make the committee respectable and newsworthy and to buffer it against criticism of possibly "socialistic" tendencies. He was also instrumental in raising over $1 million from eight foundations.

Many of those who founded and served on the committee, worked on its staff, or helped finance its research supported compulsory health insurance. Wilbur himself, though not prominent in the movement, had spoken in favor of the California health insurance referendum in 1918. But what turned out to be more central to the committee's viewpoint was a belief that medical care needed better organization. A pre-

*On these developments in the 1920s, see Book One, especially Chapter 3.

view of its perspective came from Harry H. Moore, who left the Public Health Service to become the committee's staff director. In *American Medicine and the People's Health*, published in 1927, Moore argued that despite the progress medicine had made, its services were maldistributed and badly organized. There was no coordination beyond the walls of any particular hospital or clinic. "[W]hat exists is not so much a system as a lack of system," Moore wrote, in a line that would be echoed by liberal reformers for the next half century.[74]

Sensitive to the risk of arousing opposition, the founders of the committee chose to concentrate on factual research and to "engage collaboration in quarters which would otherwise be closed to them," as one private observer wrote in 1927.[75] So anxious were they to gain the confidence of the medical profession that the organizers of the CCMC included among their members seventeen physicians in private practice, plus the AMA's secretary, Olin West. In conducting research, they enjoyed the cooperation of the AMA, the Metropolitan Life Insurance Company, and other private organizations.

During its five years, the committee published some twenty-seven research reports providing the most detailed information yet assembled on medical care in America. It gave the first reliable estimates of national health expenditures (about $3.66 billion a year in 1929, or about 4 percent of national income, which worked out to approximately $30 per capita) and the first reliable breakdown of the "medical dollar" (29.8 cents to private physicians, 23.4 cents to hospitals, 18.2 cents to medicines, 12.2 cents to dentists, 5.5 cents to nurses, 3.4 cents to "cultists," 3.3 cents to public health, 4.2 cents miscellaneous). From a survey of nine thousand white families, the committee's staff determined that while 13.8 percent of people in families with incomes over $10,000 a year received no medical care in the course of a year, the comparable figure for families with incomes under $1,200 was 46.6 percent. The committee also showed how unequally costs were distributed: The 3.5 percent of families with the largest medical bills paid one third of the cost of medical care in the country.[76] And in studies of different organizations (private group clinics, industrial medical programs, moderate-rate hospital plans) and of different communities around the country, the CCMC provided case studies of alternatives and experiments then in progress.

Yet in the committee's militantly objective research, admirable as it undoubtedly was, there were biases—unacknowledged and perhaps unconscious. These were particularly evident in the committee's treatment of two subjects: the need for medical care and the problem of power.

The committee estimated the need for medical care on the basis of data on the incidence of disease and a panel of physicians' judgments of the appropriate forms of treatment. From higher rates of disease the committee inferred greater need for medical care, not considering the possibility that a high incidence of illness might indicate even greater needs for changes in nutrition, improved hygiene, better housing, or more healthy working conditions.[77] In determining the need for medical care by asking doctors what levels of treatment were appropriate, the committee took the perspective of the individual practitioner as the basis for the social allocation of resources, even though other responses besides medical care might have reduced the level of illness more effectively and at lower cost. The committee assumed that doctors could set purely "technical" standards for medical care, independently of any economic analysis, as if achieving those standards in medical care would not cost money that might be spent to promote health in other ways.

"The real need for medical care is a medical, not an economic, concept," wrote Roger I. Lee and Lewis and Barbara Jones in their influential report for the CCMC on the determination of medical needs. "It can be defined only in terms of the physical conditions of the people and the capacities of the science and art of medicine to deal with them. Thus, it is not always a conscious need, still less an active desire backed by willingness to pay. The ordinary layman lacks the knowledge to define his own medical needs and can rely only on the expert opinion of medical practitioners and public health authorities."[78]

And as if to emphasize that their understanding of the needs of society was defined by the cultural authority of medicine, the authors proceeded to say that such a technical definition of the need for medical care was valid only in a society like America which believed in "the efficacy of scientific medicine" in promoting health. "Against an entirely different social background, as for example in modern India, need would represent merely the expression of a narrow professional opinion and would bear no relation to the 'needs' of society." In America the need for medical care could properly be defined by physicians because Americans "value health and have accepted the science and art of medicine as the proper instrument for its advancement."[79]

The committee's approach, not surprisingly, produced exceedingly high estimates of the needs for different types of medical services. Indeed, basing its judgment on the "reasonable standards" of its medical experts, the committee found that nobody was getting enough medicine: "[E]ven among the highest income group," the CCMC said in its final report, "insufficient care is the rule."[80] Ignorance as well as poverty prevented people from receiving as much professional attention as they

should. "The amount of care which people need is far greater than that which they are aware of needing, and greater than that for which they are able to pay under present conditions."[81]

Since everyone needed more medical care, the proportion of national resources going to medicine would have to be increased. This was one of the central messages of the CCMC, and it was seen as a general principle: As national wealth increased in the future, greater rewards would come if income were spent on services, including medical care, rather than on commodities. Indeed, instead of health insurance merely being a means of covering existing costs, as the Progressives had seen it, the CCMC now spoke of insurance as a way of budgeting larger expenditures. Introducing the final staff report, Wilbur wrote, "More money must be spent for medical care; and this is practicable if the expenditures can be budgeted and can be made through fixed periodic payments—even as people are enabled to spend more for other commodities by installment than by outright purchase."[82] This was the new expansionary function of health insurance—not to maintain incomes, but to expand the use of medical care.

The implications of this growing expenditure on medical care for the power of those who controlled it, the committee did not explore. Like many other studies presented as objective research, the CCMC report was innocent of any critical reflection on the problems of power. Its positive evaluations of industrial medical services in cotton-mill towns and elsewhere never mentioned the role that such welfare programs played in consolidating the employers' control over their workers. In recommending the establishment of community medical centers, the CCMC final report suggested that the method of administrative control, whether similar to self-perpetuating hospital boards or to popularly elected school boards, was "relatively immaterial, so long as the members are interested, competent, devoted to the general good, and free from political interference."[83] The writers of the report also had a deep abhorrence of any competition among medical plans. Though they approved of prepaid group practice plans, they noted as one serious disadvantage the "increased opportunity for clinics to engage in competition as to price," which the committee thought "disastrous to professional standards and therefore to the welfare of patients."[84] Nowhere in the report was there any mention of the risk that the medical profession might exercise monopoly power.

Given such assumptions, the committee's conclusions should not be a surprise, though they do not fit neatly into the categories of political analysis. The members of the committee were not simply (to use Robert Alford's terms) "corporate rationalists," "professional monopolizers," or "equal health advocates." The CCMC report exhibits elements of each such tendency: It favored reducing economic barriers to medical care, turning over power to professionals, and rationally organizing medical care on a bureaucratic model.

