

History and Health Policy in the United States: The Making of a Health Care Industry, 1948–2008

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Summary. The UK's National Health Service is approaching its sixtieth anniversary, an opportune time perhaps to consider the case of the United States, where there is no national health service. Federal law requires hospitals to treat those who enter their emergency rooms, but not for free; military veterans are offered care in health facilities supported by federal tax dollars and the national Medicare programme provides government-sponsored health insurance for specified services to those over 65 years of age and to individuals certified as disabled. However, Medicare does not provide health services, which are predominantly purchased in the private sector. This article considers the history of American health care over the past 60 years, reflecting the diverse ways in which health care is embedded in the economy, politics, power structures and culture of the United States and discussing what it is like to have a health care industry without having a national health service or universal health insurance. The article concludes that, since the Second World War, the United States has been successful in achieving highly specialized, valued, life-improving health care for most—not for all—members of the population, but at a huge and rising cost. Notable achievements have been produced by the public–private mix of the American health enterprise. However, broad questions of social class, illness, insurance and the burden of payment for health care remain in a society with widening divisions of the population by socio-economic class, education, health literacy and computer skills.

Keywords: health care; health services; health insurance; public–private; community rating; multi-specialty clinics; Medicare; Medicaid; American Medical Association

History is about the past but histories are written for the present—by historians who live and breathe in the present, and who devoutly hope their themes will resonate with themes and audiences today. Two questions arise from this observation. One is reformist, the other intellectual: what is a useful (or usable) history of health policy for would-be reformers of health care today and in the future? And are there neglected themes and promising histories to be written that could revise our understanding of what the salient history of health policy is, as experience of health care shifts from decade to decade?

These are heavy questions for British historians and policy experts to consider as the UK's National Health Service (NHS) marks its sixtieth anniversary, but they fall particularly heavily on social and policy historians of health care in the United States, where there is no national health service to provide a national analytical framework. The NHS has recognisable organisational, fiscal and management structures for analysis, however contested and changeable these arrangements may be, and a recognisable history starting in 1948.

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The history of British health policy is largely the history of the NHS, with private organisations and professions as players and co-dependants whose influence and interests rise and fall in the context of the NHS. There is national oversight and assumed political responsibility. There is no formal national health policy in the United States; no 'health service' in the British sense; no universal guarantee of care. Federal law requires hospitals to treat those who enter their emergency rooms, but not for free. Military veterans are offered care in health facilities supported by federal tax dollars, in a generally well-regarded programme that is not open to the general population. The national Medicare programme provides government-sponsored health insurance for specified services to those 65 years of age and over, and to individuals of all ages certified as disabled. However, Medicare is limited by its demographics and does not provide health services; these are overwhelmingly purchased in the private sector, with bills paid by Medicare at specified rates, on behalf of beneficiaries.

The history of American health care over the past 60 years is as messy, disjunctive and complex as its sprawling public–private health care industry. There is no single narrative of health care—a single explanatory history, or a unifying historical framework. Instead there are many possible histories, reflecting the diverse ways in which American health care is embedded in the economy, politics, power structures, and culture of the United States. The history of primary care and medical specialization (essential ingredients in the provision of services and patient expectations in the future) is a different history from the history of Medicaid (federal-state programmes for persons with low incomes) or hospital emergency services or consumerism or mental health or health maintenance organisations (insurance networks), and so on.¹ American health policy is the sum of manifold experiences, dashed experiments, clashing themes and multiple advocates, including health care experts specializing in fragmented fields.

The result has been the creation of a vibrant health care industry in the United States, representing almost one-sixth of the entire US economy in 2008. Over the last 60 years, the combination of government action, entrepreneurial responses and private consumer demand has poured money into private institutions: hospital and nursing home corporations, commercial health insurance, biomedicine and specialty centres ranging from government-initiated cancer centres to privately-financed radiological, orthopaedic or plastic surgery groups, physical therapy corporations, sleep and breast centres and so on. A leading proponent of a market orientation for health care has dubbed such ventures 'focused factories'.² What is it like to have a health care industry without having a national health service or universal health insurance—at least as observed in the American experience? The purpose of this paper is to give some sense of the multi-tracked, dynamic history of American medical care as a basis for asking this question. In no way can I be comprehensive; the eyes glaze over just thinking about any such attempt, filled as it must be with arcane details and ever-changing

¹Each of these topics is the subject of chapters in a recent book, in which I participated; the authors, collectively, could find no overarching theme; Stevens *et al.* (eds) 2006.

²See Herzlinger 1997, pp. 157–99.

acronyms.³ I do not include behavioural and mental health, or the long, convoluted histories of population and public health in their strange relationship with the health care industry. My goal is to show how government and private agencies created a health care industry alongside the unfinished quest for universal health insurance. Let us start at the chosen beginning; that is, in 1948.

‘Socialized’ or ‘Disorganised’ Medicine? Public or Private Leadership?

In the United States, 1948 was a presidential election year. Democrat President Harry S. Truman was challenged by the strong Republican slate of Thomas E. Dewey for president and Earl Warren for vice-president. ‘The face of the Republican Party’, reported *Time Magazine* in its issue of 5 July 1948, ‘has never appeared so photogenic, so confident, so politically winning’. *Time’s* opinion, like that of many other Americans, was that the Republicans would sweep to victory in the November elections. ‘Our people yearn to move to higher ground’, said Dewey, ‘to find a common purpose in the finer things which unite us. . . . We have found the means [the atom bomb] to blow the world physically apart. Spiritually, we have yet to find a means to put together the world’s broken pieces, to bind up its wounds, to make a good society, a community of men of good will that fits our dreams.’⁴

Those dreams were unlikely to include the controversial question of national health insurance, let alone a comprehensive health programme. Such proposals had led to an acrimonious stalemate by 1948. Leading Republican Senator Robert Taft’s strongly held opinion was on record: simply, that compulsory health insurance was ‘socialism’.⁵ The American Medical Association had described ‘socialized medicine’ alarmingly, as a step toward the ‘socialization of the American system of government’; that is, as a path toward the regimentation of US business, labour and financial institutions, leading inexorably to totalitarianism and finally to America’s downfall.⁶ When Truman was re-elected in November 1948, he reiterated his support of national health insurance against a clamouring background of concern, criticism and confusion. The year 1949 was to be the last serious attempt to introduce universal, prepaid personal health insurance benefits, as they were called, through the pre-existing social insurance system.

