PART IV

A Look Backward

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Five Decades of Change: A Summary

The last five decades have seen a rapid evolution of American health care and political philosophy. This period stretched from the depths of the Great Depression to the nuclear age, from an era in which the federal government exercised little control over health care to one in which it is deeply involved in health care.

The movement that resulted in a long list of health legislation seems to have been an outgrowth of an effort to enact workmen's compensation laws in a majority of states. The American Association for Labor Legislation, organized in 1906 under the direction of John Andrews, worked for the passage of such laws. The AALL wrote a standard, or model, bill that would establish nonprofit organizations to administer state-collected "sickness insurance" funds from employees and employers-health and disability insurance. The standard bill created much interest between 1915 and 1919, but the promoters of the idea, although they were successful in introducing the bill in several state legislatures, were unable to enact it into law. One notable example was in New York State: there the bill had the support of Governor Al Smith, but it still did not pass.

The influence of one man is evident in the efforts of the AALL and other social activist groups during this period. John R. Commons, professor of economics at the University of Wisconsin, was the mentor of many of the persons who were advocating

the New Deal days. Besides John and Irene Andrews, other members of the Wisconsin group who came to prominence later on were Arthur J. Altmeyer[1] and Edwin E. Witte[2] of the Social Security movement, and Wilbur J. Cohen,[3] secretary of HEW during the Johnson administration.

Workmen's compensation, unemployment insurance, old age pensions, and other aspects of social security naturally led men and women to try to design some kind of health insurance program.

Early Efforts in Health and Hospitalization Insurance

During the years 1915 to 1919, some states considered compulsory state health insurance. Several states set up commissions to consider health and health care. The Metropolitan Life Insurance Co. did a home interview study to determine the extent of illness and loss of days of work. The U.S. Public Health Service collected statistics on sickness among wage earners and concluded that a system of health insurance could be adapted to American conditions. The U.S. Commission on Industrial Relations recommended in 1915 that compulsory health insurance be instituted for all employees in interstate commerce. In 1916 the National Association of Manufacturers viewed health insurance as an extension of medical care under workmen's compensation and favored a compulsory system with free competition among carriers and insurance companies.

The AMA established a committee on social insurance, which met between 1915 and 1919 under the chairmanship of Dr. Alexander Lambert of New York City. Lambert was Theodore Roosevelt's physician, and a few years later was president of the AMA. The committee concluded that compulsory state health insurance was needed.

A few years later, however, the state medical societies and the grass roots general practitioners turned the AMA's position about; the association publicly opposed government at any level impinging in any way on the practice of medicine.

During this same period, the American Federation of Labor was suspicious of government insurance and its effect on labor unions. Prudential Insurance Company spoke out against compulsory health insurance[4] and several of the states that had seemed

1932. The Sheppard-Towner Act, benefiting mothers and children, was passed in 1921. It was short-lived, but it did act as a benchmark for that type of legislation later on. There was also some movement for state pension legislation urged by the Association of Old Age Security under the leadership of Abraham Epstein.

At a time when there was disagreement over the state and federal government's role in providing means for compulsory health insurance, prepaid group hospitalization insurance was developing and being financed independent of government.

The year 1929 is often cited as the apex of the prosperity of the 1920s, from which the rapid slide began down to the mass unemployment, hunger, deprivation, and despair of the 1930s. The year 1929 is also the date often given as the beginning of prepaid group hospitalization-and, by extension, of the Blue Cross movement. Actually 1931 is more important in this context, because it was at the AHA's annual meeting in 1931 that a paper written by Justin Ford Kimball was read by Asa S. Bacon.[5]

As discussed in part II, the paper described an experiment in prepaid group hospitalization developed by Kimball at the Baylor University Hospital in Dallas. Kimball, who had been superintendent of schools in Dallas, enrolled over 1,000 teachers in his plan. Later he extended it to employees of the *Dallas News.* This early prepayment plan was limited to services in one hospital, not to others in the community or elsewhere.

The importance of the paper lay in the fact that it was a public announcement of a new idea. Several of the people who attended that AHA meeting went home and tried to start prepaid group hospitalization plans in their own cities. Maurice Norby, for example, spoke of the effect the paper had on his father, Joseph Norby, who went home to Minneapolis-St. Paul recommending that a plan be started there (see chapter 7).

