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The Roots of Medicare

Medicare, which was passed by Congress in 1965 and became effective in 1966, made the federal government, through the Social Security Administration, directly responsible for the health care of Social Security beneficiaries. This action has been called a watershed, a breakthrough, and a decisive step in federal-state relationships and responsibilities. No longer could it be said that the states were basically responsible for the health care of the aged, either as a prime factor or in partnership or shared responsibility with the federal government.

This historic legislation did not come about through a single action of Congress, however, but through evolution. The Committee on the Costs of Medical Care furnished basic statistical data and recommendations for assessments of health care needs. Its data were updated by the work of the Commission on Hospital Care and the Commission on Financing of Hospital Care.

Some observers trace the direct lineage of Medicare much farther back. They see the first step in federal involvement as the provision of hospitals for American seamen in the early days of the republic and in the emergence of the Public Health Service in 1799 to administer the hospitals and to protect the nation from disease and pestilence.

Probably more to the point is the influence of the Wisconsin group of economists, which led the country in many social advances. Members of the group were proteges of John R. Commons,[1] many of whose ideas were seminal in the social and labor reform movements of the early twentieth century.

The American Association of Labor Legislation (AALL) was formed out of this Wisconsin group in 1906 under the leadership of John B. Andrews. The AALL grew to 3,000 or more members, including economists, political scientists, attorneys, social workers, and other public-spirited persons.

The AALL's first major effort was passage of state workmen's compensation legislation. Its next step, in conjunction with AMA leaders, was the formation in 1912 of a social insurance committee to study health insurance.

Health insurance also became an issue in the 1912 presidential campaign, in which Republican incumbent William Howard Taft, was opposed by Democrat Woodrow Wilson and former President Theodore Roosevelt as the Progressive, or Bull Moose, candidate. In a dramatic appearance at the Bull Moose convention, Theodore Roosevelt made an emotional presentation which he called his "confession of faith."[2] Among other things, he called for social welfare for women and children, women's suffrage, recall of judicial decisions, workmen's compensation, farm relief, and health insurance in industry. This was the first time health insurance had been an issue in an American presidential campaign.

In the meantime, the AALL committee designed a model health insurance bill for state legislatures. This bill was ready by 1915, and it appeared that it would be considered favorably in many states. In 1916 the AMA's social insurance committee recommended government health insurance plans, and several state legislatures began considering the model bill.[3]

Then the United States entered World War I.

One can only speculate as to whether attitudes in this country changed during the war. It is true that the government set up restrictions, asserted the authority necessary to support the war effort, and became a compelling force in the daily lives of the population. Thus, when the war was over, it is likely that people reacted against government restriction and interference and wished to return to the old ways.

In any case, after World War I the tide turned against health insurance. In 1918 California defeated a referendum for state health insurance; in 1919 the New York State Assembly failed to pass a health insurance bill; in 1920 the AMA reversed its position and opposed state government insurance. Doctors returning from the war wanted independence because they feared government interference. Even labor unions were afraid that government health insurance would be a step toward reducing union influence in bargaining. In addition, after a slight economic decline in 1920, the country repudiated Woodrow Wilson's idealistic visions and elected as president Warren G. Harding, who promised a return to "normalcy."

During the near-decade of prosperity that followed, there were agitations for a government health care program. In 1921 Congress passed the Sheppard-Towner Act, which subsidized child and maternal health care.[4] The Sheppard-Towner Act, however,

was the exception to the rule: rarely during this period did the federal government inject itself into a social issue.

Of greater influence on later events was the five-year study by the Committee on the Costs of Medical Care (see chapter 2). The CCMC recommended group health care insurance, group practice for physicians and other health professionals, and statewide planning for health needs. It also suggested improving health education-for physicians, dentists, nurses, nurse midwives, pharmacists, and nurses' aides. This study was done so skillfully that for the first time the United States had a picture of where its health care system was and where it might want to go in the future.

Another factor entered the scene: voluntary hospital insurance. The popular example used to mark the beginning of voluntary hospital insurance is the experiment at Baylor University Hospital in Dallas. In l929 Justin Ford Kimball, executive vice president of the university, proposed a prepayment plan under which school teachers in Dallas could assure themselves of up to 21 days of hospital care at the Baylor University Hospital for a premium of 50¢ a month.[5]

The rapid growth of hospital service plans modeled on the Baylor plan and others of that period is discussed in later chapters, however it should be noted that the growth of hospital service plans, along with commercial insurance coverage, began to have political significance. Some of the more conservative politicians saw voluntary prepaid hospital insurance as the answer to national health insurance. Some began to talk about voluntary plans supplemented by government subsidies for the poor and near-poor in general, and for the aged poor in particular.

Other events were taking place in health affairs as the nation moved into the Great Depression. The American Federation of Labor (AF of L), the strongest union group in 1932, changed its position and endorsed social insurance. A year later, the AHA approved private and voluntary health insurance.

When Franklin D. Roosevelt took office as president, on March 4, 1933, he faced many problems that had to be dealt with immediately. Fifteen to 17 million persons were unemployed, and many of them were unable to feed their families. Almost overnight the banks of the country were closed. Everything seemed to be at a standstill.

In that first month, the government acted under the president's leadership in what Nathan Miller has called the "Roosevelt whirlwind."[6] Congress voted $500 million in 1933 for immediate relief under an agency called the Federal Emergency Relief Administration (FERA). This agency was headed by Harry Hopkins, who had headed New York's relief organization when Roosevelt was governor. Within hours of the passage of the federal legislation, millions of dollars were shuttled to the states for direct relief– for food, clothing,

fuel, rent, whatever the immediate needs were. Some small part of that money may have helped with medical care, but the majority of it went for food and shelter.

The relief measures, although welcome, were stopgaps at best. The state of the economy was still the major problem. At Roosevelt's urging, Congress created many agencies to correct the system. This "alphabet soup" of agencies–AAA, CCC, FERA, NRA, PWA, WPA, and so on–was fair game for the humorists of the day. All of the agencies, however, were established in an effort to put people back to work, to set fair agricultural prices and fair wages, and to feed the hungry.