‘It has always been assumed in this country’, said Senator Taft, ‘that those able to pay for medical care would buy their own medical service, just as under any system, except a socialistic system, they buy their own food, their own housing, their own clothing, and their own automobiles’.⁷ This ideology of personal responsibility for medical care has been one potent thread of national politics through the last six decades of tinkering with health insurance and health services, and in the face of huge increases in health care expenditures. In 2008, American consumers spent more of their disposable income on health insurance and health services than they did on food or housing, and

³William Shonick has written the most encyclopaedic (and the best) book-length survey of US government health policy up to 1980; Shonick 1995. See also Fox 1986 and Stevens 1971, 1989 and 2007.

⁴*Time Magazine* 5 July 1948.

⁵Quoted by Starr 1982, p. 283.

⁶See *Journal of the American Medical Association* 1945, p. 950.

⁷US Congress 1949, p. 111.

much more than they spent on clothes. Health care bills have been the cause of most recent personal bankruptcies.⁸

The failure of national health insurance legislation in the United States after the Second World War has been examined many times. The consensus of twenty-first-century historians is that it was never a viable political prospect: 'Dead on Arrival' is Colin Gordon's sum-up phrase.⁹ In retrospect, if universal health insurance had been legislated in the late 1940s, the United States might have avoided many of the organisational, financial and distributional problems in health care that have plagued it ever since, though other unknown, difficult, and perhaps intractable problems would certainly have arisen, as they have in the NHS. As it was, the health insurance debates of 1945–9 illustrated inherited and continuing American themes: distrust of big government; reliance on individuals to pay for medical care out of their own pocket and/or through private health insurance; willingness, at the same time, to provide public support for those unable to afford to pay for their own care or buy insurance in the private market; the sharpening of conflicting views as lobbying groups gather at the legislative table; legislation marked by sub-optimal political consensus; and the empowering force of political rhetoric. Truman spoke of the 'right to adequate medical care and the opportunity to achieve and enjoy good health'.¹⁰ Cries of socialism vastly trumped such rhetoric, carrying as they did the taint of being 'un-American'.¹¹ The charged phrase 'socialized medicine' has continued to resonate in the United States into the twenty-first century.

Supporters of national health insurance through social security in the 1940s and later argued in vain that social insurance was not socialism. For social insurance, too, there was a prior history. The progressive reformers of the early twentieth century had developed and lobbied for labour legislation, including health insurance organised through the different states, on grounds of social, business and organisational efficiency. On the basis of their efforts, workers' compensation legislation was widely established in the states and for federal employees before the First World War; by 1943, all states except Louisiana awarded medical benefits to injured workers under what were then called Workmen's Compensation laws.¹² Federal medical care for military veterans was organised as a national health programme after the First World War, which was, and is, the nearest American counterpart to the NHS.¹³ However, government-sponsored health insurance for the general population proved a sticking point. Though a society

⁸Abelson and Freudenheim 2008, p. A36.

⁹Gordon 2003. See Stevens 1971; Poen 1979; Starr 1982; Berkowitz 1991; Hacker 2002; Quadagno 2005.

¹⁰Truman 1945, p. 475.

¹¹Historians have traced this taint of socialism-by-association back to the anti-communist 'Red Scare' after the First World War, as well as to concerns before that war about the dangerous importation of foreign ideas. The underlying fear was that aliens would weaken the social fabric of America at a time of destabilizing immigration. See, for example, Hoffman 2001. Hence 'socialism' (anarchy, among other meanings) and 'Americanism' (unity, English speaking and accepted social norms) occupied opposing ideological poles at critical stages of American history, most notably after the two world wars. A dictionary of health terms prepared for a congressional sub-committee defined socialized medicine as a general term 'without recognized or constant definition, referring to any existing or proposed medical care system believed to be subject to excessive governmental control'; US Congress 1976, p.151.

¹²Stevens 1971, p. 283.

¹³See Stevens 2007, pp. 89–112.

of healthy, trouble-free workers would benefit business and industry, and though state or federal government sponsorship would have freed later employers from the burden of organising and subsidising health insurance as an employee benefit, compulsory health insurance was not strictly 'labor legislation'. It was outside the usual frame of labour–management relations. Lurking in the background after the Second World War, as later, was the not unreasonable assumption that national health insurance legislation would provide a powerful lever to rationalise the health care system along new lines; for example, by using insurance to build up general practice (or family medicine), which was in decline in the 1940s, or to sponsor multi-specialty clinics. This was a good idea if you were (or are) a progressive reformer. It was a bad idea among those who were sceptical of big-idea experts with their own ideas about how health services should look, and leery of the creeping powers of government.

The use of health insurance as a vehicle for organisational reform had been made explicit well before the Second World War. Health and welfare expert Isidore S. Falk is a notable example, for he was a lightning rod for criticism through his role as research director of the controversial Committee on the Costs of Medical Care (1927–32), funded by private foundations, and as research director for the federal Social Security Board, where he worked on universal national health proposals in the late 1940s. Though he always argued for flexibility in approaches, Falk took it as a given that 'society must organize for payment in order to achieve improvement of service'.¹⁴ He made a similar observation in the build-up to Medicare in the early 1960s, when he became my academic mentor.

In the process of linking national health insurance with better organisational modes of care, Falk and his colleagues provoked well-organised political campaigning and the lasting enmity of the American Medical Association (AMA). With equal passion if less political competence, progressively-minded health care experts blamed AMA lobbyists for intransigence and thinking only of their own self-interest. In Falk's words: 'They blocked development of orderly and regionally patterned group [medical] practice, its support by non-profit group payment, and the urgently needed expansion of public health measures.'¹⁵ The assumption on the side of progressive reform was (and is) the creation of well-organised, accessible health services; that of the AMA was that doctors should control the practice of medicine. Up through the 1960s, this included opposition to the public or private development of major clinical organisations that would compete with independent, fee-for-service medical practice. Notable exceptions included, among other established organisations, the Mayo Clinic, the Kaiser Permanente medical groups on the west coast and the clinical responsibilities associated with teaching in medical schools.

Recent scholarly work has emphasised the multiplicity of interests for and against health reform to this day, spreading far beyond health care experts and medical interests—and neither of these groups was monolithic in terms of political and social views. Indeed, more scholarly work needs to be done on the role and attitudes of

¹⁴Falk 1936, p. 333.

¹⁵Falk 1977, p. 171.

different groups. (The promise of research into the 'medical left' in the postwar period is enhanced by the opening of the new US Health Activism History Collection at the University of Pennsylvania in 2008.) However, with some notable exceptions, such as labour-sponsored clinics, none of the groups concerned had the power to organise health services without the financial heft of organised health insurance. Not surprisingly, the word 'reform' in US politics—to this day—has usually meant extending insurance, not building or rationalising services, as it has in the UK.