It is difficult to determine whether prepaid group hospitalization plans were started to help patients pay their hospital bills or to help hospitals collect their charges. Whatever the reason, medicine was showing advances in the training of physicians, in standards of practice, and in technology. Also, prepaid group hospitalization was an idea whose time had come.

The economic conditions of the 1920s were misleading as far as general prosperity was concerned. Productivity in manufacturing and other businesses increased tremendously

Committee on the Costs of Medical Care

Concurrent with the modest beginnings of prepaid group hospitalization was the work of the Committee on the Costs of Medical Care. The committee was composed of a group of concerned health professionals and educators, as well as representatives of the general public, who set about to study the state of medical care in the United States. The group received financial help from foundations and worked under the leadership of Dr. Ray Lyman Wilbur, former president of the AMA, president of Stanford University, and secretary of the Department of the Interior under President Herbert Hoover. The CCMC worked from 1927 until January 1933 trying to get a wide view of a complex and dynamic situation. (I. S. Falk and C. Rufus Rorem relate their roles in the research undertaken by the committee in chapter 2.)

The 28-volume report of the CCMC, issued at the end of 1932 and delivered in January 1933, was almost precognitive. The committee was able to project emerging ideas such as group practice, health insurance, and the government's role in health care matters so accurately that its predictions or recommendations are still relevant and developing after five decades.

The *Journal of the American Medical Association* opposed-adamantly opposed-the CCMC report even before it was officially made public. The editor labeled it as Communistic and liable to incite to revolution. The AMA's stance was that, any time a layman passed judgment on the medical profession or suggested changes in the delivery or financing of health care, it was heresy, an unjust interference in the practice of medicine. Why physicians felt threatened by honest suggestions for change is difficult to understand.

During this time C. Rufus Rorem wrote one of the first books on group practice, while working between the Julius Rosenwald Fund and the CCMC.

Prepaid group hospitalization was emerging simultaneously in several parts of the country. While the growth of the movement cannot be directly attributed to the publication of the CCMC report, it was certainly fortified by the report.

The CCMC report also stressed the need to strengthen medical education. Although there had been improvement in medical education after the Flexner report in 1910, there was

clearly stated their attitude toward government's role in medicine. They recommended that "government competition in medicine be discontinued." They were quite willing, however, to allow government to be responsible for public health, for the medical care of U.S. Army, Navy, and Geodetic Survey personnel, and for "veterans suffering from *bona fide* service-connected disabilities and diseases. . ."

The minority report "vigorously opposed corporate practice of medicine through intermediary agencies" as being "economically wasteful and inimical to a continued and sustained high quality of medical care."[6]

Roosevelt and Health Care

The year 1933, the year the CCMC report was published, was also a turning point in the role and operation of American government. Because of the Great Depression, government became a part of every citizen's life. Unemployment, hunger, the need for financial and moral support turned citizens toward the government for help in a way never experienced before in this country. The federal government in the following few years spent billions protecting people by providing food, shelter, clothing, and make-work. The government was the rock of assurance, protection against want and against the rise of an American dictator.

However, it wasn't long before a natural question was asked: If the government can help with food, shelter, and jobs, why can't it help with health care?

President Roosevelt was not able to answer that question directly, although he showed his interest in some sort of national health insurance plan several times. During his first term in office, 1933-1937, he set up various agencies to combat the economic depression and to provide social security. Although the Social Security Act covered old age pensions, unemployment insurance, and maternal and child health care, as well as increasing the scope of the Public Health Service, it did not include health insurance.

In 1934 Roosevelt saw the need for social insurance in addition to the direct aid the government was furnishing. Some individuals attribute this to the growing pressure of groups demanding old age pensions and other benefits. In the forefront was a group in California led by Dr. Francis E. Townsend. Townsend clubs were formed across the country

Congress for the Townsend plan even before the Social Security Act was passed.

There was also a threat from Huey Long of Louisiana, who had some indefinite plan of sharing the wealth and making "Every Man a King."[7] The danger was not so much from Long's plan as from the possibility that he might run for the presidency in 1935 as an independent and take enough Democratic votes away from Roosevelt to elect a Republican.

The Committee on Economic Security

The Committee on Economic Security was created in June 1934 by President Roosevelt to "study the problems relating to economic security and to make recommendations for a program of legislation."[8]

In discussions with members of the Committee on Economic Security, the president talked of every child's being issued an insurance policy on the day he was born, a policy that would protect him against any major economic misfortunes that might befall him in his lifetime. This was Roosevelt's "cradle to the grave" idea.