No matter how hard Congress and the president worked to find solutions to the problems of the day, there was always the danger that Americans would be misled by persons propounding radical social movements and utopias. Senator Huey Long (D-La.) told his followers that he had a plan for sharing the wealth in which every man would be a king. In California, Dr. Francis E. Townsend said that his Old Age Revolving Pension Plan was the solution to the economic crisis. He would have the federal government pay each unemployed person over 60 years of age a pension of $200 a month. (This amount was far greater than the average industrial or clerical worker earned at that time.) The entire $200 would have to be spent during the month in order to be eligible for a payment the next month. The plan would be financed by a 2 percent sales tax. Hundreds of Townsend clubs were formed among the elderly. Meanwhile, the president was under pressure to do something to counteract the demagoguery of Townsend, Long, and others who were exciting the emotions of the millions of people who were suffering in the depression.[7]

Roosevelt's move was to appoint a cabinet-level Committee on Economic Security to study the situation regarding unemployment insurance, old age assistance and pensions, and health care. It is significant that this was a cabinet-level committee and therefore under the direct control of the president. Roosevelt called for quick action: the committee was named in June 1934 and had instructions to report and recommend action by the end of the year.

Frances Perkins, secretary of labor, was appointed chairman. Other members of the committee were Henry Morgenthau, Jr., secretary of the treasury; Homer Cummings, attorney general; Henry Wallace, secretary of agriculture; and Harry Hopkins, then administrator of FERA.

The Committee on Economic Security used staff members and facilities of the various departments represented. It was financed, partially at least, by funds from the WPA. Edwin E. Witte, chairman of the department of economics at the University of Wisconsin, was chosen as executive director of the committee. Witte was outstanding in the field of labor legislation.

Arthur J. Altmeyer, an assistant secretary of labor who was also from Wisconsin, was selected to head the technical committee, whose duties were to assist the executive director and to direct the larger committee's studies and investigations.[8] There was also an advisory council of 23 members; 5 labor leaders, 5 employers, and 13 members of the public interested in social welfare. The function of the council was to:

> . . . convey to the committee the views of interested individuals and groups outside the government, but the council was not expected to make a formal report . . . . The advisory council functioned much more independently than had been originally contemplated. It also made a lengthy report which contained recommendations differing in some respects from the final recommendations of the Committee on Economic Security.[9]

The Committee on Economic Security worked hard and fast, reporting to Congress in January 1935. The committee had been able to design a social security system that was not based on a dole. In a casual conversation with Supreme Court Justice Harlan F. Stone, Frances Perkins expressed fear that any social security program might fail if tested in the Supreme Court. The justice whispered in reply, "The taxing power of the federal government, my dear; the taxing power is sufficient for everything you want and need."[10]

That was the secret: unemployment insurance was based on taxation of employers; old age pensions were based on payroll taxes levied on both employer and employee. There was expected to be no need for general federal funds as long as actuarial figures were correct and Congress was willing to levy sufficient taxes.

The committee wanted to recommend a health insurance measure, but at least two things prevented it. First, no plan had been developed for recommendation. Second, and perhaps just as important, the AMA was adamantly opposed to federal health insurance. Some of the president's advisors feared that, if the administration recommended health insurance, other parts of the Social Security program–old age pensions and unemployment insurance in particular–were likely to be defeated in Congress or delayed in enactment.

Roosevelt needed a positive social security program passed before the election of 1936, and he felt that he could not afford a long-drawn-out battle with the AMA. It seemed best to enact as much of the program as possible. He was urged by secretary Perkins and Arthur Altmeyer to try another time for health insurance.

The Social Security bill without health insurance passed in August 1935, Roosevelt won in 1936, and he continued to refer to health insurance as a subject that needed to be addressed.

Wilbur Cohen, who in 1968 was appointed secretary of health, education, and welfare by President Lyndon Johnson, originally went to Washington, D.C., in 1934, after graduating from the University of Wisconsin with a degree in economics. He went to work for one of his Wisconsin professors, Edwin Witte, the executive director of the Committee on Economic Security. Cohen recalls how and why the committee was formed.

COHEN:[11]

The Social Security program was the very major result of the Great Depression of 1929. That depression really completely demoralized not only the American economy, but by 1932 it had really demoralized America's faith in itself, its institutions, and its people.

The result was that many people felt that they'd lost everything. The fact that they had saved and worked hard didn't result in their being able to sustain themselves. It was the most catastrophic blow that could be imagined. As a result, when Roosevelt became president of the United States in 1933, there were pending in Congress a number of bills on unemployment insurance and/or old age assistance.

Roosevelt's advisors recommended that instead of going forward piecemeal on these ideas, that they be studied in a comprehensive way. Harry Hopkins and Frances Perkins were the leaders in the effort, and it was as a result of their suggestions and others that a cabinet-level committee–the Committee on Economic Security–was established.

I.S. Falk, who had previously contributed so much to the research of the Committee on the Costs of Medical Care (see chapter 2) also joined in the work of the Committee on Economic Security-particularly in the health studies. He describes the makeup and the work of the new committee.

FALK:[12]

By mid-1934 the president had issued an executive order creating the Committee on Economic Security and directed it to explore measures to deal with the risks of economic insecurity, including the risks of loss of income arising out of illness and the costs of medical care. The committee was formed near the end of June, and it went to work to produce a program for the president and the Congress. A comprehensive structure was created using government people and bringing in many nongovernment people who were knowledgeable about the problems that were going to have to be confronted.

With respect to the field of health–public health, personal health care, medical care,

between the end of the Committee on the Costs of Medical Care and this period, was asked to take charge of the committee's health staff. He accepted on condition that I would join him. I did. So he and I were the primary staff members for those studies and programs relating to health and disability problems.

The committee had advisory committees for the overall structure of the program. They also had a technical board of very distinguished people and a series of actuarial consultants. On our suggestion, because of the complexity of the public relations involved and the complexity of the technical problems, the committee set up a medical advisory committee, with representatives from the various aspects of the medical profession; a public health advisory committee; a hospital advisory board; and a dental advisory committee. Collaterally, because of the proposals that were coming up in the areas of maternal and child health and welfare and related subjects, on recommendation from the people in these fields, there was a committee on child welfare, a nursing advisory committee, and so on.

So, as we were developing analyses and proposals, we met with these various advisory committees and tried out our ideas. We had extensive discussions with them and some considerable disputes, particularly with the medical advisory committee, whose members included some who had been selected from the American Medical Association and related organizations.