In the late 1940s, as later, labour organisations had a strong interest in health reform. Health, welfare and pension plans were placed under labour–management relations under the Taft-Hartley Act of 1947; at the end of 1954 union negotiations represented one-quarter of the purchase of private health insurance in the United States.¹⁶ Labour continued to be involved in national politics. Marie Gottschalk has described the role of organised labour in favouring national health insurance in the early 1970s, endorsing an 'employer mandate' (requiring employers to provide health insurance to employees) in the late 1970s, and renewing calls for national health insurance in the 1980s and 1990s.¹⁷ (The employer mandate was an idea that was taken up by the Clinton administration in its failed reform proposals of 1993–4.)

Business corporations were also interested in offering health insurance as part of their employee benefits. Jennifer Klein describes this as a continuous history of engagement by corporations in 'corporate welfare' or 'welfare capitalism' from the 1920s through the 1950s.¹⁸ After that, the role of employers shifted from benevolent protector of appreciated workers to the more mechanical task of fiscal agent, negotiating health insurance packages that were becoming more and more expensive. Employers were (and are) given a federal tax incentive, beginning in the 1940s, to encourage them to offer health insurance for their employees. In recent years, insured employees have had to pay increasing amounts (post-tax) from their own pockets.

The selling of private health insurance policies boomed after the Second World War, stimulated by tax-subsidised employee benefit packages, union negotiations and an expanding economy. Commercial insurance firms were quick to recognise the potential profits in specially tailored insurance policies, place-by-place and firm-by-firm. Contracts could be 'experience-rated'—that is, limited to specific risk groups (particularly groups, such as workers, with low overall medical risks), rather than 'community-rated', where all comers were included, sick or well. Experience rating was a rational approach for a commercial company eager to obtain new business and offer the most competitive rates. However, even in the 1950s, the long-term implications of an 'industrial' rather than a 'service' approach to health care coverage were becoming evident. Successful action by commercial firms took the most healthy Americans out of the insurance pool, leaving the non-profit Blue Cross and Blue Shield plans with a statistically sicker population, assuming they stayed with community rating.¹⁹

¹⁶Starr 1982, p. 313.

¹⁷Gottschalk 2000, p. 9.

¹⁸See Klein 2003.

¹⁹In its purest form, this means offering health insurance to all members of a community whether they are sick or well, on the same basis, at a standard rate. It contrasts with (i) selecting on the basis of individual

By the early 1960s, when I was a federally-supported graduate student in public health, community rating was difficult to sustain, even in plans with a long commitment to social equity as a matter of principle. The 'Blues' competed for employer contracts by offering a similar array of insurance choices to those of their commercial competitors. Over the years, any difference in social commitment between non-profit ('voluntary' or 'charitable') enterprise and for-profit business eroded. By the 1980s, the Blues were talking about protecting their 'brand name' and status in the market. Mergers, acquisitions and (for many) shifts to for-profit status were to follow. There were two important implications in these shifts. One effect of privatising health insurance was to wipe out a generally available, private non-profit alternative. A second was to loosen the idea of community solidarity for the public's health—we are all in this together—which was fundamental to the idea of community rating. Hospitals, doctors and other providers of care benefited from the expanding health insurance market, and built up services in response to what was insured.

In 1950, 51 per cent of the civilian population carried some form of hospital insurance, 36 per cent surgical benefits, and 14 per cent in-hospital medical benefits; comparable figures for 1966 were 81 per cent, 74 per cent and 60 per cent.²⁰ The best-covered individuals carried all three. The selling of insurance was a spectacular success for both non-profit organisations (notably Blue Cross, sponsored by hospital-associated groups, and Blue Shield, by medical associations) and commercial and mutual insurance firms. Insurance for out-of-hospital medical services trailed behind but was also rising. As with the shifts to market behaviour, this outpouring of money and coverage had lasting implications for American health care. Most notably, insurance targeted the most expensive services, not the most common. The former included hospital care and services provided there by specialists; the latter, primary care and 'talking' medicine in general, including discussions about diagnosis, family and socially-related problems, mental illness, and other medical encounters that ended without a prescription or procedure.

The heavy involvement of private insurers created a new power bloc in American health care. In 1959, 737 insurance companies reportedly sold some kind of health insurance; together they comprised a 'booming competitive industry', in the words of astute contemporary critics.²¹ Insurers had become the 'ubiquitous third party'.²² The first and second parties were, of course, doctor and patient. By the mid-1980s, the balance of power in national health care policy was shifting away from the traditional producers of medical care (notably the hospitals and physicians) to the increasingly powerful purchasers of care, the insurers. This process was completed in the 1990s. Sociologist Paul Starr depicted the overall trend toward 'market solutions' in health care in the 1980s as the end of a mandate for professional control of medicine and the 'coming of the

risk, for example, excluding individuals or charging them more if they have prior or ongoing cancer or other potentially expensive conditions, and (ii) offering favourable insurance rates for healthier groups; young workers of a major employer, for example, thus excluding the unemployed, the retired and others.
²⁰Reed 1967.

²¹Somers and Somers 1961, pp. 254, 258.

²²Somers and Somers 1961, p. 218.

corporation'.²³ However, no one could have predicted the storms that were to rage over insurers in the 1990s as they sought to impose controls over medical utilisation via so-called 'managed care'. Private controls proved as unpopular in fact as public controls had been in principle.

Over the 60 years, the expanding availability of insurance increased the demand for medical care, particularly for hospital services, and steadily increased national health care costs. There were no global budgeting procedures. National expenditures on personal health services roughly doubled between 1948 and 1957, and doubled again by 1966. However, insurance was typically partial and limited in scope, even for those who were relatively well covered. Its role was to protect individuals from the costs of major, unexpected bouts of acute illness, which were, ideally, curable via ever advancing medical procedures, medications and technologies.

Insurance was not designed to pay for less expensive doctor visits, eye checks and eyeglasses, psychotherapy, or dentistry, which (theoretically at least) could be scheduled into family budgets. The typical insurance policy also excluded long-term care and other care outside the hospital that might be essential for the improvement and/or maintenance of health for those with chronic illnesses. In 1966, for example, only 34 per cent of private personal health care expenditures were paid from private insurance benefits, with 66 per cent paid directly by patients. Collectively, in terms of actual amounts spent in 1966, private insurers contributed less to patient care in the United States than government agencies, and this was only partly due to the implementation of Medicare in July 1966.²⁴

In an expanding economy, national health expenditures (which include research, construction and other health expenditures as well as personal health care) rose steadily as a proportion of the gross national product: from 4.1 per cent in 1948 to 6.0 per cent in 1966 and on to 7.3 per cent in 1970.²⁵ The latter figure may seem nostalgically small to those who look back from the early twenty-first century, with national health expenditures surpassing 15 per cent of GNP by 2002, and 16 per cent in 2006. However, even in the 1960s, the competitive structure of insurance and rising expenditures sent out the strong political and economic message that the United States had a health care industry rather than a health service. The message has grown stronger ever since.