The final report of the committee, endorsed by thirty-five of its members, called for the promotion of group practice and group payment for medical care. But though it endorsed group payment, the report opposed compulsory health insurance. A compulsory program, the majority said, would require an "unprecedented" subsidy from government, employers, or both to reach American standards of medical care. Voluntary plans were desirable as a first step, and it would be better to develop strong group practice organizations "before insurance becomes compulsory" since an insurance system, if established immediately, would tend to freeze individual practice in place. In a somewhat vague explanation of financing, the majority proposed that local governments contribute a share of the costs of group payment plans for low-income individuals "on a per capita or lump sum basis, assisted where necessary by the state or Federal government."[85] Eight signers of the majority report dissented on this issue alone, arguing that voluntary insurance would later block a compulsory plan and would never cover the poor "who most need its protection." Two other Progressives, Hamilton and Sydenstricker, dissented from the entire report.[86]

But the sharpest dissent came from eight of the private practitioners on the committee, plus a representative of the Catholic hospitals, who denounced the majority's recommendations on group practice as the "technique of big business . . . mass production." Such a plan would establish a "medical hierarchy" to dictate who might practice in any community. The doctors' own recommendations—that "government competition in the practice of medicine be discontinued"; that "government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden"; and that the general practitioner be restored to "the central place in medical practice"—were based, they said, upon the conviction that the medical profession was the "essential element" in medical care and that its influence should be "upheld and strengthened." Not only did they reject compulsory health insurance; they denounced voluntary insurance as well, which they said in other countries had "proved to be only a longer or shorter bridge to a compulsory system." They favored the use of insurance methods "only when they can be kept under professional control and destructive competition eliminated."[87]

Upon the release of the CCMC reports in late November 1932, an editorial in the AMA's *Journal*, endorsing the minority view, described the

majority's proposals as an "incitement to revolution."[88] Not only the AMA treated the majority report as a radical document: *The New York Times* headlined its front-page story "Socialized Medicine Is Urged in Survey," and then quoted Wilbur as saying that medicine was on its way to some form of community organization and that the majority report was meant to keep the medical profession in control of such movements.[89] Politically, the CCMC utterly failed in its attempt to generate a new consensus for reform. The various dissenting opinions from both left and right gave an impression of discord and distracted attention from the wide area of agreement between the majority and minority views. The AMA's extreme reaction to the majority report confirmed the suspicions of many that it was risky even to advocate voluntary health insurance. Coming just as Franklin D. Roosevelt took office, the controversy over the CCMC helped persuade the new administration that health insurance was an issue to be avoided.

THE NEW DEAL AND HEALTH INSURANCE, 1932-1943

The Making of Social Security

The Depression might appear to have finally created the right conditions for passing compulsory health insurance. It revived the dormant social insurance movement as well as more radical currents in American politics. It saw not only the spread of unions, but the abandonment by the AF of L of its long-standing opposition to social insurance programs. And it brought to power a Democratic administration more willing than any previous to involve the federal government in the management of economic and social welfare.

But the Depression also revised the priorities of social reform. In the Progressive era, health insurance had been the top item after workmen's compensation on the agenda of social insurance advocates. Other Western countries generally moved on to health insurance as a natural outgrowth of insurance against industrial accidents. Old-age pensions typically came third, and unemployment insurance last.[90] But in America, with millions out of work in the thirties, unemployment insurance became the leading priority. Old-age benefits were second as a result of the movement of older Americans that had spontaneously gathered behind a retired physician, Francis Townsend, a sort of intuitive Keynesian, who proposed that the Depression be cured by giving every

American over sixty-five a monthly pension of $200 on two conditions: that they retire from work and immediately spend the money. Though it was a fantastic and implausible scheme—if carried out, it would have turned over half the national income to 8 percent of the population[91]—Townsend clubs had sprung up all over the country. Many congressmen had been obliged to pledge themselves to work for its enactment and saw Social Security as an acceptable way to escape from a commitment they had no intention of fulfilling.

Even before Roosevelt took office, there was a steady movement toward Social Security. Two states passed old-age pension laws in 1929, two more in 1930, five in 1931. As governor of New York, Roosevelt endorsed unemployment insurance in 1930; Wisconsin became the first state to adopt such a measure early in 1932. Although old-age pension and unemployment insurance bills were introduced into Congress soon after his election, Roosevelt refused to give them his strong support, waiting to prepare a program of his own. Then on June 8, 1934, he seized the initiative and announced that he would appoint a Committee on Economic Security to study the issue comprehensively and report with a program to Congress the following January. The committee was to consist of four members of the Cabinet and the federal relief administrator; it would be chaired by Secretary of Labor Frances Perkins.

Though Roosevelt indicated in his June message that he was especially interested in old-age and unemployment measures, the committee included medical care and health insurance in its research. Its subcommittee on medical care was chaired by Walton Hamilton and its technical study was directed by Edgar Sydenstricker, the two liberal dissenters from the CCMC majority report.

From the outset the prevailing sentiment on the Committee on Economic Security was that health insurance would have to wait. Edwin Witte, the staff director, recorded in a confidential memo in 1936 his "original belief" that medical society opposition precluded any action on health insurance. This view was shared by Secretary Perkins. Harry Hopkins, the relief administrator, was "more interested in health insurance than in any other phase of social insurance, but also realized that this subject would have to be handled very gingerly."[92]

Nor was this sentiment confined to members of the committee. In an article published in October of 1934, Abraham Epstein, the founder of the American Association for Social Security and a leading figure in the movement, advised the administration to be politically realistic and specifically to go slow on health insurance because of the opposition it would arouse—this from someone who later would become severely critical of the conservatism of the Social Security bill.[93]

Even the naming of Sydenstricker to direct the committee's research on health insurance caused an uproar in the medical profession. Witte recalled that "telegraphic protests poured in upon the President." An editorial in the AMA's *Journal* said Roosevelt would try to ram health insurance through Congress. But the protests stopped abruptly after the first meeting of an advisory committee on medical care that included the presidents of the AMA, the American College of Surgeons, and the American College of Physicians. This sudden quiet, which proved no more than a momentary truce, created the impression that the AMA might be willing to accept health insurance in some form. Sydenstricker had been arguing within the committee that at least part of the profession could be won over. His view gained force in the fall of 1934 when the American College of Surgeons endorsed compulsory health insurance. But once again reformers were seeing a mirage. At a National Conference on Economic Security in November, two prominent physicians who had been expected to favor health insurance, or at least not to oppose it, denounced the measure. At that point, Witte and Perkins returned to their original view that immediate action on health insurance would be politically unwise. On November 15, Secretary Perkins told the AMA that the committee's study of medical care would require additional time, which meant that no recommendations on health insurance would be presented to the president in January. The delay signaled a weakness that the AMA was able to exploit.[94]

Some members of the Committee on Economic Security and its staff thought that Congress would act quickly on unemployment and old-age programs and that health insurance could be introduced later in the same session. This expectation proved to be mistaken. Even a discussion of general principles for health insurance in the committee's January report aroused a storm of protest from the AMA. These principles included assurances that private medical practice would continue; that the medical profession would control professional personnel and procedures; and that doctors would be free to choose their patients, the method of reimbursement, and whether to participate in insurance practice. Without definitively recommending a plan, the committee listed as goals the provision of adequate medical services, the budgeting of wage losses and medical costs, "reasonably adequate remuneration" to practitioners, and new incentives for improved medical care. The system the committee envisioned was to be state administered, and state participation would be optional. The role of the federal government was to provide subsidies and set minimum standards for states that adopted a health insurance program. As the reformers now generally agreed, cash benefits in sickness would be separate, probably linked with unemployment insurance.[95]