The idea of having these various advisory committees was smart for public relations, but it was a stupid idea for the purpose of getting the job done because there were utterly irreconcilable elements in the medical advisory committee. The outlook for getting any consensus was nil. Also, some of the committee members didn't play fair with us. Although it had been agreed that we would be working in camera until the time came for approved and agreed releases, the AMA people immediately broke that promise and began releasing the intramural discussions. This meant floods of telegrams and letters pouring in on the White House, on the members of the committee, and on the chairman and members of the congressional committees that were going to have jurisdiction. This led to a complex and very uncomfortable situation.

At any rate, we proceeded with the studies with the help of our ancillary staff, some of whom came directly from the AMA and acted fairly. I wasn't referring to them; it was a few members of the advisory committees who played games.

We developed a program for federal support for a federal-state system of health services availability. I hesitate to say health insurance, because latitudes would be given to the states as to what kinds of programs they might prefer or might want to enact. In addition, we developed proposals for strengthening the public health services and then the programs

for disability insurance.

When we came up with the proposal for a federal-state program in the health field, two things happened to us that were very significant. One is that we caught hell from the AMA and various other groups that didn't want any such thing as "government intrusion" in medical care; and we caught hell from the labor union people, who didn't want any such thing, saying, "You are going to come up with a program that will depend on state benefits, state insurance programs, you give them [the states] choices and so on. We, the labor union people, are going to have to fight these battles out in 48 different states. We don't want any of that. We want a straight national system."

On the other hand, there were other national groups that said, "A national system in the health field! You are out of your minds. This is not for money payments, this is for service provisions. Service provisions have to be geared to the local scene, and local control, and local options."

We were on the horns of a dilemma. We had to opt for something, so we developed a program on a federal-state basis, knowing that some of our strongest potential supporters weren't going to like it.

When the economic security (later to be known as Social Security) bill went to Congress, it had in one section authorization for the Social Security Board to continue further studies in this, that, and in health insurance. Those three or four words precipitated so many telegrams and so many telephone calls and so much pressure from the medical world, obviously carefully orchestrated, that the chairman of the House committee and the chairman of the Senate committee really were so plagued by the opposition from the medical world that they said, "Look, take your whole economic security bill away, we want no part of it," or words to that effect.

Secretary of Labor Frances Perkins, as chairman of the cabinet committee, became frightened that the whole economic security program, as it was being called, would go down the drain because of the dispute about health insurance. So the matter was taken up to the president.

Roosevelt decided to take advantage of the fact that our medical advisory committee had asked for more time to study the health program proposals. The president approved that delay. A draft of guidelines was given to Congress in a preliminary report, but our definitive reports on the health insurance proposals never were submitted to Congress; and by agreeing to moderate a few words in the bill bearing on further health insurance studies, matters quieted down.

So the health insurance program was deferred and did not see the light of day until some years later. The excuse was given that the health insurance studies had not been

carried to the point that a bill was ready for submittal to Congress, which was partly but not quite true.

The public health recommendations did go to Congress. They were enacted, substantially as we submitted them, as Title VI of the Social Security Act. The maternal and child health and welfare programs went in as Title V of the act. They were enacted practically unchanged.

Wilbur Cohen continues with his description of the committee.

COHEN:[13]

Mr. Altmeyer, who came from Wisconsin, and Mr. Witte, who came from Wisconsin, were two of several of the very important leaders who worked with the Committee on Economic Security. That committee really developed the outline of the major provisions that became the Social Security Act of 1935.

However, Roosevelt, Witte, Altmeyer, Perkins were not people who were merely theoreticians. They had all given a lot of thought to the history of social reform; they had been administering programs; they had had contacts with legislators; and they realized that the Social Security program of 1935 would only be a beginning. Franklin D. Roosevelt, when he signed the act, called it a cornerstone in a developing program, and he recognized that there would have to be other changes coming along later.

The act was passed by Congress in less than eight months. It was certainly a tremendous, successftilly developed legislative event. It could only have taken place with the backdrop of the depression and under the leadership of Franklin D. Roosevelt.

Though a health insurance program was not included in the Social Security program of 1935, some positive steps were taken to keep the subject of health insurance alive. The day after the Social Security bill was signed, President Roosevelt established an Interdepartmental Committee to Coordinate Health and Welfare Activities. Following this was the National Health Survey. A further step was taken in 1937, with the establishment of the Technical Committee on Medical Care under the interdepartmental committee. The next year the technical committee published a report titled A *National Health Program.* Careful follow-through came with the sponsorship of the National Health Conference. A year later (1939) Senator Robert Wagner (D-N.Y.) introduced a national health bill comprised basically of the recommendations of the National Health Conference. The bill would make matching funds available to states to assist them in meeting minimal federal standards for public health services, child and maternal health care, health services, temporary disability insurance, construction of hospitals and health centers, and health insurance programs.

Matching funds would vary according to the states' per capita wealth. As might be expected, the state health insurance proposal generated much opposition.

All of this careful preparation of a legislative path came to nought at the moment, for the AMA organized an effective campaign to defeat the bill, which died in committee.

Wilbur Cohen talks about the interdepartmental committee.

COHEN:[14]

Immediately upon the passage of the Social Security Act, Mr. Altmeyer decided that he had to begin research and studies leading to its improvement. Just a couple of days after the act was passed, he was able to get President Roosevelt to establish the interdepartmental committee on health to study how health insurance and other aspects could be developed. In addition, Mr. Altmeyer began to set up a research staff, which ultimately was headed by Dr. I.S. Falk. As a result of these efforts, studies relating to health, disability, death benefits, unemployment insurance benefits, and changes in the welfare program became a major part of the research and planning work.

Franklin Roosevelt continued to talk about the need for complete social security from birth to death. A friendly dispute arose about who had originated the term "from the cradle to the grave." When the Beveridge report, which suggested birth-to-death national health coverage, was published in England in 1942, some journalists used "from the cradle to the grave" to describe it. Roosevelt considered that friendly plagiarism.

Some progress in health coverage was made during World War II. In 1943 Congress passed the Emergency Maternal and Infant Care (EMIC) Act to cover dependents of military personnel. This was direct federal support for a health program, probably not greatly opposed because it was supportive of families of the military during wartime.