Government as Venture Capitalist and Purchaser

The shift to an industry was not an overt or even a unified national policy. Beside the rise of private health insurance after the Second World War, three large-scale, but unconnected federal programmes stimulated a health economy based on biomedicine and technology, and encouraged doctors to become entrepreneurial specialists. The Veterans' Administration (VA) encouraged returning servicemen to enter residency programmes in specialties through government educational benefits. At the same time, federal veterans' hospitals became linked to medical schools and thus more focused on specialization and research. In the late 1980s, the VA operated the largest health care system in the United States, but was training few primary care doctors. Less than 2 per cent of all family

²³Starr 1982, pp. 420–49.

²⁴US Department of Commerce 1976, B 236–47.

²⁵US Department of Commerce 1976, B 401–12.

practice residency positions were in VA-supported residencies in 1986 compared, for example, with 33 per cent of the residencies in nuclear medicine.²⁶

A second federal programme, begun under the Hill-Burton Act (1946), provided federal subsidies to build or expand community hospitals, chiefly in rural areas, thus building new centres for specialized medical practice across the United States. And third, the rapid growth of the National Institutes of Health (NIH) in biomedical research affirmed a compelling cultural message (and the money to support it) about the value of specialized science and techniques. The institutes themselves were specialized in fields such as cancer and heart disease, and the NIH funded super-specialized research and clinical fellowships—thus adding to the growing cadre of sub-specialists. These three sets of activities can be seen today as parallel attempts to build a high-technology infrastructure for health care in the United States, but at the time they were responses to diverse public–private interests: in veterans’ benefits, rural development and scientific leadership.

By the end of the 1960s, government involvement in health had proliferated to an unmanageable degree, as one programme after another was developed to shore up perceived critical gaps in service or in training, expedient by expedient, with different governmental and private groups concentrating on the issues of most immediate interest to their constituencies. The result was federal aid to private, state and local organisations on a scatter-shot basis. In the late 1960s, there were pockets of federal action scattered across 221 federal agencies and departments. These included, for example, the Children’s Bureau (for maternal and child care), the Office of Economic Opportunity (setting up clinics in poverty areas), the Small Business Administration (making loans to small community hospitals, sometimes in competition with other federal funding), and at least 14 federal departments and agencies engaged in education and training programmes for health care.²⁷ Each programme represented distinctive views as to what the federal role should be, and each pitched its own case to the staff of various Congressional committees and sub-committees since, lacking a national health service, Congressional responsibility for health care was a subsidiary of broader, more pressing Congressional interests.

Proponents of federal aid were not just associations of government officials working with private lobbying groups representing hospitals or the elderly or children or Appalachians or medical schools; there was also a growing constituency of specialized health care experts who were also members of policy networks. I was one myself, as a member of the Scientific and Professional Advisory Board for the National Center for Health Services Research and Development. The major federal health agency, the Department of Health, Education and Welfare (later the Department of Health and Human Services) reported 407 advisory groups to that agency alone in fiscal year 1970, with a combined membership of 5,500 people.²⁸

Health care critic Odin Anderson described the American health system of the late 1960s as ‘essentially nongovernmental, with government subsidies operating at strategic points for special groups and problems’.²⁹ This is in retrospect an overly tidy

²⁶Gronvall 1989, p. 65.

²⁷Stevens 1971, pp. 502, 504.

²⁸Stevens 1971, p. 507.

²⁹Anderson 1968, p. 164.

interpretation of a very messy process. As a 'health service', the American health care system seemed broken by 1970, and the trickles or even floods of fragmented federal aid made the services more, rather than less confusing at the local level. At the same time, the more government money available, the more private, entrepreneurial opportunities there were. A report sponsored by the left-wing, reformist organisation Health-Pac in 1970 was succinct: 'Health is no more a priority of the American health industry than safe, cheap, efficient pollution-free transportation is a priority of the American automobile industry.'³⁰ The evolving health industry was diffused and fragmented. It was not (and is not) an organised giant that could act effectively as a proxy for government. Both health insurance coverage and health service organisation remained, and still remain, as problems to be resolved—or not.

Two massive governmental purchasing programmes were tossed into this bubbling brew in the late 1960s: Medicare and Medicaid. Progressive reformers had retreated in 1950 from proposals for universal, government-sponsored health insurance. There was a promising (if thin) theoretical argument as well as obvious political advantages in settling for lesser goals. Theoretically, the great majority of the working population and their dependants could be covered by employer-sponsored, privately organised health insurance. Health care for individuals on welfare could be covered through state and local welfare provisions. Without these two groups, the problem was how to insure Americans who were far less insurable: the self-employed, unemployed, retired, elderly and/or disabled.

The elderly became the first special target for a national health insurance programme, with the age of 65 made a convenient marker for inclusion. It was clear to those of all political persuasions that the average retiree simply could not afford the price of experience-rated private health insurance. Government coverage would also help private insurers by removing relatively impoverished, often uninsurable individuals from the private insurance pool.

Building a national health insurance programme that is substantially paid for by workers, but whose benefits are limited to the elderly population, may seem odd reasoning to readers outside the United States. Medicare represented the art of the possible. Theodore Marmor has captured the spirit as well as the outcomes of the bargaining, manoeuvring and trade-offs that were made among rival groups with competing proposals and with different stakes.³¹ The basic design represented intensive lobbying, compromises made by participants in debates, and efforts to remove stumbling blocks in Congress. President Lyndon Johnson signed the Medicare legislation, Public Law 89–97, in 1965 as an important part of his vision for a 'Great Society'. The result was a three-part programme representing three distinct political approaches: Medicare Part A for hospital insurance, Medicare Part B for medical insurance (doctors and other professional services) chiefly for hospital and related care; and Medicaid, an expanded programme of federal grants to states for individuals with low income who were elderly (a vital supplement to Medicare), and other recognised welfare categories,

³⁰Ehrenreich and Ehrenreich 1970, p. v.

³¹See Marmor 2000.

including families with children. Virtually all Americans aged 65 years of age and over soon carried Medicare Parts A and B.