The Committee on Economic Security was a cabinet-level committee headed by Frances Perkins, secretary of labor. Other members were the secretaries of the treasury and agriculture, and the attorney general. Harry Hopkins, administrator and director of FERA, was also a member.

Edwin Witte, from the department of economics at the University of Wisconsin, was named executive director of the committee. Arthur J. Altmeyer was appointed to head a technical committee charged with carrying on studies and collecting information. The technical committee was composed of federal employees expert in the areas to be studied. There was also an advisory council of 23 members. Five of the members were from labor, five from business, and the remainder were individuals interested in social welfare. The advisory council was expected to inform the committee of the views of persons and groups outside the government. It was not expected to submit a report.

The Committee for Economic Security worked expeditiously and had a report ready for the president by the last week in December 1934. A bill was drafted. Although the technical committee had considered the need for health insurance, this item was not included in the bill presented to Congress. One reason given was that the inclusion of a health insurance provision might endanger the passage of the entire Social Security bill. Another reason given was that the committee had not had enough time to study the health insurance situation sufficiently to offer a bill at that time.

The Interdepartmental Committee

The possibility of a health plan's passing Congress was not abandoned just because it was not included in the Social Security Act. The same month that Social Security became law, the president appointed an Interdepartmental Committee to Coordinate Health and Welfare Activities. This committee was composed of the assistant secretaries of the cabinet departments involved: Josephine Roche of treasury, chairman (the Public Health Service was under her jurisdiction); Oscar Chapman of interior; M.L. Wilson of agriculture; and Arthur Altmeyer of labor.

For a year and a half the interdepartmental committee coordinated existing government health activities. In 1937 it began a comprehensive survey of the health needs of the country and the development of a national health program to meet those needs. The interdepartmental committee appointed a Technical Committee on Medical Care to make the survey and submit recommendations.

The technical committee reported in February 1938 and recommended the following:

1. An expansion of public health and maternal and child health services under existing titles of the Social Security Act
2. Federal grants-in-aid to the states for the construction of hospitals and for defraying operating costs during the first three years
3. Federal grants-in-aid to the states toward the costs of a medical care program for medically needy people
4. Federal grants-in-aid to the states toward the costs of a general medical care program
5. Federal action to develop a program of compensation for wages lost due to temporary and permanent disability

President Roosevelt was pleased with the work of the interdepartmental committee and suggested that the health items be made public. He also said there should be a National Health Conference called, with representatives of the health professions and of the public, so that the report could be discussed. The president said, "I hope that at the National Health Conference a chart for continuing concerted action will begin to take form."

About 175 delegates attended the conference, which was held in July 1938. There was generally enthusiastic support for the recommendations of the interdepartmental

After the National Health Conference in 1938, there was a growing constituency for some sort of national health program. Some of this positive attitude came from labor unions and Farm Bureau groups. Even the Social Security Board in its 1938 suggestions for changes in the Social Security system endorsed the plan recommended by the interdepartmental committee. Harry Hopkins, then administrator of the Works Progress Administration (WPA), recommended that the WPA build hospitals across the country.

Although some of the leading physicians in the country favored a national health program, the bulk of the doctors represented by the AMA stated their opposition in unmistakable terms.

As a propaganda medium against compulsory health insurance, the AMA created in 1939 the National Physicians' Committee for the Extension of Medical Service (NPC). The purpose of the committee was to oppose any federal health program. The trustees were former AMA and state medical society officers. Financial support for NPC came mainly from drug companies. Over the ten years or so of its existence, NPC printed and distributed millions of pamphlets opposing federal participation in health care. Its lobbying efforts went full force until it sent out a letter that was interpreted as being anti-Semitic. The backfire was so great that the NPC was disbanded in 1949.

