

A Century of Failure: Health Care Reform in America

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Abstract To understand fully the persistent failure of the United States to enact national health insurance requires an appreciation not only of the role of government and the dynamics of politics but of underlying social realities. One consideration, which dates back to the Great Depression, is the absence of the middle class from a coalition in favor of such a policy. This absence reflects both the constricted vision of the middle class and the spirited campaigns of groups like Blue Cross to make certain that middle-class needs were met in order to reduce pressure for government intervention. Another critical social feature is the special entrepreneurial character of the American medical profession. Physicians saw themselves as small businessmen and, as such, shared and promoted a suspicion of governmental intervention. All the while, Americans justified the absence of a national program in terms of the ethos of voluntarism, which had a sufficient base in reality for the posture to be maintained without great embarrassment. In fact, the rhetoric that surrounded the enactment of Medicare reinforced these views, making it appear that, the elderly aside, all was well with the provision of medical services in the country. Even as national health insurance assumes a new prominence on the political agenda, it remains unclear whether these several considerations will allow for the enactment of sweeping changes.

There are some questions that historians return to so often that they become classics in the field, to be explored and reexplored, considered and reconsidered. No inquiry better qualifies for this designation than the question of why the United States has never enacted a national health insurance program. Why, with the exception of South Africa, does it remain

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the only industrialized country that has not implemented so fundamental a social welfare policy?

The roster of answers that have been provided is impressive in its insights. Some outstanding contributions to our understanding of the issues come from James Morone, Paul Starr, Theodore Marmor, and Theda Skocpol. Their explanations complement, rather than counter, each other. In like manner, the elements that this essay will explore are intended to supplement, not dislodge, their work. A failure in policy that is so basic is bound to be overdetermined, and therefore, efforts to fathom it will inevitably proceed in a variety of directions.

The Liberal State

Morone's frame for understanding American health policy in general and the failure of national health insurance in particular centers on the definitions of the proper role of the state, the acceptable limits for all governmental actions. His starting point is with the fact that the medical profession successfully "appropriated public authority to take charge of the health care field," taking for itself the task of defining the content, organization, and, perhaps most important, the financing of medical practice (Morone 1990: 253–84). This accomplishment points to more than the power of the American Medical Association's lobbying machine; AMA rhetoric, which has seemed to other observers to be bombastic, comical, or even hysterical, in Morone's terms was effective precisely because it drew on popularly shared assumptions about the proper relationship between governmental authority, professional capacity, and professional autonomy. By the terms of this consensus, the government's duty was to build up professional capacity without infringing on professional autonomy—and as long as the medical profession defined national health insurance as an infringement on its autonomy, such a policy would not be enacted. Government was permitted to build hospitals (witness the implementation of the Hill-Burton Act) and to endow the research establishment (witness the extraordinary growth of the National Institutes of Health), but it was not allowed, at least until very recently, to challenge or subvert professional autonomy.

Paul Starr also focuses on conceptions of state authority to explain health policy. Alert to the markedly different course of national health insurance in European countries, he posits that where a spirit of liberalism and a commitment to the inviolability of private property interests in relation to the state were strongest, movements for social insurance

made the least headway. Thus, Bismarck's Germany could accomplish what Theodore Roosevelt's or Franklin Roosevelt's United States could not. Put another way, the fact that socialism never put down strong roots in this country, the absence here of a socialist tradition or threat, obviated the need for more conservative forces to buttress the social order through welfare measures.

Starr is more ready than Morone to credit the raw political power of the AMA, but he also reminds us that the AMA found allies among not only corporations but also labor unions. Union leaders preferred to obtain health care benefits for its members through contract negotiation, not through government largesse—even if that meant, or precisely because that meant, that nonunion members would go without benefits (Starr 1982: part 2).

Paralleling their studies are detailed accounts of the legislative histories of various health insurance proposals, the fate of Progressive, New Deal, and Fair Deal initiatives. The work of Theodore Marmor has clarified the political alliances that came together to enact Medicare and Medicaid (Marmor 1982). So too, the writings of Theda Skocpol place health care legislation more directly in the tradition of American welfare policies (Weir et al. 1988). In all, the existing literature illuminates the effects of both conceptions of governmental authority and the realities of constituent politics to tell us why the United States stands alone in its failure to enact national health insurance.