In 1972, Congress extended eligibility for Medicare to individuals of any age with proven disabilities, and (after a dramatic public demonstration of kidney dialysis at a congressional hearing) to those with end-stage kidney disease, who would die without access to dialysis or a kidney transplant. This addition did not, however, necessarily signal that Medicare would become a platform for the inclusion of other medical conditions, irrespective of age; it was more a legislative quirk. It was a quirk, though, that stimulated the rapid development of kidney dialysis corporations and centres, and provided new opportunities for renal specialists. Proposals to extend Medicare to other population groups, notably to children, have foundered since the 1970s, but the possibility of allowing individuals under the age of 65 to participate in Medicare at their own cost remains on the table.

Medicare's design and implementation mimicked private health insurance benefits. This was not surprising, for at least three reasons. First, Medicare was offered to beneficiaries in its early years as similar to the insurance they might have held while at work, and presented to providers of care as paying comparable reimbursement to that of private insurers; in these ways Medicare proclaimed the right of older Americans to have middle-class services. Hospitals and doctors reaped the benefits of increased demand for their services at what were then reasonable fees, and were thus encouraged to participate in the programme, as almost all did. Second, the research and practical expertise of inventing and implementing a massive new insurance programme lay in the insurance community and associated university and other researchers; these were the experts whose advice would be drawn. Walter J. McNerney, a distinguished academic who was president of the national Blue Cross Association, worked long and hard on the implementation process. Third, the federal government did not want to get into the insurance business itself. Implementation of the hospital part of Medicare was typically contracted out to Blue Cross plans as intermediaries or agents, and the medical part to medical insurers. The result was that Medicare began to operate relatively smoothly on 1 July 1966, only a year after the legislation was signed, with 19.5 million beneficiaries—an extraordinary administrative achievement. Each beneficiary was mailed a Medicare card. Reflecting the demographics of ageing, by 1997 there were 38.6 million beneficiaries, about 14 per cent of the US population.³²

Recognising that this huge new purchasing programme could be used deliberately to modify health care provision, the 1965 Medicare legislation specifically promised not to interfere with the existing health care system. However, Medicare did have some organisational clout. Notably, it required racial desegregation of patients in hospitals that were still segregated as a condition for receiving Medicare reimbursements. Medicare also developed an important research programme; earmarked payments for graduate medical education (support of hospital residencies) and payments to hospitals with a disproportionate share of low-income patients; and in recent years has become bolder in specifying procedures that will not be covered. The Medicare programme was instrumental in the early 1980s in implementing payment to hospitals via diagnosis-related groups

³²National Academy of Social Insurance 1999, p. 7.

(DRGs), and in creating physician fee schedules via groups of experts. Medicare was expanded by the addition of Medicare Part C in 1997 (later known as Medicare Advantage plans) in an only partly successful effort to persuade Medicare beneficiaries to enrol in private insurance networks, which might throw in extra preventive services and provide coordinated care. Part D of Medicare, a complex, voluntary prescription drug benefit arrived through legislation in 2003. Nevertheless, Medicare dollars have not been used for planned organisational reform, such as subsidising local (public or private) comprehensive health organisations, targeting primary care, or developing coordinated services for older members of the population or persons with disabilities.

Medicare remains a popular programme, particularly among its rising number of beneficiaries. Jonathan Oberlander has described the bi-partisan congressional support of Medicare in the 30 years after its passage, with discussion governed by the politics of consensus and 'no debate over ideology or programmatic first principles'.³³ However after 1995, the burden of Medicare's costs on future taxpayers became an over-riding national political issue. What was more worrying to Medicare's supporters was that by the late 1990s, younger legislators, bureaucrats and policy analysts had little knowledge of, sympathy with, or tolerance for the principles of social solidarity, risk-sharing and fairness that were inherent in social insurance as traditionally conceived. This story is continuing.

Medicaid, too, has undergone changes, from an initial excitement (pro and con) over its potential as a national programme in the late 1960s, through charges of corruption, to gloom and doom and continuing gleams of promise in different states. As a programme of federal matching of grants to states, Medicaid is distinguished from Medicare, a federal programme. Each state wrestles with issues of costs, population needs, medical care as a tax burden, and federal regulations in the context of its own politics, fiscal ability and history. From a policy perspective, Medicaid can be defined in two ways: as an assertion of national and state responsibility for health care for low-income Americans, and (like Medicare) as a huge economic obligation, sparking run-away federal and state expenditures.

The initial idea that Medicaid could cover those who were 'medically indigent' (that is, that a socially productive individual could become poor because of high medical bills) raised the possibility that Medicaid was the 'sleeper' of the three-part Medicare legislation because it could cover a significant proportion of the population if means-test levels were set high enough, and thus provide another path to universal coverage. New York State's particularly generous proposals, if fully implemented, would have covered 45 per cent of that state's population.³⁴ In retrospect, any such hopes seem utterly unrealistic, but there was some excitement at the time, for and against. In the face of rising utilisation and costs, Medicaid quickly accommodated to link with means-test provisions under welfare in the states. The notable exception turned out to be nursing home provision for members of the middle class in the 65-and-over population.³⁵ Though such individuals have to 'spend down' their assets in order to receive public benefits, it is not unusual in the early twenty-first century for someone to enter

³³Oberlander 2003, p. 5.

³⁴Stevens 2007, p. 126.

³⁵See Grogan in Stevens *et al.* (eds) 2006.

a nursing home on a self-pay basis and gravitate to Medicaid when designated personal resources are depleted. As a result, Medicaid joined Medicare in signifying massive government aid targeted at older rather than younger members of the population: a potent political issue in itself. Although Medicaid is a multigenerational programme and serves more children than elderly individuals, the latter are much more expensive.

Requiring substantial tax funds from the residents in each state to match federal subsidies, Medicaid has had a major impact on state budgets. Thus Medicaid has been instrumental, in turn, in stimulating state responses to health care reform, with a view to cost containment and service improvement. A number of states have become testing grounds for experiments in organised insurance through private ‘managed care’ organisations. Oregon tried a rationing schedule of services for its Medicaid beneficiaries (excluding nursing home residents). Hawaii developed its own state health insurance programme, designed to include the whole population. In the early 1990s, these states, together with Florida, Minnesota and Vermont, each with their own idiosyncratic approaches, were dubbed ‘five states that could not wait’ for national health reform.³⁶ More recently, Massachusetts and California have been visible as states, which, respectively, established a requirement that residents must have health insurance, and failed (so far) to gain sufficient popular support for universal coverage. States continue to provide an important laboratory for trying out new methods and ideas. With funding from the Milbank Memorial Fund, a private foundation, state legislators and health officials have established a vigorous, bi-partisan Reforming States Group to share expertise across state lines. In one way or another—from budget crises to policy successes—what different states do (and cannot do) is a critical ingredient for national policy, now and into the future.