The Social Security bill itself included only one glancing reference to health insurance as a subject the new Social Security Board might study. Nonetheless, the declaration of principles in the committee report was widely reported in the medical press as if it were a legislative proposal. Alarmed by what might follow, the AMA called a special meeting of its House of Delegates in February 1935—only the second in its history—where it once again denounced compulsory health insurance and any lay control of medical benefits in relief agencies. But in what appeared to be a small concession to moderates, the association accepted voluntary insurance plans for medical service, so long as the plans were under the control of county medical societies and followed AMA guidelines.[96]

Though sentiment in favor of health insurance was still strong among members of the Committee on Economic Security, Witte was convinced that any health insurance amendment would "spell defeat for the entire bill." The president shared this judgment, and informed Secretary Perkins to file a report on health insurance, reserving for himself any decision about how to proceed. The committee's report, transmitted in June 1935, supported a program that would have been optional for the states, but compulsory for residents of those states where it was adopted. But in a separate letter, recognizing how "controversial" the subject was, Secretary Perkins advised the report not be made public until the Social Security bill was safely passed. Roosevelt never released the report. This secrecy in itself testifies to the administration's wariness, since the committee proposed giving only "small financial aid" to the states and did not suggest any legislative action until further study by the Social Security Board.[97]

The omission of health insurance from the Social Security Act was by no means the act's only conservative feature. It relied on a regressive tax and gave no coverage to some of the very poor, such as farm laborers and domestics. The standards for unemployment insurance were weak. Requirements that state pensions for the aged had to assure a "reasonable subsistence compatible with decency and health" were struck out, according to the economist and later Senator Paul Douglas, because of objections by Southern political leaders that the federal government might use such phrases to force their states to pay higher pensions to blacks than they thought desirable.[98] Though the Social Security bill finally passed both houses by a wide margin, it had a hard time in the Senate Finance Committee, where it was approved by only a few votes.

While omitting health insurance, the act extended the government's

role in public health in several provisions unrelated to social insurance. It gave the states funds on a matching basis for maternal and infant care, rehabilitation of crippled children, general public health work, and aid for dependent children under age sixteen. This last provision was to have unanticipated implications for medical care.

The Depression, Welfare Medicine, and the Doctors

Increased state and federal financing of medical services for the poor originated inadvertently and inconspicuously during the Depression. It was a hidden consequence of the failure to develop a health insurance system that would have covered the middle class and the poor alike.

The fall in personal incomes after 1929 severely curtailed the use of medical services by the poor. In ten working-class communities studied between 1929 and 1933, the proportion of families with incomes under $150 per capita had increased from 10 to 43 percent. Families whose incomes had dropped from over $425 in 1929 to less that $150 per capita in 1933 called upon physicians only half as often as did families whose incomes remained above $425 per capita throughout the entire period.[99] A 1938 Gallup poll, asking whether people had put off seeing a doctor because of the cost, found that 68 percent of lower-income respondents had done so, compared with 24 percent in the upper-income brackets.[100]

Less use of medical services and reduced ability to pay meant lower incomes for physicians. According to one study, the average net income of doctors in California fell from approximately $6,700 in 1929 to $3,600 in 1933. Nationally, according to Kuznets and Friedman, private practitioners had lost 47 percent of their 1929 incomes by 1933. A 1933 government survey compared the ratio of bills unpaid six months or more to the total number of accounts receivable for the same period for different types of creditors. The delinquency percentage for department stores was 8.9 percent; for grocery stores, 24.7 percent; for landlords, 45.1 percent; for dentists, 55.6 percent; and for physicians, 66.6 percent.[101] Not only were patients seeing doctors less often; they were paying their doctors' bills last.

Hospitals were in similar trouble. Beds were empty as utilization fell, bills were unpaid, and contributions to hospital fund-raising efforts tumbled.

So private physicians and private charities simply could no longer afford to meet the demand for free services. For the first time, they asked welfare departments to pay for the treatment of people on relief. Before the Depression, medical care had been a minor function of welfare agencies, but now it grew in significance. Beginning about 1930, medical care became recognized in many localities as an "essential relief need." Many cities and a few states gave beneficiaries a right to needed service at public expense; increasingly, welfare agencies provided supplemental payments to help defray medical costs. As federal and state relief funds became available, local hospitals and social agencies began to charge welfare departments for services previously rendered free, so the cities could get reimbursed and shift costs to the state or federal government. This system of welfare payment for medical care was seen as a temporary expedient, but it continued after the Depression ended.[102]

Yet another federal program helped pay for medical care in the farming areas of the country. In 1935 the Resettlement Administration began to set up and subsidize cooperative medical prepayment plans among the poor farmers it was assisting. The agency had found that many of its clients defaulted on loans when they fell sick. Under these programs, which in 1937 were taken over by the Farm Security Administration (FSA), the local medical society typically agreed to accept a limit on the total fees they would receive. In effect, this was government-sponsored health insurance. Barely noticed in political debate, the plans covered a quarter of the population of the Dakotas.[103]

These new developments disturbed the AMA. Never before, warned its Judicial Council in 1934, had government so invaded private medical practice as through federal emergency relief. The willingness of physicians to accept government payments "must be considered as a temporary expedient only, due to the unparalleled stress of the times, and must be discontinued as rapidly as the stress on the profession is relieved." Some state and county societies had recommended to their members that they provide services to all in need and refuse to accept compensation from the government. The AMA Judicial Council agreed: "One of the strongest holds of the profession on public approbation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. . . . The abandonment of that ideal and the adoption of a principle of service only when paid for would be the greatest step toward socialized medicine and shortly state medicine which the medical profession could take."[104] Like men ashore urging self-reliance on their drowning companions, the wealthy doctors in the AMA were asking their poorer colleagues to hold the line against health insurance.

The Depression posed a severe test for the AMA. It was no easy matter to maintain a common front against government intervention when physicians themselves were in economic difficulty. Many doctors whose waiting rooms were empty and whose bills were unpaid were now more

willing to consider some form of health insurance. In Michigan a liberal faction sympathetic to compulsory insurance gained power in the state medical society in 1932, only to face a campaign by the AMA aimed at restoring conservative control. In March 1935 the California Medical Association endorsed compulsory health insurance in a vote reported to express the views of the "little men" in the profession who knew what costs meant to patients as well as to themselves.[105] And as we have already seen (Book One, Chapter 6), in Washington and Oregon—two states where many doctors had long been out of compliance with AMA rules against contract practice—the county medical societies tried during the Depression to drive out profit-making medical corporations by setting up a health insurance program of their own.[106]