The National Health Bill

The next step in the legislative path for a national health services financing plan was the national health bill introduced in Congress by Senator Robert Wagner (D-N.Y.) in 1939. Basically, the bill called for federal aid to state plans of medical care. Five areas for support were identified:

1. Child and maternal health care
2. State public health services
3. State systems of insurance for temporary disability
4. Construction of hospitals and health centers
5. State-sponsored general programs of medical care[10]

Hearings were held before the Senate Committee on Education and Labor to consider the bill. "Liberal labor" spokesmen were in favor of the bill, as was a group of physicians and medical educators called the Committee of Physicians for the Improvement of Medical

mony and revealed in the course of his comments that he had not read the bill. However, the statement that capped the AMA opposition was made by Dr. Morris Fishbein, who said, "A little sickness is not too great a price to pay for maintaining democracy in times like these."[11]

The bill did not pass in 1939; Wagner was hopeful for 1940. Roosevelt, however, slowed any momentum the bill might have had by saying that, for 1940, he favored an experiment with one phase of the bill: the federal construction of hospitals. Wagner therefore introduced a bill for construction of hospitals. The hospital construction bill passed in the Senate, but it lay dormant in the House through the rest of the session.

Problems During World War II

When World War II broke out in Europe in 1939, the United States became involved as the "arsenal of democracy." Every effort went into supplying war material to Britain and Russia and to building our own defense. After Pearl Harbor in December 1941, we were not just a supplier, we were a principal.

There was a great shift in population from the farms to the industrial cities of the Northeast, the Midwest, and California. Supplies for civilian use became scarce. Housing and health care became national problems. The building of hospitals for domestic use practically stopped, because supplies and equipment were in extremely short supply.

Kaiser Industries is an example of a war plant that felt the lack of medical care for its workers. Kaiser shipyards on the West Coast were attempting to build new ships fast enough to replace the ones that were being destroyed with alarming regularity. Kaiser, like other war industries, had to depend for workers on women and 4Fs, men classified as unfit for military service and thus likely to have illnesses and disabilities needing medical attention.

The high incidence of need for medical care and the scarcity of physicians became such a problem that Henry Kaiser had to use his personal influence in Washington to get the release of enough doctors from the draft to take care of the shipbuilders. The doctors were found, the ships were built, and the war was eventually won.

During the war years, when Americans on the home front were tightening their belts and adjusting to ration books, a revolution was taking place in clinical medical care.

situation made many thoughtful persons realize that, once the war was won, the nation would have to take stock of itself and bring some kind of order to the industrial and economic confusion that was likely to result during the initial postwar period.

George Bugbee was one of those thoughtful persons. In 1943, he became the executive director of the American Hospital Association. The AHA was in the midst of great organizational change and on its way to assuming a national role in health care. Bugbee believed the war would be over in a year or two and that the country would face great readjustments, particularly in the health field.

Actually, little detail was known about the health care situation in the United States then. The CCMC study, completed in 1932, had been the last major, definitive study. Something more, therefore, was needed to update its work. Dr. Thomas Parran, surgeon general of the U.S. Public Health Service, was of the same mind as George Bugbee: a study should be done, and plans should be laid for the postwar years.

Commission on Hospital Care

The Commission on Hospital Care was born of this need to know and plan. It was founded with the support and help of the AHA, however it was not a part of the AHA. Foundation financial support was found, and a staff and study effort was formed under the leadership of Dr. Arthur Bachmeyer of the University of Chicago. Bachmeyer was assisted by Maurice Norby, who was on leave from the AHA.

Bugbee, Norby, and Pattullo relate in chapter 3 how the commission prepared a voluminous questionnaire designed to gather as much information as possible about hospitals and other health care institutions. The Public Health Service participated unofficially in the study, arranging for the collation of the data obtained through the commission's questionnaire. In turn, the information was immediately made available to the Public Health Service for its use in planning for the postwar years.

Wagner-Murray-Dingell Bill

It was in 1943 that George Bugbee and others began thinking of plans for the postwar years. It was also the year Senator Robert Wagner introduced his second health bill. This bill was usually referred to as the Wagner-Murray-Dingell bill. Senator James Murray (D-Mont.)

3. Nationalizing the U.S. employment service
4. Nationalizing and extending the unemployment insurance system
5. Expanding the coverage and benefits under old age insurance
6. Establishing a national system of temporary and total disability benefits
7. Paid-up benefit rights under Social Security for veterans' time spent in military service
8. Special reemployment benefits for veterans during readjustment to civilian life

The bill was drafted by Senator Wagner's legislative aides under his close supervision and with the advice of many groups, including the AF of L, the CIO, the Committee of Physicians for Improving Medical Care, and the American Association of the Blind. Extensive help was also given by experts from federal agencies with related interests.