Universal Coverage, Technological Improvement, and Service Efficiency

While Medicare and Medicaid have become lightning rods for concern over high tax expenditures, over the years since 1965 the push for universal insurance has continued, through one incremental approach or another, and from one administration to another. Examples include Republican President Richard M. Nixon’s (unsuccessful) proposal to require or ‘mandate’ employers to offer minimally adequate insurance to employees (as part of a more comprehensive proposal), Democratic President Jimmy Carter’s push (unsuccessfully) for federally-supported health care for children. Also, Republican President Ronald Reagan’s (successful) attempt to fold 22 federal health programmes into four block grants to states but leave insurance issues as far as possible to the private marketplace, and the most ambitious, Democratic President Bill Clinton’s health plan (unsuccessful) of 1993–4, which would have established an employer mandate, purchasing cooperatives, a standard health plan and caps on spending, among other provisions.³⁷

Reform proposals remain on the drawing board. As I write this in 2008, a presidential election year, there is renewed excitement about the need and possibility

³⁶Fox and Iglehart 1994.

³⁷See Skocpol 1997.

for change—and renewed scepticism by long-time observers.³⁸ Earlier assumptions about reliance on employer-based insurance for workers, backed by government programmes, have not held up. The employment structure is no longer characterised by large corporations. The viability of employer-based health insurance is in jeopardy. Smaller corporations and individuals in business for themselves often cannot afford insurance costs. Family structures have changed; and workers are less able to pay health care costs for themselves, let alone for those who have retired. Health care bills have been the cause of most personal bankruptcies in recent years. After 60 years of experiment, an estimated 47 million Americans are uninsured. Over and above this, an uncounted number are underinsured for services they might need (and be billed for) any day.

Following the requirement that took effect in Massachusetts in 2007, the idea of mandating (i.e. requiring) individuals to carry health insurance has gained traction, though this would not necessarily deal with the problem of under-insurance. Meanwhile, Medicare and Medicaid are the primary government purchasers of health care in the private sector in the United States: the elephant in the room in policy debates. Here the major political question is cutting costs rather than providing better health services. By judgement or default, allocation decisions are made within the ever-shifting, uncoordinated health care industry in response to multiple, diverse purchasing arrangements.

This has not happened all at once. Rather it has been the result of policies taken, such as Medicare, and others not taken, as in the failure to coordinate health services through either public or private decision-making. *De facto* government policy has been investment of tax resources in largely private institutions without a strategy for organisation of services into a health care system. In turn, non-profit organisations (such as hospitals) and independent professions (such as medicine) have embraced a business, for-profit orientation.

The transitions have been heady, for the additional purchasing power unleashed by Medicare and Medicaid from the late 1960s led to huge opportunities and changes in disconnected aspects of health care provision. These included *inter alia*: the building of a new (largely for-profit) nursing home industry; encouraging major public hospitals to close their doors (such as the large Philadelphia General Hospital in the early 1970s), on grounds that the poor and the elderly would now be covered under Medicare and Medicaid; and giving older Americans (as well as younger ones) the privilege of by-passing primary care and seeking direct access to an array of medical specialists in private practice, thus strengthening the decline of primary and coordinated medical care and encouraging the rise of single-specialty medical firms. In some areas, profitable enterprises such as orthopaedic surgical or cardiovascular groups have provoked competitive bidding among local hospitals to buy their exclusive services, or started their own single-specialty hospitals—leading in turn to concern about the future viability and quality of service of the ‘general’ hospital which loses its orthopaedic or cardiovascular team. Such skirmishes increase local costs without necessarily improving services.

By the 1980s, the old idea that non-profit hospitals (still the majority of American hospitals) were ‘charities’ with public responsibilities had diminished almost to extinction. Investor-owned hospitals and non-profits competed in a single, profit-oriented, health

³⁸See Brown 2008.

care market. Patients, or ‘consumers’, could not generally tell under which kind of ownership each operated. Today, the president of a major investor-owned or not-for-profit hospital and senior executives may be paid as business executives, with incentives for increased performance by the institution. This practice leads to obvious questions about how decisions are made (and by whom) when there are trade-offs between making a profit and providing health care services. Critics, from legislators to the Internal Revenue Service, have made an increasingly strong case, place by place, for specific charity and community service that should be provided (and documented) by charitable institutions that wish to retain their tax-exempt status.

There was nothing particularly new about diverse ownership patterns for hospitals in the United States, or even a business orientation.³⁹ What was new after Medicare and Medicaid was the expectation that hospitals (often described as ‘community hospitals’) were in business for themselves, and were not responsible to their communities for health care. If hospitals and other providers were selling medical services as a commodity in the market, they were not necessarily responsible, either, for the care of the uninsured—though many hospitals are burdened with patients who cannot pay their bills. And all this from two nominally ‘social’ programmes designed to assist the elderly and poor.

From the 1960s through the 1980s, there were half-hearted attempts to use government funds to encourage the coordination of an increasingly fragmented delivery system and thus improve access to care and efficiency in health services provision; that is, to act on the supply side while also increasing the demand for care. Legislation passed in 1965 offered grants to encourage coordination of academic medical schools and hospitals through so-called regional medical programmes, with the definition of regions to be defined locally; but the outcome was limited and the idea of university-based regionalism faded, with some exceptions for coordinated training programmes. Legislation in 1966 offered tax funds for local communities to organise, more or less democratically, to plan local health services themselves. The resulting, grandly named ‘comprehensive health planning agencies’ and later ‘health systems agencies’ cropped up in different areas around the United States, stimulated by federal funding; by 1974 there were at least 150 such agencies.⁴⁰ Surveys were done and plans developed. Federal funds also helped produce new experts: health planners. What seems obvious in hindsight was not so obvious at the time. It was unrealistic to expect the rational knowledge of problems, as outlined in a plan, to be a sufficient goad for hospitals, nursing homes, and other local organisations and groups to give up some of their autonomy and expansive building schemes in favour of the public good, as defined by an agency with no money to offer in return.

Certificate of need legislation, requiring state approval of construction by hospitals above specified amounts, had more teeth; by 1972 twenty-three states and the District of Columbia (Washington) implemented some form of CON legislation, and a few states continue such controls today.⁴¹ However, as with many other aspects of

³⁹See Stevens 1989.

⁴⁰Stevens 1989, p. 306.

⁴¹Stevens 1989, p. 307.

government regulation, some needed programmes were turned down. There were also loopholes. One unintended consequence was to encourage capital expansion *outside* hospital ownership; for example, new radiology facilities owned by a corporate radiology group. In this as in many other ways, the effect of government policy was to make health services more rather than less fragmented, and to further emphasise entrepreneurial business practices.