Co-opting the Middle Class

Despite the sophisticated and perceptive quality of these arguments, still other considerations underlie the failure to enact national health insurance. An analysis of them does not subvert the basic contours of the other interpretations but provides a deeper social context for the story.

The starting point for such an analysis is a frank recognition of the fact that what is under discussion is essentially a moral failure, a demonstration of a level of indifference to the well-being of others that stands as an indictment of the intrinsic character of American society. This observation, however, is not meant to inspire a jeremiad on American imperfections as much as to open an inquiry into the dynamics of the failure—not only how it occurred but how it was rationalized and tolerated. Americans do not think of themselves as callous and cruel, and yet, in their readiness to forgo and withhold this most elemental social service, they have been so. This question arises: How did the middle class, its elected rep-

representatives, and its doctors accommodate themselves to such neglect? To be sure, Morone, Starr, and others have made it clear that ideas on the proper scope of government were powerful determinants of behavior, that leaders like FDR made strategic political calculations that traded off health insurance for other programs, and that the AMA smugly equated physician self-interest with national interest. But given the signal importance of health care—and, a minority of commentators aside, the ongoing recognition that it is more than one more commodity to be left to the vagaries of the marketplace—there is a need for an even broader framework for understanding these events. The chess moves of politicians, and even the rules of the game of politics, seem somewhat too removed and abstract. Put most succinctly: How could Americans ignore the health needs of so many fellow countrymen and still live with themselves? How could a society that prides itself on decency tolerate this degree of unfairness?

For answers, it is appropriate to look first to the 1930s. As a result of the Great Depression, American social welfare legislation was transformed, as exemplified by the passage of the Social Security Act. Moreover, by the 1930s, the popular faith in the efficacy of medical interventions was firmly established and the consequences of a denial of medical care, apparent. Already by the 1910s, some would-be reformers defined the goal of health insurance not merely as compensation to the sick for wages lost during illness but as the opportunity to obtain curative medical care. Twenty years later, this credo was accepted by almost all reformers, although the efficacy of medical interventions was, at least by current standards, far from impressive. Also by the 1930s, the hospital, which had earlier been almost indistinguishable from the almshouse, had become a temple of science and its leaders, *Men in White*, widely celebrated. In keeping with these changes, physician visits and hospital occupancy now correlated directly, not inversely, with income.

Why then was national health insurance omitted from the roster of legislation enacted in the 1930s? If medicine was so valued and government so receptive to novel (at least for Americans) social insurance programs, why was health insurance kept off the roster? Although such considerations as FDR's reluctance to do battle with the AMA or to fragment his southern alliance were important, perhaps even more determinative were the tactics, thoroughly self-conscious, that were helping to remove the middle classes from the coalition of advocates for change. And eliminating the middle classes from the alignment successfully deflated the political pressure for national health insurance.

One of the pivotal groups in designing and implementing this strategy

was a newly founded, private health insurance company, Blue Cross. Against the backdrop of the report of the Committee on the Costs of Medical Care, urging greater federal intervention in health care, Blue Cross presented itself as the best alternative to government involvement. Its organizers and supporters, such as Rufus Rorem and Walter Dannreuther, held out the promise that enrolling the middle class in its plan would blunt the thrust for national health insurance. Blue Cross, declared Dannreuther, would “eliminate the demand for compulsory health insurance and stop the reintroduction of vicious sociological bills into the state legislature year after year.” Blue Cross advertisements, pamphlets, radio programs, and publications insisted that neither the rich nor the poor confronted difficulties in obtaining medical services, the rich because they could easily afford it, the poor because they had ready access to public hospitals. Only the middle classes faced a problem, and unless their needs were met, they were bound to agitate for a change in governmental policy. (“It is the people in the middle income group who often find it most difficult to secure adequate medical and hospital care,” declared Louis Pink, president of New York Blue Cross. “It is sometimes said that the very poor and the rich—if there are any rich left—get the best medical care.”)¹ The idea was not to buy the middle classes off by expanding the services of public hospitals and persuading them to take a place on the wards to meet emergency needs. Such a solution, as Blue Cross proponents explained, would not only strain the public hospital system beyond its capacity, but would not work because the middle classes considered the public hospitals to be charity, with all innuendo intended, and they were not about to accept charity. As one Blue Cross official insisted: “The average man, with the average income, has pride. He is not looking for charity; he is not looking for ward care. He wants the best of attention for himself and his family. . . . Yet out of his savings, he is very seldom prepared to meet unexpected sickness or accident expenses.” Thus, to use the public hospital was not only to get second-best care but to be stigmatized as dependent, incapable of standing on one’s own two feet. Like the dole, the public hospital violated the American way. Were this the only choice, the middle classes would push for, and obtain, national health insurance.