Health insurance promised to stimulate use of physicians' services and help patients pay their bills. The AMA's response to the economic crisis, however, emphasized restricting the supply of doctors rather than amplifying the demand for their services. In 1934 Walter Bierring, the incoming president of the association, recommended eliminating half the medical schools in the country.[107] That same year the AMA's Council of Medical Education warned medical schools against admitting too many students, and enrollments thereafter declined. (Each of the five years prior to 1934 had shown an increase in applicants accepted by medical schools; each of the next six years showed a drop.) In the same period, medical licensing boards adopted more rigorous standards for foreign physicians, then arriving in growing numbers in flight from the Nazis. The proportion of foreign doctors failing the examinations increased from 5.7 percent in 1930 to 20.7 percent ten years later.[108]

In effect, the reformers and the AMA were engaged in a struggle for the political loyalties of physicians. Hoping to pry loose at least part of the profession, reformers often emphasized, as a virtue of health insurance, its value to physicians in shoring up their incomes. The appeal did not succeed. None of the movements toward health insurance within the profession proved long lasting. The Michigan medical society was back in conservative hands by 1935. The American College of Surgeons quickly rescinded its endorsement of compulsory insurance after the death of its founder, Franklin Martin, who had used his prestige on behalf of the measure. The proposal endorsed by the California state association would have restricted eligibility for health insurance and vested all control in the medical profession. These conditions so aroused the opposition of reformers that they destroyed any chance of legislative approval.[109] The insurance plans adopted by doctors in Washington and Oregon, though providing service at fixed rates, were aimed at

eliminating lay-controlled competition. Therefore, even these moves toward health insurance were fundamentally in line with the AMA's objectives.

In the mid-thirties, the AMA began to adjust its position on health insurance, at least in its official pronouncements. Instead of opposing all insurance whether voluntary or compulsory, it began to define the terms on which voluntary programs might be acceptable. These terms, as we shall see in more detail in the next chapter, insisted that there be no direct intervention in the doctor's business by any financial intermediary. The AMA would countenance group hospital insurance plans only if limited to paying hospital bills, and it would allow voluntary insurance for medical service only if controlled by county medical societies. Yet while accepting such plans in principle, the AMA did nothing to encourage their development.

Despite pressures, the AMA held its membership, and it held its ground. Though between 1930 and 1935 the proportion of doctors belonging to the association fell from 65.1 to 60.8 percent, five years later membership reached 66.8 percent, higher than ever before.[110] The ties that bound physicians to the AMA, as I indicated earlier, were based on career imperatives as well as a shared professional culture. Membership in the local medical society, which required membership in the national organization, was the key to hospital privileges and patient referrals as well as malpractice liability protection. The inner fraternity who typically controlled the local society discouraged wayward tendencies. The AMA was a democratic organization, but in the 1920s and 1930s, as Oliver Garceau showed in a careful study of its internal political life, the association was dominated by an "active minority" composed primarily of urban specialists. These physicians ran its governing councils and were disproportionately represented among the long-term members of its House of Delegates. They had little use for dissent. Votes in AMA meetings and elections were typically unanimous; dissenting opinions were seldom recorded in its proceedings and almost never given any space in its journal. "The basic attitude of the active minority," wrote Garceau, "appears to be that the differences of opinion are dirty linen. Quite understandably they wish to keep dirty linen from public inspection."[111]

How well this active minority represented professional opinion is unclear. A 1938 Gallup poll was widely reported as showing that seven out of ten doctors actually favored compulsory health insurance, but the survey had asked only about voluntary insurance, and the significance of the finding is uncertain because the question asked was so vague.[112] Undoubtedly, more doctors disagreed with the AMA's policies than its

leadership acknowledged, but fewer than the reformers hoped for. Most physicians were politically inactive and seemed content to let a small group of financially successful specialists set policy for the profession.

Aside from the few doctors who belonged to the socialist American League for Public Medicine, the only significant organized dissent from AMA policies emerged in 1936–37 among a group of liberal academic physicians calling themselves the Committee of Physicians for the Improvement of Medicine. In a short statement of "Principles and Proposals" signed by over 400 doctors by the fall of 1937, the group recognized that health was a "direct concern of the government" and called for the formulation of a national health policy. They urged that public funds be used to finance medical education and research; laboratory, diagnostic, and consultative services in hospitals; preventive and public health work; and medical care for the "medically indigent." By no means a radical organization, the committee did not declare in favor of compulsory health insurance, though some who signed the committee's statement supported it. The distinguishing feature of the group's position was its emphasis on education, research, group practice, and hospitals in contrast to the AMA's celebration of the individual practitioner.[113] In 1938 John Peters, the committee's secretary and Ely Professor of Medicine at Yale, author of over 200 scientific articles, told the American College of Surgeons that the practitioner had fallen "almost completely into the derivative position of distributor or dispenser" of medical care. Educational and research institutions had taken over the "productive services" of medicine, and no program for improving medical care that considered "only the distributors to the neglect of these productive services" could be satisfactory. "It is a little tiresome," Peters went on, "to hear from our professional publicists of medicine that only practitioners have any comprehension of the problems of medical care .... They exploit scientific services to which they have contributed nothing."[114]

Though it had little political influence at the time, the Committee of Physicians foreshadowed the emphasis on medical research and hospital care that was to pervade government policy after 1945. Some reformers, however, misread the patrician liberalism of academic physicians as a sign of a deep rift in the profession that might aid their cause. The AMA itself seems to have overreacted. Before the initial statement of the Commitee of Physicians was released, the AMA's *Journal* denounced the group, insinuating that they had obtained signatures by devious and deceptive means.[115] Yet while some of the dissidents used acerbic language to describe the profession's leadership, the committee never split off from the AMA, nor did it presage widespread professional acceptance of government-sponsored health insurance. It did, however, shatter the image of a unanimous profession that the AMA was trying to project. In that respect, the Committee of Physicians contributed to the pressure that led the AMA in 1938 to make its biggest concessions to reform, as it sought anxiously to stop what now seemed like the most serious movement yet toward compulsory health insurance.

A Second Wind

The new push for health insurance in the late thirties developed within the Roosevelt administration, though it never received the president's full backing. In 1935 an Interdepartmental Committee to Coordinate Health and Welfare Activities, consisting of assistant Cabinet secretaries, had been set up to oversee the various federal social programs that had grown up helter skelter in different agencies. The Public Health Service was then located in the Treasury Department; the Social Security Board was an independent agency; and the Children's Bureau, which dealt with maternal as well as child health, was to be found, perhaps appropriately, in the Department of Labor. Chaired by Josephine Roche, assistant secretary of the Treasury, the Interdepartmental Committee first concentrated on coordinating programs and then turned to a study of the nation's health needs. In March 1937 it established a Technical Committee on Medical Care, which several months later it authorized to formulate a national health program. Following the CCMC and the Committee on Economic Security, this was now the third group in ten years to take on the task. I. S. Falk, who had been on the staff of the two previous committees, represented the Social Security Board in this new effort and was the chief spokesman within it for health insurance. The Public Health Service had three representatives; the fifth member and chairman was the assistant chief of the Children's Bureau, Martha Eliot.