The most ambitious set of ideas for reorganisation was the 'health maintenance organization' (HMO), supported by the Nixon administration in 1970. Though the name was new, the logic was old: namely that the corollary of specialized medicine was the organisation of specialty services through multi-specialist medical groups. A national network of such groups (effectively polyclinics) would decentralise health services to independent organisations able to offer comprehensive health services to a defined population of subscribers. In the ideal world, the subscriber (or consumer) would choose to sign up with one out of several competing organisations, after careful consideration of the advantages of each. This became the ideal of 'managed competition' (a phrase no longer prominent in policy circles). The HMO as originally conceived thus advanced a consumer-oriented view of the health care marketplace and a supply-oriented direction for the market.

Such HMOs would have required massive investment in new facilities and organisations. Not surprisingly, this was not forthcoming. The government was already reeling from the escalating costs of Medicare and Medicaid. The health care industry, buoyed up by demand, was careening in different directions. A health service system based on competing polyclinics would have required an upheaval in the medical profession, since doctors worked for the most part in solo practices or small groups (and still do), and this too would have demanded enormous expenditures to achieve the necessary buy-in. In any event, sweeping reorganisation plans were not politically palatable in Congress. The term 'HMO' was soon relaxed to include insurance networks of defined providers, without the necessity of providing coordinated services. As a result, with some notable exceptions, such as the Kaiser system, decisions for and against paying for specific specialty services were ceded to the insurer rather than to organised, medically-run health care corporations.

Insurers thrived in the marketplace of the 1980s and 1990s, offering networks of preferred providers to purchasers of health insurance as a less expensive alternative to the unregulated provision of services. A given doctor could participate in any number of networks, in turn pushing up the costs in the doctor's office, while those insured were typically limited to services of doctors in the client's insurance network. In attempting to keep costs under control, insurers imposed 'gatekeeper' and other requirements on consumer behaviour; gate-keeping required referral to specialists by a primary physician as a condition of having the insurer pay the specialist's bill on your behalf. Thus the original service-driven HMO of 1970 became the unpopular 'managed care' of the 1990s.⁴²

⁴²Bradford Gray has described the disparate influences that led to this result. These included provisions of the initial HMO Act of 1973 and its amendments, the Reagan administration's shift toward private investment in the 1980s, specific tax policy and retirement policy changes unrelated to health care, and continuing changes in the operation of the health care market. See Gray in Stevens *et al.* (eds) 2006.

In response to widespread complaints and regulatory action in some states, gate-keeping and other restrictive provisions were largely dropped by the year 2000, though managed care (insurance for service through specified provider networks, with or without required permissions for second opinions and consulting services) remains the dominant form of private health insurance in the United States. Patients may choose to visit doctors out of the network and may be able to do so under their insurance for an additional fee. The result is not entirely popular. Patients can have great difficulty obtaining appropriate medical care as they define it; and their insurance may not pay for the most costly treatments or prescription drugs. Doctors often feel over-regulated, drowned in paperwork, and professionally frustrated. Some resent having to consider out-of-pocket costs to the patient in working up a treatment plan, irrespective of their own view of the optimal course of treatment.

Attempts by hospitals to extend their own service networks in the 1980s and 1990s had mixed results. The urge to increase or defend their local market share (measured in patient admissions) in a climate of fierce competition for patients and dollars led some hospitals to diversify—for example, by acquiring or developing exclusive affiliation arrangements with other hospitals, long-term care facilities, or physician practices. At a time of frenetic mergers and acquisitions in other industries, hospital mergers blossomed in the health care market. Huge investor-owned hospital chains in the 1990s exemplified the power and nimbleness of private enterprise. However, as in other economic sectors, not all succeeded. The fall of Columbia/HCA in 1997, one of the largest investor-owned hospital companies, was accompanied by charges of fraud in government Medicare billings, as well as cost and management deficiencies, and ethical concerns about incentive payments made to doctors. Changes in the external regulatory environment made it difficult to keep any institution on an even keel. A spectacular example in the not-for-profit sector was the failure of the Allegheny hospital system in Pittsburgh and Philadelphia, Pennsylvania, which filed for bankruptcy in 1998, claiming \$1.3 billion dollars of debt owed to 65,000 creditors.⁴³

These and other examples revealed the costs as well as characteristics of the industrial approach to health care in the United States. They also point up the roiling, sometimes conflicting mass of influences that are brought to bear on health care from the wider business and legal contexts. Changes in bankruptcy provisions, tax provisions, capital requirements and other financing mechanisms, as well as reimbursement levels under Medicare and Medicaid and from managed care negotiations, jostle together with other influences and affect the prosperity of health care institutions and health professions.

Anti-trust provisions, designed to maintain and improve the working of the market by eliminating unfair competition, became an important influence on hospital and medical behaviour in the 1970s, bringing the Federal Trade Commission and the Justice Department into the regulatory fray. Carl Ameringer has argued that antitrust was a primary cause of the medical profession's loss of economic and organisational power after 1970, and more generally that the success of 'market reformers' over advocates of

⁴³Burns and Burns in Stevens *et al.* (eds) 2006, p. 273.

government approaches to health care in the United States 'succeeded in large part because certain institutions and legal mechanisms were in place to further their objectives'.⁴⁴

Conclusions

What conclusions can be drawn from the volatile, often unpredictable history of the American health care industry, as it has grown since 1948? The most obvious conclusion is that this particular industry has not solved the social problems of universal access to affordable care at the time of need; the second, that there is no particular reason why it should. Social problems require social solutions, and these have not solved the most egregious, widely acknowledged problems of equity, efficiency, coverage and costs. The federal government and the states have not been idle. There has, rather, been a surfeit of policies to improve health services, each with a special purpose, sponsorship and scope.

Side by side with its high costs, profligacy and waste, its distressing exclusion of millions of people from insurance coverage, and its lack of coordination of services, the American health enterprise has produced notable achievements out of its public–private mix. More than half of all spending on hospital care in the United States was from federal, state and local governmental sources combined in 2006.⁴⁵ Since the implementation of Medicare in 1966, older Americans have had extraordinary access to inpatient hospital services, from neurosurgery to knee replacements with everything in between, and have come to expect those services to be available to them on a timely basis. Official figures show that 'private' expenditures outranked 'public' expenditures on personal health services as a whole in 2006 (54 per cent to 45 per cent), but these figures are incomplete. They leave out private out-of-pocket expenditure that is not reported, exclude the 'public' contributions for private health insurance for government employees, and fail to take into account the value of substantial tax relief (foregone taxes), including incentives to employers to manage health insurance for their employees. Government sources probably account for 60 per cent or more of total costs.