In 1943 the first of the noted Wagner-Murray-Dingell bills was introduced in Congress. The bill was sponsored by Senator Robert Wagner (D-N.Y.), Senator James Murray (D-Mont.), and Representative John Dingell (D-Mich.). The bill was the result of many consultations and much cooperation among labor leaders, physicians, the Public Health Service, the Social Security Board, the Children's Bureau, the U.S. Employment Service, and others. It was an ambitious bill, calling for compulsory national health insurance, nationalized and extended unemployment insurance, expanded coverage and benefits for old age insurance, new national systems of temporary and permanent disability payments, paid-up Social Security benefits for veterans for the time they spent in the service, unemployment benefits for veterans while getting back into civilian life, a

assistance. Huthmacher[15] points out that the bill stressed nationalizing programs that had been state administered even though support may have come from federal grants-in-aid or matching funds. The bill failed in committee.

Roosevelt kept referring to the need for health insurance after the demise of the first Wagner-Murray-Dingell bill. In 1944 he talked about an individual's *right* to adequate medical care. That same year the Social Security Board in its annual report recommended comprehensive national health insurance. In his 1945 State of the Union speech, Roosevelt again referred to the right to good medical care; however, in that same year, the California legislature defeated Governor Earl Warren's proposal for comprehensive state health insurance. Physicians labeled it "socialized medicine."

Franklin Roosevelt died in Warm Springs, Georgia, in April 1945. Harry S. Truman, although largely unprepared for the presidency when he succeeded Roosevelt, was a decisive man. He was willing to take the responsibility for making tough decisions, and he was stubborn once he had made one.

In spite of having an unfinished war on his hands, a difficult ally in the USSR, and a powerful and colorful leader to follow, Truman took a determined position supporting national health insurance.

He was the first president of the United States to do so, and he did it forthrightly, time and again–in messages to Congress and in other public statements, as well as in remarks to the press.

For example, in a letter of September 9, 1949, to Dr. Sam Roberts, who had warned him of the danger of national health insurance, Truman said:

> . . . there is something wrong with the health of this country and I am trying to find a remedy for it. When it comes to a point where a man getting $2,400 a year has to pay $500 for prenatal care and then an additional hospital bill on top, there is something wrong with the system and I am going to try to remedy it. I suggest you doctors had better be hunting for a remedy yourselves unless you want a drastic one.[16]

On July 11, 1952, in a letter to his cousin Ethel Noland, Truman wrote, "I am sorry that Nellie has had to go back to the hospital. What a bunch of robbers they are! Why can anyone be against my health program? We'd be able to meet situations like Nellie's if we had it."[17]

Truman was in New York City in January 1954, after President Eisenhower had delivered his State of the Union address to Congress, and reporters asked him to comment on the address. In his diary Truman wrote:

> I told them that Ike's New Deal recommendations merited support, that his political statements had the usual demagogic sound. I was thinking particularly about his statement that he is against "Socialized Medicine." So is everyone. The American Medical Association in 1952 had a mild case of hydrophobia over my suggestion that a health tax be levied by the federal government so the ordinary fellow could pay his doctor and hospital bills when an emergency arose in his family.
>
> Most people can't pay $12.50 to $25.00 a day for a hospital room and $500.00 for a minor operation in addition to nurse hire and incidentals. So I thought, and I still think, that a nest egg held out of the regular pay as is social security might meet the situation. If the propaganda of the AMA is studied, you'd find the doctors don't want guaranteed payments for fees. Why I'll never know.[18]

In his first health message, in 1945, Truman recommended to Congress comprehensive prepaid medical insurance for persons of all ages as a part of Social Security.[19] Truman said everyone should have "ready access" to all necessary medical, hospital, and related services. Coverage was recommended for all employed persons and their dependents. The financing suggested was a 4 percent tax on wages and salaries up to $3,600 a year. Needy persons and other groups he said could be taken care of with funds from the general revenue. Truman wanted the proposed plan to cover doctor, hospital, nursing, laboratory, and dental services. He countered the arguments of "socialized medicine" by saying there should be a free choice of doctors and hospitals.

A second Wagner-Murray-Dingell bill was introduced in Congress in 1945; this one included the provisions recommended by President Truman. (A request for veterans' benefits was not carried over from the 1943 bill, because the GI Bill of Rights had been enacted in the meantime.) A committee for national health insurance was organized to promote the new bill, but to no avail. The bill foundered.

The following year, 1946, was one of substantial activity but little in the way of results in health legislation. The Republicans introduced the Taft-Smith-Ball bill to counter the Wagner-Murray-Dingell bill. The Republican bill called for $200 million in matching funds for states to provide medical care for the poor. This failed to pass. One bright spot, however, was that the Hill-Burton Act was passed in 1946 (see chapter 3).

In 1947 a familiar routine was played. President Truman sent a message to Congress asking for a national health program; the Wagner-Murray-Dingell bill was re-introduced; the Taft-Smith-Ball bill was re-introduced. Neither of the bills passed.

The next year, 1948, was a presidential election year. Truman, running for reelection, again advocated national health insurance. He instructed Oscar Ewing, the federal security

administrator, to call a national assembly to consider the problems of health care. The assembly approved all the previous recommendations of the president except national health insurance as a method of financing medical care.[20] The AMA organized resistance to national health insurance through what it called a "national education campaign." Truman was reelected, and a Democratic Congress was returned. Many party members considered this a mandate for enacting a national health insurance law.

The Republicans brought forth in 1949 their version of a health bill, the Flanders-Ives bill, which many considered merely a rewarming of the Taft-Smith-Ball bill of 1946. It called for support of health care through subsidies to private insurance companies.

The AMA reacted to the reelection of President Truman and the return of a Democratic Congress with great alarm. It quickly assessed each member $25 and hired a public relations firm to organize a campaign against any national health insurance legislation and to educate the public about the dangers of such a system of insurance. Apparently the AMA felt that the rise in the number of Blue Cross and other private insurance subscribers might obviate the need for a federal or state system of insurance, so it supported private insurance.

I.S. Falk and Wilbur Cohen reflect on the events in which they were participants during the period of the Wagner-Murray.-Dingell bills and the development of proposals for insurance for Social Security beneficiaries.