These agency affiliations are important to keep in mind because of a new element in the politics of health insurance: internal conflict among government bureaucracies over the priority of health insurance versus other programs. At the inception of the committee's work, Dr. Eliot suggested that instead of all working together, they work separately on the sections of the program that would affect their particular agencies—an indication of the narrowing allegiances that would characterize health politics for many years to come.[116]

The Technical Committee's final report resembled the recommenda-

tions made by the Committee on Economic Security three years earlier. Like the earlier committee, it favored subsidies to the states to operate health programs instead of a national insurance system. It proposed (1) expanded public health and maternal and child health services under the Social Security Act; (2) expansion of hospital facilities through federal aid to the states for construction and three years of operating support; (3) increased aid for medical care for those on relief and others who had no funds for health care; (4) consideration of a general medical care program supported by taxes, insurance, or both; and (5) federal action toward a program of compensation for wage losses due to temporary or permanent disability. These recommendations were not entirely consistent—if the fourth were fully carried out, the third would not be necessary—and the committee recognized that they could not all be put into effect immediately. The first two were deemed most important. The report withheld as complete support for health insurance as it gave to other measures.[117]

The president decided to make public the part of the committee's report that described the nation's health needs and to call a conference in Washington, D.C., on the national health program. This conference, which convened in July 1938, represented an important moment for reformers in their drive for public attention. The conference brought to Washington over 150 representatives of labor, farmers, and the health professions—though not, as AMA Secretary Morris Fishbein told the hosts, American business—in what the AMA construed to be an effort to orchestrate support for a predetermined agenda. And though the delegates were concerned most about the programs that directly affected them, they strongly supported the Technical Committee's view of the nation's health needs and its entire program.

So concerned was the AMA about the public response to the National Health Conference that the following Sunday its representatives met with the Interdepartmental Committee to offer a deal. They would support all the other recommendations if the committee would agree to drop compulsory health insurance. The committee declined this offer.[118] The AMA then called another emergency session of its House of Delegates, which for the first time approved protection of loss of income during illness as well as cash indemnity insurance, so long as it met the approval of county and state medical societies. It also endorsed the expansion of public health services and even recognized that federal aid might be required for the care of the medically indigent, though these efforts had to remain under local authority.[119] The aim of this new and more receptive stance was plainly to isolate compulsory insurance from other issues and thus to bring about its defeat. The AMA then succeeded in gaining support for its new position from other organizations, including the American Public Health Association. The APHA, reflecting differences of opinion about the legitimate boundaries of public health, was divided between those who believed public health required a concern for medical care and those who believed that public health came first and medical care was best left to clinicians.[120]

The AMA could not have known that events unrelated to medical care were about to make its conciliatory stance politically unnecessary. Initially, Roosevelt's reaction to the National Health Conference was so enthusiastic, according to Arthur Altmeyer, chairman of the Social Security Board, that the president wanted to make the national health program an issue in the 1938 election. Then he changed his mind and said maybe it would be better to wait until the 1940 presidential election.[121] Yet Roosevelt never made it an issue in either. The 1938 elections brought a major conservative resurgence. From that year on, conservative Dixiecrats and Republicans formed a congressional alliance that made any further innovations in social policy extremely difficult. Almost all major New Deal legislation dates from before 1938. Thereafter, the administration lost influence with Congress and turned its attention to foreign affairs. Shortly after the 1938 election, Roosevelt sent the national health program to Congress with a message recommending it for "careful study" but no immediate legislative action.[122]

However, in February 1939 Senator Robert F. Wagner of New York, a prominent liberal and administration ally, introduced a bill incorporating the report's recommendations. Wagner emphasized the extent of agreement between his proposal and the AMA's recent position. The only difference, he said, was health insurance, which his bill left as an option to the states.[123] But in spite of its earlier concessions, the AMA now testified against the legislation in toto. Although the Wagner bill, hardly a radical measure, was reported to face only minor opposition in the Senate, the president indicated late in 1939 that he only wanted aid for hospital construction. Whether concern about the cost or election-year implications were uppermost in his mind is unclear. In January 1940 Roosevelt sent a message recommending a modest program to construct hospitals in needy areas, but even this bill, though passed by the Senate, died in the House.[124]

So petered out the movement for compulsory health insurance after the National Health Conference. Just as the AALL's campaign ran into the declining fortunes of Progressivism and then World War I, so the campaign of the thirties ran into the declining fortunes of the New Deal and then World War II. However, more was at work in this new defeat than bad timing. Roosevelt's unwillingness to press for health insurance

was basically consistent with the pattern of his administration. The New Deal responded to organized pressures. "Roosevelt's predilection for balanced government," the historian William Leuchtenberg writes, "often meant that the privileges granted by the New Deal were in precise proportion to the strength of pressure groups which demanded them. . . . causes which were not sustained by powerful interest groups frequently made little headway."[125] In the passage of Social Security, the Townsend movement and riots of the unemployed gave old-age pensions and unemployment insurance priority. No similar pressure existed for health insurance—but there was much pressure against it.

One study of the omission of health insurance from the New Deal argues that the fundamental obstacle to its passage was that Americans were not yet ready to abandon traditional ideals of individualism and adopt the new concept of freedom that health insurance embodied.[126] There are two chief difficulties with this interpretation. The first is that the individualistic values of Americans were an obstacle to all major social insurance programs. Yet by the end of the New Deal, the United States had adopted compulsory unemployment insurance and old-age pensions as well as workmen's compensation. Health insurance was the exception, but it demanded no greater a departure from individualism than did the other programs.

The second difficulty is factual. Public opinion polls suggest that Americans were ready in the Depression and after to abandon individual responsibility for the costs of sickness. Beginning in 1936, national polls asked a series of questions about health insurance. The data from these surveys present a complex, though consistent picture.[127]

When Americans were asked whether government ought to help people pay for the medical care they need—a direct test of their belief in self-reliance—the answer was overwhelmingly yes: Three of every four people approved of such help in polls taken in 1936, 1937, 1938, and 1942. Beginning in 1943, the polls also asked whether people thought it was a "good idea" if Social Security also paid for doctors' and hospital care that Americans might need in the future. This, too, a majority approved: 58 percent in 1943 and 68 percent in 1944 and 1945.

Yet another question, however, introduced the consideration of higher Social Security taxes to pay for health insurance. When the issue was presented this way, support fell to 44 percent in 1943 and 51 percent in 1945. In still another variation, respondents were asked to choose between "a plan set up by the government which would require every person to take part" and "a plan set up by the medical profession which would include only those persons who were interested." The private plan gained a slight edge among respondents in 1944 and 1945

when higher taxes were also mentioned in connection with the government program, while in another poll, which omitted reference to taxes, a majority supported national health insurance. Finally, yet another type of survey question asked for open-ended responses about what "could" or "should" be done about making it easier to pay medical bills. In two such surveys only about 13 percent spontaneously came up with national health insurance.

These different survey results allowed both advocates and opponents of national health insurance to claim majority support, so in 1945 the Opinion Research Corporation made a careful attempt to find out more exactly what people thought. It asked people three questions in succession: first, whether they thought it was a good idea if Social Security paid for medical care that people might need in the future; second, whether it was a good idea if some "pay-in-advance plan for doctor and hospital care were offered by insurance companies through employers all over the country"; and third, whether it would matter much which plan was offered, and if so, which would be better? The answers were revealing: 68 percent thought extending Social Security was a good idea; 70 percent approved of private plans; and, in answer to the final question, 35 percent chose Social Security, 31 percent the private option, 17 percent said it wouldn't matter, and another 17 percent gave "qualified" answers or no opinion.