The alternative that embodied the American way was a private subscription plan, which, for as little as three cents a day (the Blue Cross slogan), protected members from the high cost of hospitalization. “The

1. Statements from Blue Cross representatives are taken from Rothman 1991.

Blue Cross Plans are a distinctly American institution,” declared one of its officials, “a unique combination of individual initiative and social responsibility. They perform a public service without public compulsion.” Another executive asserted that Blue Cross exemplified “the American spirit of neighborliness and self-help [which] solves the difficult and important problem of personal and national health.” All of which led inexorably to the conclusion: “Private enterprise in voluntarily providing hospital care within the reach of everyone is solving the public health problem in the real democratic way. The continued growth of the Blue Cross Movement might well be considered the best insurance against the need of governmental provision for such protection” (quoted in Rothman 1991).

Blue Cross was notably successful in enrolling middle-class subscribers, serving, as intended, to reduce or eliminate their concern over the payment of hospital bills. To be sure, it took some time to build up a membership, but by 1939 there were thirty-nine Blue Cross plans in operation with more than 6 million subscribers. Indeed, the plans became even more over time, with some 31 million subscribers by 1949 (Starr 1982: 298, 327).² In fact, from its inception the impact of Blue Cross was probably greater than even the membership statistics indicate. Its extraordinarily active advertising campaigns made a compelling case that private, as against public, initiatives were more than sufficient to meet the problem, so that even those who did not immediately enroll may have accepted the viability of this alternative. There was no reason to press for political change when the private sector seemed to have resolved the issue. Thus both in rhetoric and in reality, Blue Cross helped to undercut middle-class interest in and concern for national health insurance. The result, fully intended, was that they did not join or lend strength to a coalition for change. Politics could do business as usual, allowing a variety of other considerations to outweigh support for such an innovation.³

In fact, the dynamic set off by Blue Cross in the 1930s gained strength

2. In addition, there were another 28 million people enrolled for health care benefits with commercial insurance companies, so the private system was extensive.

3. It may well be that a felt need for health insurance was an acquired, not innate, characteristic. The first Blue Cross advertisements tried to build up a demand for insurance by emphasizing the unexpected character of illness, the sudden and unanticipated strike of disease. One of its popular advertising images represented Blue Cross as a helmet protecting against the club of the hospital bill that lay hidden, waiting to assail the unaware victim; the accompanying slogan read: “You never know what jolt is around the corner.” Blue Cross’s strategy was to emphasize the unpredictability of health care needs and that illness could strike anyone at any time, suggests that just when it raised consciousness about the need to carry health insurance, it provided an answer as to how best arrange it.

in the post-1945 period, not only from its own growth but from the labor movement. Not just private insurance but union benefits served to cushion the middle classes from the impact of health care costs. Over these years, contract provisions negotiated with business corporations provided unionized workers with health care benefits, reducing their felt need for government programs. With that many more middle-class households effectively covered, it would require empathy, not self-interest, to push for national health insurance, and that empathy, for reasons that we will explore further below, was in short supply. As a result, public responsibility for health care became linked to the welfare system, serving only the poor, not the respectable. Coverage was something to be provided for “them,” not what “we” needed or were entitled to as citizens.