Such observations point up the extent of government as well as private involvement in health care in the United States. However, they can be misleading as a guide to power and influence. There are mixed and multiple money streams. There are not two independent 'public' and 'private' sectors; the two are inextricably interconnected and mutually dependent. Health care in 2008 is the result of a long, disjointed cavalcade of government and market action: of legislation passed with lasting effects (such as for biomedical research, Medicare, Medicaid); legislation passed with fugitive effects (as in the original concept of HMOs, and health planning legislation); legislative proposals unachieved (as in attempts to create universal insurance coverage); market contributions to all of these outcomes; and market responses to the opportunities these outcomes have presented, case by case.

What is it like to have a health care industry without having national health care or universal national health insurance? Exciting, alarming and frustrating. The United States has

⁴⁴Ameringer 2008, p. 199.

⁴⁵Catlin *et al.* 2008, p. 27.

been remarkably successful in achieving highly specialized, valued, life-improving health care for most members of the population since the Second World War, but at a huge, inexorably rising cost—and not for all. Expenditures represented more than \$7,000 per person in the population in 2006, yet one of every six Americans under the age of 65 did not carry health insurance—and the number has been rising.⁴⁶ There is little or no disagreement that everyone should be covered; the debate is about ends and means. Old bugaboos remain: extending public coverage to all without making controversial systemic changes would drive up national expenditures. Further, the prospect of cost control raises fears of unacceptable limitations on service among those who are now well served.

More than a whiff of inegalitarianism lingers on. Though Medicare and Medicaid came in with avowedly egalitarian goals, there does not seem to be an egalitarian sentiment across the health system as a whole. For some, 'Reform' is another word for 'Rationing'. In turn, 'Rationing' is another word for cutting back services for those in higher social echelons. In some ways, 'Choice' may be the new proxy for social class, allowing consumers to find their own level of economic and social comfort through their insurance-purchasing decisions (including privately-purchased Medicare supplements) and ability to pay out of pocket, and to select sources for treatment that are within their means. While primary care continues to decline for the general population, the affluent are offered private 'concierge' services: an upscale doctor on call, for a substantial retaining fee.

There remains the hope that, bit by bit, better coverage will be achieved: perhaps through requiring everyone to have health insurance (an 'individual mandate'), accompanied by affordable, regulated and subsidised insurance policies; and perhaps, for those who hew to individualistic approaches, through extending existing opportunities for Americans to save money tax-free in 'health savings accounts'. However, as Timothy Jost has stressed, this 'consumer-driven' approach is of most value to upper-income Americans who can afford to put money away in tax-sheltered savings accounts. A more formal multi-tiered system may result. Most of the population may find themselves able to afford to buy insurance with high deductible amounts; that is, having to pay the monthly insurance premium for their insurance and also pay out of pocket for any medical expenses incurred up to a declared minimum deductible, say \$2,500 or \$4,000. Some individuals may not be able to pay this deductible amount when they need medical care; and some may put off going to the doctor if they have to pay the full fee. The underlying question is fundamental: how far should consumers be held responsible for unhealthy behaviour and/or their health care decisions?⁴⁷ The jury is still out on this.

As in earlier years, there are no easy or obvious solutions. Larger questions, such as whether the money now in health care should be redistributed toward chronic illness or prevention, or whether it would make more sense from a social perspective to build up education rather than health services in a consumer-oriented culture, have less relevance in the United States than elsewhere, if only because there is no concentrated source for financial leverage in the system.

⁴⁶Catlin *et al.* 2008, p. 14; Kaiser Commission 2007, p. 1.

⁴⁷See Jost 2007.

How can scholars best write about this varied, dynamic, ever-changing industry, and what are the useful historical perspectives in our present? The first answer to both these questions is multidisciplinary. Much of the scholarly work I cite in this paper has been written by scholars interested in broad policy areas, rather than primarily interested in medicine—not surprisingly, since health policy has typically been an outcrop of policy decisions (or lack of decision) in other fields. Hence the value of labour, welfare, regulatory and corporate history as an approach for understanding national health care. Other valuable studies of the federal role across economic sectors include David Moss's work on the larger historical role of the federal government in shouldering risk, whether for banking or health insurance,⁴⁸ and Christopher Howard's examination of tax policy as an essential American method for advancing social goals, whether job policy, home mortgage interest, pensions or health care.⁴⁹ These and other scholarly approaches underline the mixed messages inherent in American health care over the past 60 or so years, and help us to understand the catholicity of American health care as a national enterprise—its sheer profusion of forces, unexpected swerves, and abundant possibilities.

A second set of answers to writing usable history demands examination of an obvious aspect of the public–private American health industry. For all its flaws, and for all its energy, this industry is inefficient at providing health services. As David Cutler and others have argued, for the most part American medical care is far better in 2008 than in 1948, and this increased value should be taken into account in any assessment of health care costs and quality; we would not wish to return to the scientific and technological expertise of health practitioners and institutions in the 1940s.⁵⁰ What seems to have been lost in the United States in the past 60 years is the idea of health care as a necessary part of the social infrastructure. There is a gulf between a health care 'industry' and 'social medicine'.

The United States offers historians of social medicine rich themes to explore in the future, but they may be different themes from those of most interest in the NHS. How well, for example, does primary care work (and what is it?) when a given American may sometimes use a convenience clinic (perhaps in a chain pharmacy or Wal-Mart store) for an ear infection, pick up a flu shot at work or in an apartment building, and go directly to a gynaecologist, ophthalmologist, orthopaedic specialist, neurologist or other specialist of his or her own choice, without feeling the need to inform a primary care practitioner?

The consumer-owned, Internet-based, electronic medical record makes more sense in the United States, on the face of it, than in many other countries. But how many, and which Americans can take advantage of current medical knowledge effectively, in order to optimise their health, their budgets and their medical bills? Broad questions of

⁴⁸Moss 2004.

⁴⁹In health care alone, in 1995 there was an estimated loss of \$45.8 billion in potential tax revenue for subsidising employer contributions for medical insurance premiums and medical care, and another \$20.5 billion for a mixed bag of deductions, ranging from untaxed Medicare benefits to exclusion of tax-free interest on state and local government hospital bonds; Howard 1997, p. 21.

⁵⁰Cutler 2004.

social class, illness, insurance and burden of payment for health care become more important in a society with widening divisions of the population by socio-economic class, education, health literacy and computer skills. Are the assumptions of social equity in Medicare dwindling to extinction? Why do opinion polls consistently report popular support for national insurance coverage, but little is done? The list of potential questions goes on and on.

Both politics and the market have short-term vision. Two basic questions continue as long-term challenges for American health care over the next 60 years. Will the United States meet social, behavioural and medical goals for its population as a whole? Will there be a workable consensus as to what those goals should be?

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