The bill was introduced in Congress in June 1943. President Roosevelt gave it his best wishes but little direct support. It was supported by the liberal press and other liberal interests, but it lay in Congress for two years without coming to a vote.

In the meantime, Congress passed in 1944 what is commonly called the GI Bill of Rights. This bill encompassed the veterans' items included in the 1943 Wagner-Murray-Dingell bill.

The 1943 Wagner-Murray-Dingell bill was the first major legislative proposal in which there was a decided shift from state action to federal action in the health field. Up to this point, most federal legislation called for grants-in-aid to states to carry out health programs, even compulsory health insurance. With the Wagner-Murray-Dingell bill, the emphasis was on federally administered programs, many of them to be carried out by the Social Security program.

The historic fourth-term victory for Roosevelt came in November 1944. By December of that year he seemed at last ready to make an all-out drive for a national health program. Harry Hopkins (a confidant and personal assistant to the president) telephoned Michael M. Davis in New York and asked him to come to Washington and work with judge Samuel Rosenman[12] on a message to Congress. The president planned to deliver the health

Truman and Health Care

President Harry S. Truman, on assuming office after the death of Franklin Roosevelt, carried out some of the tasks on FDR's agenda. The health program proposal, which Michael Davis and Samuel Rosenman were working on at the time of Roosevelt's death, was useful in the writing of Truman's message to Congress on health, delivered November 19, 1945.

Many of the recommendations in this presidential message on health—the first to be delivered on this topic—were similar to those of the Wagner bills (of 1943 and 1945), the items stressed by the technical committee of the interdepartmental committee, and other study groups.

Truman recommended:

1. Federal aid for hospital construction
2. Enlarged federal aid for public health and for maternal and child health services
3. Federal aid for medical education and research
4. A national health insurance plan as part of "our existing compulsory social insurance system"
5. Disability insurance

The president's message evoked support from liberal physicians and labor leaders. Within three months of the delivery of the speech, many of these individuals and other supporters of the president's plan organized a Committee for the Nation's Health to help bring the plan into effect. The principal financial support for the committee came from labor. The president's message on health aroused not only support, but also the AMA's stubborn opposition to any health insurance program (including Blue Cross) not under the control of state and county medical societies.

Hill-Burton

The AMA opposed the Hospital Survey and Construction (Hill-Burton) Act, which was enacted by Congress in 1946. The preliminary studies of the Commission on Hospital Care, the cooperation of the Public Health Service, the lobbying effort of George Bugbee as part of the AHA support of the bill, and the active participation of Senators Lister Hill, Harold Burton, and Robert Taft in making this great hospital construction program possible

hire an outside agency to evaluate its attitudes and its public positions and statements. The AMA retained Raymond Rich Associates, a public relations firm, for the job. The agency's report was critical of the NPC, of the total medical control of Blue Shield, of the type of economic "research" carried on for AMA, and the lack of opportunity for minority views in the profession to be expressed.

In 1948, about two years after the Raymond Rich Associates evaluation, the AMA hired another public relations firm, Whittaker and Baxter, to actively work against "socialized medicine." (Whittaker and Baxter, working for the California Medical Association, had been active in defeating California Governor Earl Warren's plan for state legislation for health insurance in 1944.) The AMA's opposition to any efforts to institute compulsory hospital insurance continued until after the Medicare and Medicaid legislation was passed in 1965.

In connection with the AMA's opposition to compulsory health insurance, Dr. Morris Fishbein, a genius of vituperation, should not be passed over. As editor of the *Journal of the American Medical Association (JAMA),* he was a strident opponent of national health programs. His phrases characterizing the recommendations of the Committee on the Costs of Medical Care in 1933 as "Communism" and "inciting to revolution" are probably best remembered. Beginning in 1924 and for about 25 years thereafter, Fishbein's pen was an effective weapon in the AMA's war against change in the health care system.

One of the features in JAMA in the 1940s was a column Fishbein wrote and labeled his "Pepys' Diary," after the work of the 17th century English diarist. Unfortunately for Fishbein, he made a slip in one of his columns describing his activities during a trip to England, and Nelson Cruikshank brought it up in a radio debate with him. Cruikshank pointed out that while Fishbein was reportedly making a study of the British National Health Service (NHS), he in fact merely picked up a few papers on the subject from the NHS office. Instead of studying, Fishbein had been socializing. There was no misbehavior on Fishbein's part, but the incident destroyed his credibility and effectiveness. He was removed as editor in 1949.