How this divide between “we” and “they” shaped welfare policy emerges with particular vividness in the history of the almshouse in the 1930s. When the decade began, the institution was still one of the mainstays of public welfare policy, particularly for the elderly and for those considered the “unworthy poor.” Although the post-World War II generation associates the almshouse with Dickensian England, it was of major importance in this country even at the start of the Great Depression. Only in the mid-1930s did the almshouse begin to lose its hold on welfare programs, moved aside by such New Deal relief programs as the Works Project Administration (WPA) and the Social Security Act. In fact, WPA regulations prohibited the expenditure of funds to build or enlarge these institutions; the WPA was ready to build roads but not to build or refurbish almshouses. Why this distinction? Why the abandonment, at long last, of the almshouse? Because for the first time, almshouse relief would have had to include the middle classes. With state and city budgets staggering under the burden of relief and private charities altogether unequal to the task, absent a WPA or Social Security Act, many of the once-unemployed would have had to enter the almshouse. The prospect of having respectable middle-class citizens in such a facility was so disturbing as to transform government relief policy.

Imagine this same dynamic at work in health care. Picture the middle classes having no alternative but to crowd into the public hospital, to receive medical services in the twelve-bed wards. It is by no means fanciful to suggest that had this been the case, a different kind of pressure would have been exerted on the government to enact health insurance coverage. Blue Cross, however, self-consciously and successfully short-circuited the process and thereby allowed the play of politics to go on uninterrupted.

The Physician as Entrepreneur

A second critical element that underlay the American failure to implement national health insurance was the character of its medical profession. The speeches, letters, and writings of American doctors over the period 1920–1950 indicate broad sympathy for the positions of the AMA, perhaps somewhat less dogmatic but fully sharing of the organization's commitment to a fee-for-service system. Although some historians have found significant diversity of medical opinion on national health insurance earlier in the Progressive Era, by the 1920s most physicians were profoundly uncomfortable with proposed government intrusions into health care.

Narrow financial self-interest, the fear of a loss of income through national health insurance, was a force in shaping some doctors' attitudes, but it was far from the only consideration. For one, physicians' earnings were not so large as to turn them necessarily into dogged defenders of the status quo. Physicians' average income, for example, was below that of lawyers and engineers; in 1929, of the 121,000 physicians in private practice, 53 percent had incomes below \$4,000, and 80 percent, less than \$8,000. To be sure, some 12 percent of physicians had incomes over \$11,500, but the profession was far from a lucrative one (President's Research Committee 1933: 1104). In strictly financial terms, it would not have been illogical for doctors generally to have supported national programs, particularly in the 1930s. They might have accepted government intervention with some enthusiasm, on the grounds that it was better to receive some payment from Washington than no payment from a patient. But this was not the position commonly adopted, and to understand why requires an appreciation of the essentially entrepreneurial character of American medicine. In more precise terms, the mind-set of physicians was that of the independent proprietor. They identified themselves as businessmen and, as such, shared an aversion to government interference.

It may be that the very differentiation in income among physicians at once reflected and reinforced a scramble for income that is not commonly associated with the practice of medicine. This was the conclusion that the Lynds reached in their portrait of "Middletown" in the 1920s. "The profession of medicine," they wrote, "swings around the making of money as one of its chief concerns. As a group, Middletown physicians are devoting their energies to building up and maintaining a practice in a highly competitive field. Competition is so keen that even the best doctors in many cases supplement their incomes by putting up their own

prescriptions” (Lynd and Lynd [1929] 1956: 443). It was not unusual for physicians to invest in proprietary hospitals or to accept fee-splitting arrangements. Doctors also purchased common stocks and invested in local businesses—albeit not always very cleverly. By the 1920s, doctors had such a reputation for being suckers that advice books on business addressed to them devoted large sections to discussions of “Why Do Doctors Fail to Choose the Right Investments?” The answers were generally variations on the theme of “There is a host of people who have found out that the doctor likes to take a chance. . . . He has worked so hard to accumulate his small savings and the possibility of making prodigious returns are presented to him so plausibly by some glib talker that all too frequently this nest egg is frittered away on some unsavory scheme, for he seldom has the time, inclination and facilities to make the essential investigation” (Thomas 1923: 174–75). In effect, the financial dealings that occupy physicians today are far less novel than critics like Arnold Relman might like to imagine.