These polls suggest that while a majority would have accepted and approved national health insurance, only about a third of the population clearly preferred it to a private system. Public approval existed, but strong sentiment in favor did not. However, there was no clear preference for private plans, and so public opinion does not account, in any simple fashion, for the outcome of the conflict.

In a revealing remark to a key Senate committee chairman in 1943, Roosevelt said, speaking of health insurance, "We can't go up against the State Medical Societies; we just can't do it."[128] Whether or not the president could have successfully challenged the AMA is an impossible question to answer. Altmeyer, who was intimately involved in the decisions, believed the president's judgment was right in 1935 but wrong in 1938. He later wrote that after the National Health Conference the administration could have secured favorable congressional action "if the President had actively supported" Wagner's bill.[129] At that moment, the obstacles to health insurance may have been more political than structural—that is, more a matter of a political judgment than of the kind of overwhelming opposition that blocked reform during the Progressive era. But hindsight, of course, is cheap, and reformers may also see mirages in the past.

SYMBOLIC POLITICS, 1943–1950

Socialized Medicine and the Cold War

Compulsory health insurance had stood on the periphery of national politics throughout the New Deal—omitted from Social Security, never fully backed by the president, subordinated to other programs even by many reformers. In the 1940s the issue finally moved into the center arena of national politics and received the unreserved support of an American president. But the opposition also acquired new strength. For now compulsory health insurance became entangled in the cold war, and its opponents were able to make "socialized medicine" a symbolic issue in the growing crusade against communist influence in America.

The shift to the national arena was written into health legislation in the forties. Even as late as the Wagner bill of 1939, reformers were still proposing health insurance as a state option. But by the early forties, as it became clear the Supreme Court would accept a national program, the advocates of reform felt less constrained by possible states' rights objections. They finally proposed that health insurance be operated as part of Social Security. They also dropped most limitations on coverage: National health insurance was to be universal and comprehensive. These principles were incorporated into a bill first introduced in 1943 by Senator Wagner, Senator James Murray of Montana, and Representative John Dingell of Michigan.[130] The Wagner-Murray-Dingell bill also called for other changes in Social Security that were meant to bring about a system of "cradle-to-grave" social insurance comparable to the Beveridge plan then being discussed in Great Britain.

As is often the case, a new generation of reform saw a turnover in organizational leadership. After the deaths of John Andrews, who had directed the American Association for Labor Legislation, and Abraham Epstein, who had founded the American Association for Social Security, the two main organizations concerned with health insurance had disappeared. In February 1944 representatives of organized labor, progressive farmers, and liberal physicians met in the office of Senator Wagner to set up a new group called the Social Security Charter Committee. Two years later, under Michael Davis, this became the Committee for the Nation's Health.[131]

Toward the end of his life, Roosevelt had indicated that he would finally press for health insurance once the war was over. In 1944 he asked Congress to affirm an "economic bill of rights," including a right to adequate medical care. Shortly after becoming president, Truman repeated the request and in November 1945, three months after the end of the war, he called upon Congress to pass a national program to assure the right to adequate medical care and protection from the "economic fears" of sickness.[132]

Truman's plan closely resembled the national health program of 1938, but there was a difference in emphasis. The president was now strongly committed to health insurance, and he was more forthright in advocating expanded investment in the medical system. Reversing the order of the 1938 program, Truman's first recommendation called for expansion of hospitals and the second for increased support of public health and maternal and child health services. Truman's third recommendation, federal aid to medical research and education, had not been part of the earlier program. Most significant, whereas the 1938 program had a separate proposal for medical care for the needy, Truman proposed a single health insurance system that would include all classes of the society, even those like professionals, agricultural workers, and domestics not covered by Social Security. Public agencies would pay the insurance premiums of those too poor to pay for themselves. The president readily admitted that this extension of services would cost more money. Medical services "absorb only about 4 percent of the national income," Truman stated. "We can afford to spend more for health."[133]

Truman was emphatic, however, that this program was not "socialized medicine." Under his plan, he stated, "our people would continue to get medical and hospital services just as they do now."[134] Altmeyer, as chairman of the Social Security Board, said that doctors and hospitals would be permitted to choose "the method of remuneration they desire" and that doctors had the right to expect higher average earnings than they had received before.[135]

Thus the Truman program was expansionary in several senses: It aimed to expand access to medical care by augmenting the nation's medical resources and reducing financial barriers to their use, and it promised doctors higher incomes and no organizational reform. Since voluntary hospital insurance was now rapidly developing among the middle class, the comprehensive and universal features of the program became central to its identity. Unlike the Progressives, who had proposed a plan only for the working class and who sought economies in medical organization and greater efficiency for society, liberals after the New Deal were both more egalitarian on distributive issues and less radical on organizational ones.

The accommodating attitude toward physicians in the plan did not win the Truman program any support from that quarter. Immediately after the president's message, the National Physicians Committee, a

professional lobby set up in 1938 to receive contributions mainly from the drug industry, sent out an emergency bulletin calling upon doctors to resist the program. The AMA said in an editorial that Truman's health insurance plan would make doctors "slaves." In December the AMA House of Delegates offered as an alternative the extension of voluntary insurance and expanded public services for the indigent.[136]

Public reaction to Truman's plan was initially sympathetic. Among those who had heard of the proposal, 58 percent approved in national polls taken in November 1945.[137] However, more complex surveys in California and New York disclosed several points of weakness in public support for compulsory health insurance. A survey conducted for the California Medical Association in 1943 found that while a "socialized government controlled medical plan" was approved 50 to 34 percent, support for a government program fell to about one quarter when it was compared with voluntary insurance.[138] Another survey, conducted in January 1946 in New York for a legislative commission, found that the comprehensive program liberals were advocating had less support than a more modest plan.* This division in sentiment between the core supporters of health insurance and the public represented a hidden but serious political problem: What the supporters wanted most, the public was least willing to approve. Finally, all surveys indicated that support for compulsory insurance varied inversely with social class. The AMA had as its allies those who ran community organizations, the media of opinion, the large corporations.[140]

The medical profession's struggle to turn around public opinion began in California, where the liberal Republican Governor Earl Warren proposed a health insurance plan much like the one the California Medical Association had favored ten years earlier. The doctors now hired a public relations firm, Whitaker and Baxter, to combat the proposal. Explaining that "you can't beat something with nothing," the firm urged the doctors to publicize their support for voluntary insurance. It then secured endorsements from private groups and businesses and had doctors and their friends visit public officials and the heads of community organizations. During this campaign the number of papers

*The New York survey tested public reaction to four alternative proposals, each presented with estimated monthly costs. A compulsory insurance program covering all services for children, plus laboratory tests and visiting nurses for others, would have been approved 64 to 25 percent in a state referendum. A plan to cover hospital expenses for everyone would have been adopted 55 to 31 percent. The third alternative—covering the services in the first two plans, plus all surgical and maternity bills—would have passed more narrowly, 47 to 37 percent. But the most comprehensive plan, including all doctors' bills in addition to the services in the first three proposals, would have been defeated 38 to 47 percent. Yet among the respondents who supported any plan, this last alternative was preferred.[139]

in the state opposing the Warren plan increased from about 100 to 432. In an article in the AMA's *Journal*, the secretary of the California Medical Association explained that newspaper executives had at first been unsympathetic because doctors did not advertise. "We now have an answer to that," he continued, explaining that the association had begun advertising at the rate of $100,000 a year. "We have found the response from editors, in publicity, has been beyond anything we expected when we started the campaign."[141] The Warren plan was defeated.