FALK:[21]

The impasse on the Wagner-Murray-Dingell bills persisted year after year. The impasse led me to begin to think about the possibilities of having a paid-up health insurance plan for the beneficiaries of the Social Security system particularly, but not limited to the aged, recognizing that it might later extend to the disabled when they might become beneficiaries. (They weren't yet under the Social Security program at the time.) But it could extend to survivors of covered and insured persons. I undertook, with members of my Bureau of Research and Statistics staff, a systematic exploration of how such a compromise proposal might be designed, what its specifications could be, what its scope and potential impact and effectiveness might be, what such a proposal might cost, and how it would fit within the framework of financial measures such as payroll taxes, general revenue support, or otherwise. We worked out the specifications systematically and developed the design of the program and the cost estimates rather quietly and with very little about this work known throughout the Social Security Administration.

When we arrived at the point where we had a systematic presentation ready, I showed a copy of it in April 1952 to Wilbur Cohen, who was then technical assistant to the Social Security commissioner. He in turn called this possible program development to the

attention of Mr. Oscar Ewing, who was the federal security administrator.

Mr. Ewing seized upon it very vigorously. He had been displaying indications of presidential ambitions and was very much concerned with the possibilities of broadening the scope of the social insurance program, particularly with reference to what might be done in the health insurance field. He had been less than enthusiastic about the Wagner-Murray-Dingell bills. He indicated that he thought that this was potentially a useful, perhaps even a promising alternative approach to be pursued. He read the draft report and asked me to confer with him about it. He explored it, had various members of his immediate staff and the general counsel review it. He also made drafts of it available to some other people outside of federal government, people he knew well, whose judgment he respected.

Attention to the proposal became quite extensive, long before I thought it was ready for general public discussion. However, the development and spread couldn't be contained, so Mr. Ewing submitted the proposal for review to the various responsible authorities in the federal government: the Bureau of the Budget, the Treasury Department, and other departments of the government. He also made copies available to some of the staff in the White House.

President Truman was a little cool about acting on our proposal, because the Magnuson Commission on the Health Needs of the Nation was approaching completion of its studies. Mr. Truman, I was told, was reluctant to inject a new set of proposals into the political scene, since it might intrude into the issue he had delegated to that commission. But he did authorize the Bureau of the Budget to, in turn, authorize Mr. Ewing to proceed to make the proposal public and to make the design of the program available to possible sponsors of legislation in the Congress.

Accordingly, in the middle of 1952, Mr. Ewing released the content of the proposed program at a press conference, and a bill was prepared and was made available to Senators Murray and Hubert Humphrey [D-Minn.], and to Representatives Dingell and [Emanuel] Celler [D-N.Y.], and through them in turn to others. The proposal was that beneficiaries, primarily old age beneficiaries, of the Social Security program should become eligible for a paid-up program of health benefits, rather broadly designed to extend to hospital, physician, and some collateral services. The costs of the program were to be met by a relatively small adjustment of the payroll taxes that were being paid by employers and employees covered by the Old Age and Survivors Insurance program.

The program, as a whole, was very well received except by the American Medical Association and some related health professional organizations. It was quite well received by most of the insurance industry, which had long been plagued by the difficulties of

embracing within their programs the aged–the people who had the greatest need for health care and, generally speaking, the least means for obtaining health insurance. Insurance carriers in very broad measure thought that they would be relieved under this program of an obligation to extend their insurance carrier functions to the aged.

The bill Falk mentions was different from the Wagner-Murray-Dingell bills in that it was designed for Social Security beneficiaries. This new bill was, generally known as the Murray-Dingell bill or the Murray-Humphrey-Dingell-Celler bill. It was introduced into Congress in April 1952. This was a presidential election year, so Truman took no position on the bill out of deference to the Democratic candidate who would be nominated that summer. (Senator Wagner's name does not appear on the bill because he had resigned from the Senate in 1949 due to poor health.)

Cohen also comments on this period when emphasis was changing from the national coverage of the Wagner-Murray-Dingell bills to coverage for Social Security beneficiaries only.

COHEN:[22]

In about 1950, after it appeared that the Wagner-Murray-Dingell bill and the Truman health proposal were not going to go anywhere, Mr. Oscar Ewing, who was then the federal security administrator, asked Mr. Altmeyer whether he had anybody to help him in developing some kind of alternative or substitute health proposal. Mr. Altmeyer assigned that responsibility to me. I checked around with various staff members, and, after talking with them, I produced a memorandum which included in it what we would now call Medicare. When Mr. Ewing received that memo, he was very enthusiastic about that idea and asked us to draft it up. That major responsibility fell to Dr. I.S. Falk. So in 1950-1951, Dr. Falk and I spent a lot of time designing, with the help of other staff members, what ultimately became Medicare, and it was introduced in Congress.

We were not able to get any of the major members of Congress to introduce it. We had to take whatever we could. A number of other people outside the House Ways and Means Committee, like Representative Emanuel Celler and Senator James Murray, originally introduced the bill, but while it was reintroduced each session, it never got anywhere until 1957. Then [in 1957] Representative Aime Forand, a member of the House Ways and Means Committee from Rhode Island, introduced it and thus gave it major public attention. There were hearings on it, and this resulted in making it a major issue in the 1960 campaign.

General Dwight D. Eisenhower, who opposed national health insurance, was elected

president of the United States in 1952. On the face of it, little happened in the health field in the early years of the Eisenhower administration except organizationally. A Department of Health, Education, and Welfare (HEW) was formed; it included the Federal Security Agency, of which Social Security was a part. The new department was headed by Oveta Gulp Hobby, of Houston. Hobby had formerly been a Democrat of some influence in Texas. Her acceptance of a post with a Republican administration made her relations with leading Democrats, especially Sam Rayburn of Texas, Democratic leader in the House, a little unpleasant sometimes. This was true when she tried to promote administration alternatives to national health insurance.

The administration favored the extension of unemployment insurance, the extension of old age pensions under Social Security, and "a limited government reinsurance plan that would permit the private and non-profit insurance companies to offer broader protection to more of the many families which want and should have it."[23]

Several things that were significant in the evolution of Medicare legislation did take place during the early Eisenhower years.

- A federal program was established in 1956 to provide health care for dependents of military personnel.
- Medical vendors were paid directly for welfare patients (this required federal subsidies to the states for health care).
- A special subcommittee on aging (which later became a special committee) was appointed, with Senator Pat McNamara (D-Mich.) as chairman.
- Disability cash benefits were allowed to totally and permanently disabled persons age 50 or older under an amendment to the Social Security Act.
- The American Hospital Association called for public hearings on various insurance bills.
- The AFL-CIO joined with others in an effort to secure government-sponsored health insurance.
- The first Forand bill was introduced in the House, late in 1957, calling for 60 days of hospital care, surgical, and nursing home benefits for all Social Security beneficiaries.
- The AMA hired a public relations firm to oppose the passage of the Forand bill.
- A Joint Council to Improve Health Care of the Aged was formed to see whether the health care problems of the aged could be taken care of without government participation. The AMA, the AHA, the American Nursing Home Association,

and the American Dental Association were members of the joint council.