To account for physicians’ entrepreneurial perspective, it is vital to remember that their social world overlapped with that of the local business elite, particularly in smaller towns. When one upper-class resident of “Regionville” was asked by sociologist Earl Koos to list the five most important people in the town, he responded: “I put Doc X on that list because . . . he is one of the best-educated men in town, and makes good money—drives a good car, belongs to Rotary, and so forth. . . . Of course, some doctors aren’t as important as others, here or anywhere else, but unless they’re drunks or drug addicts, they’re just automatically pretty top rank in town” (Koos 1954: 54).

The pattern of recruitment to the profession also encouraged this orientation. Medical school classes in the 1920s and 1930s were the almost exclusive preserve of white, upper-middle-class males. From birth, it would seem, physicians were comfortable, socially and ideologically, in the clubhouse locker room. The image is properly one of Wednesday afternoon off, doctor chatting with town banker, lawyer, and principal store owner about investment opportunities and politics, with a shared antagonism to what all of them considered the evil of Government Control.

Physicians voiced their opposition to national health insurance not only collectively through the AMA but individually as well, in the process helping to mold public attitudes. As Koos aptly observed, in towns like Regionville, especially before 1950 (before the rise of a more national media and greater opportunities for travel), doctors were opinion leaders: “In the small town, the doctor is most often ‘a big frog in a little puddle’;

what he thinks and does can assume an importance in the community not paralleled in the life of his urban counterpart" (Koos 1954: 150). In brief, the entrepreneurial style of American physicians helps explain much of their own and some of their neighbors' disinclination to support national health insurance.

The Ethos of Voluntarism

But then how did Americans live with the consequences of their decision? How did they justify to themselves and to others their unwillingness to provide so essential a service as medical care to those unable to afford it? The need for pragmatism in politics (we dare do no other) and definitions of the boundaries of state authority (we should do no other) surely mattered. So, too, in health care as in matters of social welfare more generally, they could always fall back on such truisms as "The poor have only themselves to blame for their poverty—they should have saved for the rainy day." And middle-class Americans could also invoke the safety net of the public hospital, noting that its services were available to all comers, regardless of income.

But there were other justifications as well, particularly the celebration of the ethos of voluntarism, the credo that individual and organizational charity obviated the need for government intervention. Individual physicians and community charities ostensibly provided the needy with requisite medical care. This idea was not fabricated from whole cloth, for Americans, and their doctors, had good reason to believe that their own initiatives were sufficient to meet the problem.

Physicians, for their part, insisted that they turned no one away from their offices because of an inability to pay for services. They used a sliding scale for setting fees, charging the "haves" more and the "have-nots" less, so as to promote the social good. The claim was incessantly repeated and undoubtedly had some validity to it. "It was probably true," reported Koos, "that no physician in Regionville would leave a worthy case untreated." The physician, claimed the New York Medical Society in 1939, "has socialized his own services. Traditionally, he is at the call of the indigent without recompense. . . . For those who are self-supporting, he graduates his fees to meet the ability to pay, and extends time for payment over long periods." As late as 1951, a survey of physicians in Toledo, Ohio, found overwhelming support for a sliding scale of fees and widespread agreement that, to quote one response: "It's fair, the fairest thing we can do. If a man is wealthy, you certainly would charge him more than

if he didn't have a dime. It's not uncommon for a doctor to call me and say, 'These people don't have any money,' or can pay only a little, and I say, 'Sure send 'em on in. I'll take care of 'em' " (Schuler et al. 1952: 60, 69, 85). Thus, physicians justified their opposition to national health insurance by citing their own altruism. Their charity rendered government intervention unnecessary.

By the same token, community philanthropy often stepped in where the circumstances went beyond the scope of individual physicians. It was not only a matter of a voluntary society establishing not-for-profit hospitals or organizing outpatient dispensaries. Voluntarism seemed capable of meeting the most exceptional challenge. To choose one of the most noteworthy examples, in the case of polio, private charitable efforts helped to make certain that no child, whatever the family's income, would lack for access to an iron lung or to rehabilitative services. By November 1931, only two years after Philip Drinker perfected the iron lung, there were 150 respirators to be found in hospitals across the country. Foundations, including Milbank and Harkness, underwrote the cost of some of the machines, and their efforts were supplemented by the fund-raising work of local ladies' auxiliaries. As for patient rehabilitation, the National Foundation for Infantile Paralysis, founded in 1938 by FDR and directed by onetime Wall Street attorney Basil O'Connor, supported both research and the delivery of clinical services. Several thousand local chapters and one hundred thousand volunteers made certain that no person with polio was denied medical assistance because of economic hardship. And the foundation defined "hardship" liberally, to cover the case where medical expenditures would force a family to lower its standard of living.