In Congress, the reception of Truman's proposal was mixed. The chairman of the House committee was an antiunion conservative who refused even to hold any hearings, and in the Senate, hearings yielded more controversy than support. In his introductory remarks the first day, Senator Murray, the committee chairman, asked that the health bill not be described as socialistic or communistic. Interrupting, Senator Robert Taft of Ohio, the senior Republican, declared, "I consider it socialism. It is to my mind the most socialistic measure this Congress has ever had before it." Taft suggested that compulsory health insurance, like the full employment act, came right out of the Soviet constitution. When Murray refused to allow him to continue, Taft walked out, announcing that Republicans would boycott the hearings.[142]

While not as vehement as the AMA, most other health care interests opposed the Truman plan. The American Hospital Association favored government subsidies for private insurance. Support for voluntary insurance was also the position of such groups as the American Bar Association, the Chamber of Commerce, and the National Grange as well as most of the nation's press.

Even the agencies of the federal government did not all wholeheartedly back the president's plan. The Children's Bureau was more interested in expanding an insurance program for wives and dependents of servicemen that had been started during the war. The bureau was wary of jeopardizing the future of this program by associating it with the more controversial national health bill. The medical director of the Veterans Administration opposed the Truman plan, and the chief of the Public Health Service was "decidedly cool."[143]

In 1946 Truman himself gave the proposal only occasional publicity. Even though in the spring of that year he expressed some hope that the bill would pass, its chances were nil. In August, the president signed into law the Hospital Survey and Construction Act, which carried out the first recommendation in his plan. But this part had the approval of the AMA; its approval was no sign the rest would be carried out.*

*On the hospital construction program, see Book Two, Chapter 3.

Although the supporters of the president's program said they would try again after the next election, the Republicans took control of Congress in 1946 and had no interest in enacting national health insurance. Senator Taft, who now replaced Murray as chairman of the Committee on Labor and Public Welfare, had his own plan for the nation's health: a system of welfare medicine for the poor financed by federal aid and administered by the participating states. Liberals objected that the program segregated the poor from other Americans, subjected them to a humiliating means test, and provided charity rather than the right to service which they would have under health insurance. Taft responded that his plan left most Americans to pay for medical care as they paid for other commodities. Only the poor, he argued, should be subject to "compulsory" medicine and they should "have to take it the way the State says to take it."[144] Taft, however, made no serious effort to pass his measure and may have proposed it only to gain AMA support in his bid for the presidency.

The Republicans now charged that national health insurance was part of a larger socialist scheme. In May 1947 Senator Homer Ferguson accused the administration of illicitly spending millions "in behalf of a nationwide program of socialized medicine." A House subcommittee investigating government propaganda for health insurance concluded that "known Communists and fellow travelers within Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line." The charge centered on one employee on I. S. Falk's staff who had written a positive account of socialized medicine in New Zealand. The Federal Security Administrator immediately called off a trip by the suspect employee and ordered an FBI investigation, which later cleared him of any communist affiliations.[145]

If the Republicans used health insurance as a symbolic issue for political purposes, so did Truman. The president and his aides focused more attention on the national health bill as the 1948 election approached. FSA Administrator Oscar Ewing convened yet another conference to define the nation's health needs. Though this National Health Assembly only endorsed voluntary insurance, Ewing transmitted a final report to the president reaffirming the need for his original program.[146] In his campaign, Truman cited national health insurance as an example of the Republican "do-nothing" Congress that had obstructed his best efforts to secure liberal programs. Fighting to keep votes from the left-wing Progressive candidate Henry Wallace, Truman continually hammered at the issue, promising national health insurance if the Democrats were returned to power.

After Truman's surprise victory, the AMA thought armageddon had

come. It assessed each of its members an additional $25 just to resist health insurance and hired Whitaker and Baxter to mount a public relations campaign that cost $1.5 million in 1949, at that time the most expensive lobbying effort in American history. As in California, Whitaker and Baxter used pamphlets, the press, public speakers, and private contacts to stress that voluntarism was the American way and to persuade private organizations—1,829 of them, according to its count—to endorse the AMA position. "Would socialized medicine lead to socialization of other phases of American life?" asked one pamphlet, and it answered, "Lenin thought so. He declared: 'Socialized medicine is the keystone to the arch of the Socialist State.' "[147] (The Library of Congress could not locate this quotation in Lenin's writings.) So successful was the campaign in linking health insurance with socialism that even people who supported Truman's plan identified it as "socialized medicine," despite the administration's insistence it was not. Support in public opinion polls, among those who had heard of Truman's plan, dropped from 58 to 36 percent by 1949; three quarters of those who had heard of the plan knew of the AMA's opposition.[148] As anticommunist sentiment rose in the late forties, national health insurance became vanishingly improbable.

Yet compromises were available that might have faced less opposition. In November 1947 the financier Bernard Baruch recommended a national system of voluntary health insurance for high-income Americans and compulsory insurance under Social Security for low-income people, an arrangement common in many Western countries and similar to the original Progressive era proposals. Because of possible business support for Baruch's plan and the likely approval of some Southern Democrats, Michael Davis urged it be given consideration. The AF of L was willing, if necessary, to exempt families with incomes over $5,000 a year as well as farmers. This compromise, however, was doomed as Truman's breach with Southern Democrats over civil rights widened.[149]

A second compromise, sponsored by several Republicans in Congress, including Senator Jacob Javits of New York and Representative Richard Nixon of California, called for a locally controlled, government-subsidized, private nonprofit insurance system, with premiums scaled to subscribers' incomes. Unlike other Republican proposals, this one had no means test. Altmeyer later wrote that the Democrats made a serious mistake in not seeking a compromise of this sort.[150] Another proposal for subsidizing the purchase of private insurance by the poor, sponsored by Representative Lister Hill and Senator George Aiken, had considerable support, but neither the AMA nor liberals were interested.

The deadlock over health insurance stands in contrast to the expansion of Social Security in other areas during the postwar period. Amendments passed in 1950 broadened coverage under old-age and survivors' insurance to include an additional 10 million Americans and raised payments by an average of 80 percent. The opposition of the AMA and the Chamber of Commerce, however, still blocked the addition of coverage for those permanently and totally disabled before age sixty-five. The AMA denounced disability insurance as "another step toward wholesale nationalization of medical care and the socialization of the practice of medicine."[151] Yet in an obscure provision, the 1950 amendments provided matching funds to the states for payments to doctors and hospitals for medical services to welfare recipients. These "vendor payments," as they were called, increased the federal subsidies for welfare medicine that had been growing quietly since the Depression.