– The AMA urged physicians to cut fees for the aged.

– The Kerr-Mills bill was enacted to provide aid to the poor and the aged poor.

One event not listed above was the establishment of the Commission on Financing of Hospital Care. This took place early in the Eisenhower administration, and the commission worked between 1952 and 1954. It was an outgrowth of the Commission on Hospital Care, which had reported almost a decade earlier. The earlier commission had been unable to study the financing of hospital care within its allotted time, thus it had been suggested that financing be covered later, by a separate research group (see Appendixes G and H).

The Commission on Financing of Hospital Care was formed in 1952 with the support of several foundations.[24] The group was chaired by Gordon Gray, president of the University of North Carolina, and had a distinguished membership. A malignant fate seemed to dog the directors of the study. The first director, Graham Davis of the W.K. Kellogg Foundation, resigned early on because of illness. Davis was followed by Arthur Bachmeyer of the University of Chicago, who had been the director of the Commission on Hospital Care. Bachmeyer died in the Washington airport after attending a meeting of the Commission on Financing of Hospital Care. Bachmeyer was succeeded by John H. Hayes, who had retired as superintendent of Lenox Hill Hospital in New York City. Maurice J. Norby, deputy director of the AHA and chief staff person for the Commission on Hospital Care, acted as a special consultant to help see this project through to a successful conclusion.

Robert M. Sigmond, who served on the staff of the Commission on Financing of Hospital Care, commented recently on the commission and the study.

SIGMOND:[25]

Sometime in 1952 I was approached by Maurice J. Norby, at that time the deputy director of the American Hospital Association under George Bugbee, to consider a position with the newly established staff of the Commission on Financing of Hospital Care. At that time I remember taking a trip to Chicago and staying overnight with the Norbys at their home and having a long talk with Maurice about the situation. He reported that the commission was formed as a logical outgrowth of the Commission on Hospital Care, which had not dealt with issues of financing operations, as contrasted with the issues of capital financing. George Bugbee had decided that they should try the national commission approach again

and had raised over one-half million dollars to fund the new commission.

Norby had wanted to name Harry Becker of the United Auto Workers as the director, but George Bugbee was concerned that he would be viewed as being too radical. George Bugbee convinced Graham Davis to head up the new commission, and Norby was successful in convincing Becker to sign on as the associate director. Graham Davis eventually left the commission for health reasons. At that time, Bugbee and Norby brought Bachmeyer in as director.

Becker's primary interest was in the financing of hospital care, but the commission was committed to devoting a significant part of its energies to the issue of rising costs. Norby wanted me to come on and head up that section of the work, explaining that Bachmeyer was not in a position to give direct leadership to this phase of the work and that Becker did not have the background.

Norby indicated that the major issues would be on the financing side, centering around prepayment plans and government role, but that he wanted a really good job done on issues centering around control of hospital costs and wanted someone in charge of that who knew something about hospitals. He told me that I would find it difficult to work with Bachmeyer because of his virtual total deafness and that I would find Harry Becker to be an extremely stimulating guy, who might be hard to handle. Norby assured me that he would help me with handling either Bachmeyer or Becker if I took the job. Subsequently, I met with Harry Becker and found him to be a fascinating person and learned to respect Art Bachmeyer.

I took a leave of absence from the Albert Einstein Medical Center and came to Chicago and spent two years working with the commission. This was a very stimulating experience for me, as very little work had been done on control of hospital costs. So I was dealing with a relatively new field. Also, being with the staff of the national commission gave me an opportunity to meet a great many key people throughout the country and to become quite close with many of them.

As is well documented in the foreword by the chairman, Gordon Gray [Appendix G], at the beginning of each of the three volumes that were published from the commission studies, Arthur Bachmeyer was very much involved in developing the plans for the study and served not only as the director of the study, but also as a member of both the commission and the commission's executive committee. Unfortunately, Bachmeyer died suddenly, immediately following a meeting of the commission in Washington, D.C., on May 22, 1953. He was succeeded by John H. Hayes, who had just retired as director of Lenox Hill Hospital. Hayes was a very fine gentleman and a respected hospital administrator,

however he had no special skills in the field of studies and commissions.

The most helpful person to me in connection with my work on the commission was Morris Fishbein, M.D., who served on my committee and offered to give me editorial advice and consultation. I was scared to death that he would inject his philosophy into the report, but he never did so. He read every page and made detailed editorial suggestions, line by line, all of which were extremely helpful. He really taught me how to write. I would meet with him at his home for lunch about once every two weeks and he couldn't possibly have been more helpful.

I was not directly involved in the other two reports of the commission, namely, the report on prepayment and the report on financing hospital care for nonwage and low-income groups.

The weakest part of the work on the commission, I believe, was in the category of financing hospital care for nonwage and low-income groups. This was under the direction of Carl Schmidt, but Harry Becker insisted on taking over. Harry tried to resolve the fundamental differences between the traditional folks in the health establishment and those associated with organized labor, etc., but failed. As a result, the book essentially centers around the problems of the "needy," and divides those who are needy into the aged, the unemployed, the disabled, the low-income group, and public aid recipients. Of the entire book, about 20 pages are devoted to problems of the aged. The recommendations centered around the "needy" aged.

In fact, those who were promoting national solutions had not yet begun to focus in on insurance for the aged as contrasted with national health insurance generally. The labor members of the commission filed dissents against the commission report because it did not pay special attention to the problems of the aged as such. As I recall, the only person who paid special attention to the commission's recommendations for the aged was the guy from commercial health insurance, who was against any attachment of health benefits to OASI [Old Age and Survivors Insurance], even for the needy. As I recall, the entire report with respect to the aged was focused almost exclusively on "means test" approaches, and the commission generally accepted that approach, except for the labor folks.

In another interview, Sigmond spoke about Hayes again and about his own disappointment at the reception the commission's report received.