The polio experience was particularly important in confirming a belief in the adequacy of voluntarism. With a world-famous patient, in the person of President Franklin Roosevelt, and an extraordinarily successful foundation, a compelling case could be made for the capacity of voluntary action to meet the most unusual and costly health care needs. Moreover, the lesson was felt particularly strongly by the middle classes, because polio was in many ways their disease, disproportionately striking children raised in hygienic, uncrowded, and (epidemiologically speaking) protected environments. Those from lower-class and urban backgrounds were more likely to be exposed to the virus at a young age and had thereby built up immunities to it. Thus the foundation, like Blue Cross, served the middle classes so well that it insulated them from the predicament of health care costs. No wonder, then, that they, and their political representatives, to the degree that they looked out on the world from their own

experience, found little need for government intervention and were able to maintain this position without either embarrassment or guilt.

The Dual Message of Medicare

Surprising as it may seem, the rhetoric that surrounded the enactment of Medicare reinforced many of these constricted views. The most significant government intervention in health care did not, the wishes of many of its proponents notwithstanding, enlarge the vision of the middle classes or make the case for national health insurance. To the contrary. The debate around Medicare in a variety of ways made it seem as though, the elderly aside, all was well with the provision of medical services.

In the extensive hearings and debates that Congress devoted to Medicare between 1963 and 1965, proponents of the bill, undoubtedly for strategic political reasons, repeatedly distinguished Medicare from a national health insurance scheme. So intent were they on securing the passage of this act that they went to great pains to minimize the need for any additional interventions once Medicare was in place. And as they offered these arguments, perhaps unintentionally but nevertheless quite powerfully, they reinforced very traditional perspectives on poverty and welfare and the special character of middle-class needs.

The opening statement given in November 1963 to the House Committee on Ways and Means by then secretary of Health, Education, and Welfare, Anthony Celebrezze, laid out the themes that other advocates consistently followed. His goal was to demonstrate that the elderly presented "a unique problem," and thereby warranted special support. Just when their postretirement incomes were declining, they faced disproportionately higher health care costs: "People over sixty-five," Celebrezze calculated, "use three times as much hospital care, on the average, as people under sixty-five." Moreover, the private health insurance system that worked so well for others did not meet their needs: the premiums were too expensive (one-sixth of their medium income), and the policies often included restrictive clauses (for example, ruling out preexisting conditions). Hence, Celebrezze concluded, "this combination of high health costs, low incomes, and unavailability of group insurance is what clearly distinguishes the situation of the aged as a group from the situation of younger workers as a group" (U.S. Congress 1964: 28).

It was a shrewd argument, but it left open several problems. The first was to justify excluding the young from a federal program. To this end, Celebrezze and the other Medicare proponents frankly and wholeheart-

edly endorsed the status quo: "The vast majority of young workers can purchase private insurance protection. . . . I think for younger employed people, voluntary private plans can do the job" (U.S. Congress 1964: 36). Those below sixty-five were less likely to require health care interventions, and, should they encounter sudden needs, they could always borrow the sums and pay them back through their future earnings. In effect, the Medicare proponents swept under the table the problems of access to health care for those who were outside the net of employer-provided private insurance.

The second and even tougher issue for the Medicare supporters was to explain why the elderly in need should not be required to rely on the welfare system to meet their health care requirements. After all, as one critic noted, these people had been remiss in not saving for the rainy day, and the government ought not to bail them out. They would not have to forgo health care services. Rather, to the opponents of Medicare, which included to the very end the AMA, the just solution was to aid them through a program like Kerr-Mills. Under its provisions, the needy elderly would demonstrate (to public assistance officials) their lack of resources, take a place on the welfare rolls, and then receive their health care services under a combined federal-state program. The counterargument from the Medicare camp was that to compel the elderly to demonstrate their dependency was too demeaning. "We should take into account the pride and independent spirit of our older people," Celebrezze insisted. "We should do better than say to an aged person that, when he has become poor enough and when he can prove his poverty to the satisfaction of the appropriate public agency, he may be able to get help." But if welfare was so humiliating, why should anyone have to suffer such a process? If welfare demeaned the elderly, why did it not demean the young? To which the tacit answer was that if the young were poor, they had only themselves to blame. Those on welfare, the elderly apart, were so "unworthy" that humiliation was their due, at least until they reached sixty-five (U.S. Congress 1964: 31).