The passage of these amendments, with no provision for health or disability insurance, confirmed the pattern of government intervention since 1935. Instead of a single health insurance system for the entire population, America would have a system of private insurance for those who could afford it and public welfare services for the poor. The year 1950 also saw the attention of the Truman administration turn to Korea and the decline of any serious effort to pass national health insurance. Discouraged by yet another defeat, the advocates of health insurance now turned toward a more modest program they hoped the country would adopt—hospital insurance for the aged.

As the movement for national health insurance stalled, the coalition supporting it began to break up. A faction within the Committee for the Nation's Health, led by Albert and Mary Lasker, two wealthy donors, urged that the committee shift attention from health insurance to federal aid for medical education and research. Michael Davis resisted this change, and when organized labor supported Davis, the Laskers and the Rosenwald family withdrew their financial support. Although the Democratic Party and organized labor made up the deficit for a few years, the committee finally went out of business in 1956. So closed yet another effort at reform.

Three Times Denied

Why had reform failed yet one more time?

The burial of national health insurance during the cold war was only the culmination of a long process of treating it in symbolic terms. America is frequently described as a less ideological society than Europe, more given to interest-group than ideological politics. The AMA's battle against health insurance is often cited as a premier case of interest-group political influence. But throughout the debate over health insurance in the United States, the conflict was intensely ideological, much more so than in Europe. The interest groups opposed to health insurance repeatedly found it useful to cast the issue in ideological terms. By accusing the supporters of health insurance of being the agents first of German statism and then of Soviet communism, they meant to inject a meaning into health insurance that the reformers deeply resented. The reformers' efforts to detoxify the conflict were to no avail. And their attempt to present national health insurance as a technical matter of meeting the "health needs" of the society had its ideological bias, too.

Each side in the controversy sought to prevail by linking its case to some deeply rooted aspect of American belief (liberty for the opponents, and efficiency and fairness for the supporters). The opponents did not win because their views were more truly rooted in American culture than those of the supporters. Each side had a plausible case in playing up the American values that favored its cause. So the values themselves do not provide an explanation for the outcome.

Public opinion, as I indicated earlier, was highly malleable. It was generally in favor of health insurance but uncertain as to what kind. The opponents were able to take advantage of this uncertainty to nullify whatever advantage the reformers originally held in public support. Then, like many other highly organized lobbies, they were able to marshall political influence to prevent any action from being taken against their interests.

Between the two sides in the conflict, there was a gross imbalance in resources—partly material, partly social, partly symbolic. And these imbalances reinforced one another: The edge that the opposition enjoyed in its social bases of support could be translated into material advantages and means of influence.

The gap in material resources was overwhelming. While the reformers struggled along on shoestring budgets, the opponents had access to considerable wealth. The annual budget of the Committee for the Nation's Health was about $50,000; in 1950 it spent only $36,000. That same year, the AMA spent $2.25 million in its "national educational campaign" against national health insurance. More than $1 million was spent in two weeks in October alone, just before the 1950 congressional elections. During that period, the AMA also offered businessmen the opportunity to join in sponsoring advertisements denouncing compulsory health insurance. Companies paid over $2 million for this privilege. In those two weeks, as Monty Poen describes it, "every bona fide weekly and daily newspaper in the United States (10,033 in all) carried a five-

column-wide, fourteen-inch-deep ad from the AMA or from one of its business allies decrying the enemies of free enterprise, while 1600 radio stations broadcast spot announcements and 35 magazines carried similar advertisements."[152]

But this material advantage, as the participation of business in the AMA's campaign suggests, was itself only a reflection of the ample social foundations of the opposition's strength. Beginning with the National Civic Federation and the insurance industry during the Progressive era, the most powerful economic interests in the society had opposed health insurance. Both economic and ideological considerations brought the AMA its business support. Many employers did not want the additional cost of health insurance, which constituted a de facto increase in the minimum wage, while others stood to gain from providing health benefits on their own. And, more generally, they shared a desire to draw the line against socialism. The AMA also benefited from alliances with the specific industries that profited from a private market in medical care. Organized medicine received large contributions from pharmaceutical firms to fight health insurance, in addition to the revenues from pharmaceutical advertising in AMA journals. The doctors received this support in part because of the strategic location they held in the marketing of drugs; their gatekeeping function allowed them to collect a toll for use in political agitation. Physicians were also able to draw upon the elaborate network of contacts that medical practice yields. Congressmen and state legislators, newspaper editors, and other community leaders frequently found their personal physicians paying them a visit to talk about health insurance. Many doctors' offices became outposts in a political struggle, dispensing literature, cartoons, and other propaganda against "socialized medicine."

The changing ideological temper of the postwar period was itself a resource for the opponents of health insurance. The forties witnessed a growing confidence in American capitalism as anxiety about a relapse into Depression abated. In 1942 a Roper poll for *Fortune* had found that only 40 percent of Americans definitely opposed socialism, while 25 percent were in favor of it and 35 percent said they had an open mind. By 1949 a Gallup poll found that only 5 percent of the public wanted to move more in the direction of socialism, while 61 percent wanted to move more in the opposite direction.[153] This cold war ideological shift was not decisive. Otherwise one would not have expected the liberalization of Social Security in 1950. The rejection of health insurance stands out as an exception to the postwar pattern of rising social welfare expenditures in the United States and other advanced Western societies. In most of Western Europe, governments that were no less anti-

communist than the United States took part in the steady expansion of health insurance to all sectors of the society. Only in America was growing anticommunism channeled into opposition to health insurance.

In the face of all these considerations—material, social, symbolic—the potential supporters of national health insurance sought other remedies to their problems. The middle class continued to buy private insurance, and the unions began to look to collective bargaining for health benefits.

Another large group, American veterans, received extensive medical care in the hospitals and clinics of the Veterans Administration (VA), which were greatly expanded and modernized after the Second World War. Veterans were entitled not just to treatment for war-related injuries, but to all medical care to the extent the VA had room for them. A rule requiring them to vouch that the services were otherwise beyond their means was not seriously enforced. So this large group of working-class, predominantly white males was able to receive government-financed health services, which when advocated for other Americans were denounced as likely to undermine self-reliance. The AMA opposed the extension of the veterans' program to nonservice-connected illness, but the veterans were one lobby even the medical profession could not overcome.

So instead of the universal system that Truman had proposed, American society provided insurance against medical expenses primarily to the well off and the well organized. The people who lost out were those without membership in groups, like the veterans and unions, that had political influence or economic power. The poor, for whom health insurance was originally conceived, were precisely the ones who did not receive its protection.

The political failure of universalism also had its reflection in the fragmentation of public policy. Each government agency—the Children's Bureau, the Public Health Service—pursued its own agenda. The hospitals sought relief through aid for construction, and the medical schools through aid for research. The culmination of this piecemeal approach was categorical legislation on behalf of constituencies organized around specific diseases, such as cancer and heart disease. The opposition to compulsory insurance did not prevent a steady growth in state intervention in medical care. Government financing increased, but it was channeled into avenues that did not, at least immediately, threaten professional sovereignty.