SIGMOND:[26]

I concentrated on the cost of hospital service. That's volume one…

He (John Hayes) theoretically supervised me in the preparation of volume one, with Harry Becker concentrating on volumes two and three. We spent two years on that, and, in my

opinion, we came up with some of the best early studies and best ideas on what to do about rising hospital costs, all of which are in the first volume. That commission report came out at a time when nobody cared. Nobody was interested in the problem.

James Hague,[27] an official of the AHA in the days of the Commission on Financing of Hospital Care, spoke of one of the outcomes of the commission's work: drawing attention to the health care needs of the elderly.

HAGUE:[28]

The Commission on Financing of Hospital Care was an outgrowth of the unwillingness of the Commission on Hospital Care to tackle the subject of health care financing. They just weren't going to get anywhere on that issue, so they decided to put it aside. George Bugbee, then the executive director of the American Hospital Association, recognized this and created in 1951 another commission, the Commission on Financing of Hospital Care.

The Commission on Financing of Hospital Care did do one thing: it focused the attention of the AHA on health care for the aged. A committee was appointed by the AHA board to study the findings of the Commission on Financing of Hospital Care. What should the position of the AHA be with respect to the health care of the aged? E.A. van Steenwyk (president of Philadelphia Blue Cross) made the recommendation and the AHA board adopted it. From that point on, it seems to me that the AHA debate was more methods than anything else.

The AHA quickly accepted the need of the aged for health care help and the need for federal assistance in the solution.

The AHA's approach was to be via a Blue Cross card for everyone, destroying the differential between those who couldn't pay because everyone would have a Blue Cross card. It would base a person's contribution to that premium on some income basis but applied with some humaneness. No hardbench [sic] means test approach.

Such a lack of entitlement was attractive to many of the hospital conservatives. It's an acceptable thing, if done properly, to liberals such as I. I found, despite my liberal beliefs, and I am much more liberal than most people in the hospital field, that I could live in this AHA climate. I couldn't live in the American Medical Association climate. The AMA came up with Kerr-Mills as a way of stopping Medicare. It didn't stop Medicare, of course.

At the time the commission's reports were published, there may not have seemed to be much enthusiasm for their findings and recommendations. Nevertheless, the commission's work was valuable to the writers of the stream of bills introduced into Congress and evolving ultimately into Medicare.

One notable legislative event was the passage of an amendment to the Social Security Act in 1956 making possible disability cash benefits for totally and permanently disabled persons age 55 and over. The amendment came about because of the determination of the newly merged AFL-CIO to take a positive and meaningful step in the health field.

Nelson Cruikshank talks about the efforts of the AFL-CIO to promote the passage of the disability amendment.

CRUIKSHANK:[29]

In the disability thing we in a way made that a test of the first thing we could do in our field following merger. We put on the agenda what would be the first piece of legislation the merged organization would try to enact. We decided that disability insurance would be our test. The disability insurance idea had been around for a long time. It was first reported in 1938 by the advisory committee that made changes in the old age thing and added survivors. They had tried to get disability adopted then. That was in 1938, now this was in 1956. We knew we couldn't get Medicare or national health insurance. We thought that disability was the test. Of course, AMA opposed it with all the vigor and enthusiasm and venom that they had directed toward other policy things. They said, and we agreed, that it was a foot in the door for health insurance.

What is generally unknown about the action that took place in pushing the disability amendment through Congress is the sacrifice that Senator Earle C. Clements (D-Ky.) made and the eloquence of Senator Walter E George (D-Ga.) in holding the bridge against the opposition while Senator Lyndon Johnson (D-Tex.) mustered enough votes to pass the measure in the Senate. (The bill had narrowly passed in the House.) Nelson Cruikshank gives a first-hand account of the behind-the-scenes action–especially what happened to swing one or two key votes.

CRUIKSHANK:[30]

In 1956 Senator George was up for reelection and he felt that under the unit rule in Georgia he couldn't win against Herman Talmadge because it was badly weighted against him. So he withdrew. He announced he was not going to run again. Then at that time he announced he didn't want to see any people. The disability thing was very tight. It had passed the House by a narrow majority. It had been turned down by the Senate Finance Committee. We knew we needed somebody of great prestige on the floor, particularly with

There was a congressman by the name of Page whose son was an assistant to Senator George, on his staff. Andy Biemiller (of our legislative staff) said to me, "I think we can see Senator George and get him to make this his kind of swan song. I think I can get to see him."

I said, "He isn't seeing anybody."

Andy said, "We can see him on a Saturday morning, if we are going to be willing to go down there and wait and hang around."

"Well," I said, "I usually go over to the [Chesapeake] Bay on Saturday."

I remember my wife and I packed up the car. I told her we probably would have to wait around a while. So I parked on the Capitol grounds and went into George's outer office. He had somebody in there, somebody from the sugar interests or Coca Cola from Georgia. Anyway we saw them file out.

We heard him say to young Page, "You mean to say these men have stayed here all morning?"

Hour after hour went by; my poor wife was sitting out in the car.

We heard Senator George say, "Tell them I'll see them for five minutes."

So he came out and ushered Andy and me in. We made our pitch. He would lead the battle to override the Senate Finance Committee, of which he was a member. He was in a clear position because he had voted for us but he was not in the majority. So he was not reversing his personal position; but to take on the Senate Finance Committee was a major job. But, he carried on that battle.

Lyndon Johnson also was with us. He was the Senate Majority Leader at the time. We met in his office with Clements of Kentucky, who was the Majority Whip, and we counted noses. We went down every member of the Senate and where we thought they were. We had a bare majority.

Clements then said, "Look, you have counted me with you. I can't be with you. I am up for reelection, and the AMA in Kentucky has vowed to defeat me if I vote for disability." Lyndon Johnson was pretty upset.

He said, "This is a party position. You are the Majority Whip, you can't go against us." He argued with him. Finally Johnson said, "I'll tell you. If we need your vote, if it's that close, can we have your vote?"

Clements said, "Yes. If my vote makes the difference, you can have my vote. Please don't call me. Let me get out of this if I can. I'll not vote one way or the other unless my vote is critical."

It came up on the floor in August. I was in the gallery. The debate was started. Senator George was speaking. I saw Lyndon Johnson searching around the gallery. He caught my eye and pointed down. I knew he wanted me to meet him down in his little private office off the floor. I rushed down.

He said, "How many votes have you got, Cruikshank?"

I said, "We've got a bare majority."