The third and probably most difficult question was whether a federal health insurance program for the elderly ultimately rested, as one opponent put it, on the premise that "the federal government, as a matter of right, owes medical care to elderly people." Again Celebrezze backed off a general principle in order to separate out the case of the elderly. Admittedly, he had opened his testimony with the statement that for the elderly, "the first line of defense is protection furnished as a right." But in response to hostile questions, he retreated, declaring that the federal

government did not owe anyone “medical attention as a right.” Medicare was to be part of the social security system, which meant that beneficiaries had paid for their benefits. And even if the first recipients would not have done so in strictly actuarial terms, still they had made their contributions “on a total program basis” (U.S. Congress 1964: 158). Although the meaning of that phrase was altogether obscure, the gist of the argument was clear: Medicare would not establish a right to health care. Ostensibly, it was not the opening shot in a larger campaign. In some oblique but still meaningful way, the principle remained that you got what you paid for, more or less.

Clearly, all these maneuvers were part of a strategy to get Medicare enacted, and many proponents insisted after the fact that they had been confident, undoubtedly too confident, that Medicare would be the first step on the road to national health insurance. They were, of course, wrong—for all the reasons we have been exploring, along with one other consideration. These Medicare proponents may have been too successful in marking off the case of the elderly. Having taken the pragmatic route, they reinforced older attitudes, afraid to come out in favor of a right to health care, afraid to break out of the mold of a quid pro quo mentality for benefits, afraid to advocate a program in terms that were more universal than middle-class interests. It was the 1930s almshouse dynamic revisited—because the worthy middle class could not be expected to go on relief to gain medical benefits, the system had to change. True, others would benefit from the program, including non-middle-class elderly. But that seemed almost serendipitous. Medicare was to protect the elderly middle classes from burdensome health care costs, not break new ground more generally by changing demeaning welfare policies or rethinking health care rights or the limits of private insurance for those under sixty-five. Thus, it should be less surprising that for the next several decades, Medicare did not inspire a new venture in government underwriting of health care.

Future Prospects

In light of a tradition of narrow middle-class self-interest, the entrepreneurial quality of American medicine, and the tradition of voluntarism, what are the current prospects for a national health insurance program?

Perhaps the most encouraging point is that each of the elements that have been discussed here are in flux. The middle classes, by all accounts, are feeling the impact of rising health insurance costs and are becoming

increasingly vulnerable (through periodic unemployment or narrowing eligibility requirements of insurance companies) to the loss of insurance benefits. The weaknesses of a private system are in this way becoming quite apparent to them. At the same time, there are signs that American medicine is becoming less entrepreneurial, witness the increased numbers of salaried physicians employed by HMOs, corporations, and hospitals. And by now, the limits of voluntarism are glaringly obvious: whether the case is kidney dialysis or the future of the voluntary hospital, it is practically indisputable that the not-for-profit sector is incapable of shouldering the burden of health care.

All this would be grounds for optimism, were it not for one final element: the persistence of a narrowed vision of middle-class politics. With no largesse of spirit, with no sense of mutual responsibility, the middle classes—and their representatives—may advocate only minimal changes designed to provide protection only for them, not those in more desperate straits. In policy terms, it may bring changes that are more exclusive than inclusive, serving the employed as against the unemployed, protecting the benefits of those who have some coverage already as opposed to bringing more people to the benefits table. It may also promote schemes that will serve the lower classes in the most expedient fashion. The Oregon model, through which health insurance expands by restricting the benefits that Medicaid patients can receive, may become the standard response. Our past record suggests all too strongly that politics will find a way to protect those several rungs up the social ladder, while doing as little as possible for those at the bottom. Whether we will break this tradition and finally enact a truly national health insurance program remains an open question.

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