Insurance

President Truman, during his last years in the White House, continued to speak for health insurance, particularly for the aged and indigent, however nothing tangible came of

In 1952 (the presidential election year), voices were raised for compulsory health insurance as a part of Social Security. Oscar Ewing, the federal security administrator and a Democratic presidential hopeful, advocated it. The Social Security Administration recommended it in its 1951 annual report, as did the President's Commission on the Health Needs of the Nation. That same year the Murray-.Humphrey-Dingell-Celler bill, calling for the same thing, was introduced in Congress. These various efforts were to no avail.

Eisenhower and Health Care

The election of Dwight David Eisenhower ushered in a quieter period in the drive for and against a national health program. The medical profession seemed to think the president was with them. Furthermore, the growth in voluntary health insurance through commercial insurance companies and Blue Cross-Blue Shield plans made many persons in government conclude that the need for the federal government's participation might pass.

The new president believed in a moderate approach to a health program.[14] He proposed a plan to:

1. Extend Social Security to 10 million more persons and to increase benefits
2. Continue the construction of public housing at the rate of 35,000 units a year for at least four years
3. Bring four million and more persons under unemployment insurance
4. Increase grants for the construction of hospitals and clinics

Another idea broached during the Eisenhower years was for the federal government to reinsure health insurance policies written by non-government agencies. The goal of this proposal was to ensure that the needy would have insurance protection. Although the idea was incorporated into legislative language, the bill never got out of committee.

There was nothing really new about Eisenhower's ideas; they were mainly just a conservative progression of existing programs.

Even though Eisenhower's plans for health were moderate, there was an obstructive force abroad, one based on vindictiveness. The Department of Health, Education, and Welfare was formed early in Eisenhower's first term. The president appointed Oveta Cuip

also a Texan, as a deserter. Anything she officially proposed was likely to be opposed by Rayburn, thus Hobby was at a disadvantage as a proponent.

One outstanding health program during the Eisenhower years was the development of the Salk polio vaccine and the administration of it to millions of children. Before this time, the nation worried about outbreaks of the disease every autumn, since there was little remedy and no prevention. The production of a large amount of vaccine and the administration of a nationwide program of inoculation was plagued by delays and confusion, but the program was finally a success.

On the legislative front, the Forand bill, a labor-backed bill calling for health insurance for Social Security beneficiaries, was introduced in Congress in 1957. It proposed benefits of 60 days of hospital care as well as surgical and nursing home coverage. This bill aroused the opposition of the medical profession, so in 1959 Forand dropped the surgical and nursing home benefits. The bill was still unable to get a favorable vote in the Ways and Means Committee. Nelson Cruikshank describes this action in his oral history.[15]

Throughout the closing months of Eisenhower's second term, pressure was mounting for health insurance for the elderly and needy. One product of this pressure was the passage of the Kerr-Mills bill, which proved to be inadequate, as Cruikshank discusses in chapter 4.

The last days of the Eisenhower administration were capped by the White House Conference on Aging. The conference was planned by the Republicans, however it was covertly managed by the Democrats and labor. Cruikshank describes this in chapter 5.

Kennedy and Health Care

President John E Kennedy sent a special message to Congress about a month after his inauguration advocating health insurance under Social Security. This was on February 10, 1961. Three days later, the King-Anderson bill, which was referred to as "Medicare," was introduced.

Arthur M. Schlesinger, Jr.,[16] who was close to the president, believed Kennedy did not expect Medicare to pass in 1961 or 1962 but felt that, since he had sent up a message to Congress and an administration bill had been introduced, there would be committee hearings and publicity. All of this he expected would lead to passage of the legislation later.

To add to the publicity and support for Medicare legislation, the presidential Task

although Medicare legislation did not pass in that congressional session, the momentum that was generated helped carry it through under the guidance and energy of Lyndon B. Johnson.

Johnson and Health Care

Wilbur **Mills,** the chairman of the Ways and Means Committee, felt increasing pressure for a Medicare bill after Lyndon Johnson was elected president in 1964. Johnson was striving to pass the social legislation initiated by President Kennedy, and one of the most important pieces was Medicare. There was a great wave of sympathy and a wish to carry out the programs of the assassinated president, however one should not overlook the great power Johnson wielded in Congress. He turned some of that power on Wilbur Mills and demanded action on Medicare. Mills up to this point had faced a very close vote on Medicare in his own Ways and Means Committee. With the landslide election of Johnson and the Democrats, however, the makeup of the Ways and Means Committee changed and Mills could get a favorable vote. Mills was a skilled tactician, and he suddenly presented a plan that pleased Democrats and Republicans alike—the three-layer cake compromise described in the Medicare chapters of this book.

The final flourish was the signing of the bill by President Johnson in the presence of former President Truman in Independence, Missouri, on July 30, 1965.

Medicare and Medicaid changed the American health care world forever. The elderly and needy gained new access to care. Hospitals found themselves with a new but restricted source of revenues. Physicians were raised to new economic levels. The federal and state governments were faced with health care demands and costs beyond the imagination of the best of the actuaries. The history of the time from the mid-1960s to the mid-1980s has been one of trying to adjust to this and accompanying events, which revolutionized the practice and economics of health care.

The Pathways of the Future

In the early 1960s, before Medicare, Walter J. McNerney, then president of the Blue Cross Association, and Wilbur Cohen, later to be secretary of HEW, were on the University

with only the slightest federal participation. After some discussion, a consensus emerged. The American way was not likely to be monolithic, but pluralistic. Many ideas for health care delivery and financing would be tried, some of them simultaneously. Now, more than 20 years later, this statement is still valid.

Pluralism implies different approaches to problems, and in many cases opposing views. A few approaches likely in the future are suggested below, with no assessment of degree of magnitude or possibility of occurrence.

Hospital versus Health Center. It would seem that the movement toward the hospital's becoming more and more the center of diagnosis and treatment of disease will continue. Physicians, dentists, therapists, home care services, and community mental health services could be linked so that all diagnostic and therapeutic inpatient and outpatient services would be provided in the most efficient and convenient way.

Hospital versus Ambulatory Centers. The urgency of containing costs has encouraged the use of ambulatory care, walk-in clinics, one-day surgery, and other services in freestanding centers. Although investor-owned centers have sprung up, it would seem that alert hospitals would establish such centers, if they do not have them already, in order to compete with the freestanding units. Furthermore, patients may find ambulatory units more convenient to use and may thus choose them.

Solo versus Group Practice. Physicians have learned in the past few years that group practice has many advantages over solo practice. Specialties and subspecialties have multiplied to such a point that a cooperative group can offer much better care over a varied patient load than can a solo practitioner. Further, working hours, office routines, vacations, and leisure time can be arranged more conveniently in groups.

New Technology. Technology has changed so rapidly that, as one radiologist put it, a radiologist today can no longer finish his residency with competence and training that will last for some years; today a radiologist must realize he is destined to continue his education unremittingly for the rest of his professional life in order to try to keep up with the advances in his field. In fact, one radiologist has said that, with CAT, NMR, PET, and ultrasound, it is possible to diagnose conditions for which there is no known treatment-and that is only in radiology![17] Technology is going to challenge the best brains in all fields of medicine to keep abreast in therapeutics.

Voluntary versus Investor-Owned. Investor ownership of hospitals and other health

excellent managers, a wide range of computerized data for management analysis and research, self-insurance potential, and audiovisual facilities for training employees and medical staff are a few of the reasons voluntaries are finding it difficult to compete as individual institutions.

Voluntaries, however, have learned from investor-owned chains in many ways. They are moving toward hospital systems and networks of voluntary hospitals, and this would seem to be the pathway to the future for them.

Women versus Men. In the last 20 years, women have been entering professional schools (in addition to the traditional ones of nursing and education) in increasing numbers. Medical schools now have a high percentage of female students (as much as 50 percent in some schools). The same is true of programs in health administration, pharmacy, physical therapy, and related professions. Women in medicine may supply an element some people say is missing in the profession-an understanding of the social problems of patients and of how they affect health and health care.

Blue Cross versus Commercial Insurance. The insurance picture has become so complex that few individuals have a broad view of it. Gone are the days when Blue Cross just sold full-service benefits in hospitals and the commercial insurance companies paid specified dollars for certain services (indemnity insurance). Instead, insurance policies today are tailor-made to fit the needs of the group purchaser, even to the extent of designing partial self-insurance schemes. Furthermore, many insurance entities are offering optional plans, including HMOs. This trend seems likely to grow.

Providers. Federal money is paying a large percentage of health care costs in the United States. Because these costs have been rising faster than the national inflation rate, regulations are becoming more restrictive. The most recent plan, that of using prospective pricing (diagnosis-related groups) for determining payment to hospitals for care of Medicare patients, may set a pattern for other payers.

Political Voice. The AHA has traditionally been the national voice in Washington for hospitals, while the state association has been the voice for hospitals at the local level. In fact, action has not been as independent as that statement might imply, because national, state, metropolitan, regional, and sectarian hospital associations have found that they can cooperate and complement each other in the political arena. This rather complicated cooperation has to be carefully orchestrated for the full benefit of all concerned. The AHA, because of its national scope, should attempt to keep improving this working relationship.

may now be the service workers (housekeeping, dietary, laundry, maintenance), nurses are becoming organized and unions are increasingly looking to white-color workers for future membership growth.

Research. With the growth of the voluntary and investor-owned chains of health care institutions-and with the information age upon us-masses of data covering whole regions of the country will give us a new profile of patients, diseases, treatments, accounting, personnel, and management. These data will be a gold mine for researchers. Our picture of health care in the United States should be more finely tuned in the coming years and so guide our efforts toward excellence in care.

The Elderly. As everyone knows, elderly persons are increasing in number. With this increase will come both new and increased demands for health care services.

The American care of the elderly in nursing homes is not a shining example of success. More thought must be put into the problem. More nursing home beds must be built to keep up with the growing need. Better management and regulation are needed. Some persons recommend that the federal government go into nursing home operations, as some other national governments have done.

Not all elderly persons, nor even all old-old (over 85 years of age) persons are in nursing homes, although many of them need a specially designed residence. A few proprietary groups are experimenting with residences for the ambulatory elderly. These elderly individuals need the company and companionship of others; they need activities they can enjoy; and they need regular, planned meals. Many of the elderly can afford these pleasant living conditions for a monthly fee. For those who cannot finance such care out of their own resources, another way must be found to meet the cost.

One of the basic beliefs since the founding of our nation has been that there would be continuous progress, that life would be better and better for each generation. Inventions, new technology, better social conditions, and new understanding of the problems facing our nation would lead to that progress and a better life. Along the way there have been some setbacks, depressions and wars. The dream of progress, however, seems inbred and carries over from generation to generation. The future therefore continues to be bright, simply because we believe we shall find answers to our problems.

Notes

Committee on Economic Security, a member of the Interdepartmental Committee to Coordinate Health and Welfare Activities, a member of the first Social Security Board, and Social Security commissioner when that entity became part of the new Federal Security Agency formed in 1939. Altmeyer also held administrative positions in several wartime agencies.

2. Witte of the University of Wisconsin headed the Committee on Economic Security. The data and information gathered by that committee were used in the writing of the Social Security bill.

3. See Profiles of Participants, in the center of this book, for biographical information.

4. Michael M. Davis, *Medical Care for Tomorrow* (New York: Harper 1955), p. 274.

5. Bacon was a Chicago hospital administrator and treasurer of the AHA.

6. For further information on the minority report, see Appendix C.

7. Slogan used by Huey Long.

8. Arthur J. Altmeyer, *The Formative Years of Social Security* (Madison: The University of Wisconsin Press, 1966), p. 3.

9. Ibid., pp. 93-96.

10. J. Joseph Huthmacher, *Senator Robert Wagner and the Rise of Urban Liberalism* (New York: Atheneum, 1968), pp. 263-67.

11. Ibid., p. 265.

12. Rosenman was an early political adviser and speech writer of Franklin D. Rooseveltteven before Roosevelt was elected governor of New York in 1928. Roseriman was a member of the Brain Trust, which worked for Roosevelt for president in 1932. Roosevelt appointed him to the New York Supreme Court in 1932, and Rosenman worked closely with Roosevelt outside government until 1943, when the president urged him to resign from the judiciary and become counsel to the president, which he did.

13. Davis, *Medical Care, pp.* 280-81.

14. Robert J. Donovan, *Eisenhower: The Inside Story* (New York: Harper, 1956), p. 228.

15. *Nelson Cruikshanle, In the First Person: An Oral History.*