He said, "I can't believe that."

He showed me a list that he had of guys that had gone back on what we had thought was their position. So I went out in the hall and gathered together all the labor and welfare people I could round up. We divided up those names and started working on them.

Johnson said, "I'll pass a note to George to keep talking for an hour. He'll have the floor for an hour. You've got an hour to get those six votes."

One of the peculiar votes that we rounded up was Joe McCarthy. Now Joe McCarthy was a very conservative guy, of course. Joe McCarthy had been taken to task by Nixon. Eisenhower sent Nixon, who was then vice president, to McCarthy to ask him to slow down on his Communist drives. He was sore at Nixon for having done this. Nixon was in the chair as vice president. Very seldom did the vice president actually occupy the chair; however, he had come over that day knowing that it was going to be close and that he might have to cast the deciding vote in case of a tie.

The machinists' representative said, "I know how to get Joe McCarthy. Tell him that he will embarrass Nixon." So we worked on him, and McCarthy voted with us. Then, when he saw his vote wasn't needed, he called up to the clerk and reserved his vote, which made it a tie. You see, it carried the first time, but then, when McCarthy reversed his vote, it made it a tie.

At that point I saw Lyndon Johnson stride up the aisle in six-foot strides and hold up the arm of the reluctant Clements, who cast his vote. It wasn't a tie. We carried it in the end by two votes. At that moment Clements' vote was the vote that was needed to break it.

Incidentally, that was in August, and in November the AMA defeated Clements. It cost him his seat in the Senate to put disability on the rolls. But today there are 7 million people in their wheelchairs in hospitals and so forth that benefit because of that vote. I don't think Clements would regret it.

Another event that occurred during the Eisenhower presidency was the introduction of the Forand bill in the House late in 1957. The Forand bill was the successor of the long series of health insurance bills going back to the Wagner health bill of 1939 (or to earlier events), and it was followed, in turn, by a whole series of Wagner-Murray-Dingell and Murray-Dingell bills. The Forand bill presented a new approach: if health insurance legislation could not be passed for the entire population, why not concentrate on a federal program for Social Security beneficiaries? The bill called for 60 days of hospital care and certain nursing home and surgical benefits.

It became the Forand bill because Aime Forand (D-R.I.) was induced to introduce it. The bill was written by legislative specialists and was supported by, among others, the AFL-CIO. The sponsoring groups looked for someone to introduce the bill in the House. Jere Cooper, then chairman of the House Ways and Means Committee, said, according to

Cruikshank, that he didn't want to touch it. Finally the labor group went to Forand, who was third in rank among the Democrats on the committee. Forand had worked closely with the American Public Welfare Association over the years; it is questionable whether he had any direct interest in the subject of health insurance. Cruikshank talked about going to Forand seeking his help.

CRUIKSHANK:[31]

He said, "We'll look it over and see."

We kept going back to him: well, he was busy, he hadn't had a chance to look at it yet. Meanwhile, there was a chap by the name of Greenberg who was kind of a medical expert on the Providence *Journal* and had written a number of articles we thought were pretty good. Most journalists don't know what they are talking about in the health field. He was of a different stripe. He had written a series of articles for the Providence *Journal.* I had met him at a couple of conferences. I called him and said, "Your Congressman is thinking about putting in a bill." I said, "If he gets some support in Rhode Island it will strengthen his hand. There is no reason I can't give you a scoop, if he does this."

He said, "Fine! Great!"

Then Forand, when we went back to him, said to Andy Biemiller and me, "Will you fellows guarantee me that this is a good, sound bill?"

We said, "We have worked it over. It's got the advice of the medical group. It's got the advice of our social security committee. It's endorsed by the AFL-CIO, and now the combined organization. It's gone through several refinement procedures. We can tell you, you don't need to be worried about this bill. Your people in Rhode Island will be happy about it too."

He said, "I haven't had time to look it over. Write me a speech of introduction."

So we went back and wrote him a speech. He introduced the bill. I sent a copy of the speech up to Greenberg with a note on it saying that when Forand made the speech I would give him a call and that if there were any departures from the speech I would let him know.

He made the speech word for word. I called Greenberg, and the next day the Providence *Journal* came out with banner headlines with everything in favor of it. Forand was absolutely delighted. From then on, Aime Forand thought he invented the whole idea. We didn't bother to disillusion him. He was a great friend. That's the way it was done.

The Forand bill received the support of many labor and professional groups, but it was opposed by the AMA, the Chamber of Commerce, insurance groups, and the Farm Bureau, among others. The bill was not reported out by the Ways and Means Committee after

hearings were held in June 1958. The Ways and Means Committee stated that it needed more information before it could act and called upon HEW to study the problem of health care for the elderly. The department reported back in April 1959. Its report outlined the problems of the aged but ended equivocally, by questioning whether the government should do something directly to aid the elderly at that time or whether the government should wait to see if the growing enrollment of citizens in private insurance would eventually solve the problem without government intervention.

The Forand bill was on the scene until 1960. The last form of the bill was stripped of surgical benefits, hoping to lessen the animosity of physicians, but to no avail.

Falk, who had been busy with Cohen and others in writing legislative proposals for health insurance since the days of Wagner's original health bill, discusses the latest reincarnation (the Forand bill) and the substitution of the Kerr-Mills program for it in an attempt to care for the aged and indigent.

FALK:[32]

By 1958 there were indications that a health insurance bill might be able to be enacted. This led to very vigorous countermeasures from some who were strongly opposed to expansion of the Social Security system. Finally–skipping a lot of intermediate steps–it resulted in development of an expanded means test program as an alternative to a paid-up insurance program–the Kerr-Mills program.

The Kerr-Mills program was intended to broaden the availability of public assistance medical care so that it would extend to the medically indigent and not be limited to the indigent in need of money payments for support. That program, enacted in 1960, if I remember correctly, was expected to be very effective. This was the expectation, because the financial support to the states from the federal government was increased–to buy the support of the states–so that they could undertake broadened public assistance, medical care programs with very little additional cost to them. The additional costs were borne by increased federal grants-in-aid to the states.

That program was very quickly picked up and developed in six to nine relatively wealthy states that could put up their matching funds. Otherwise it was a general disaster. Most of the states could not afford to take advantage of the program's opportunities, even though the federal grant support had been considerably increased. Within two or three years it was evident that the majority of the federal money was going to a few of the wealthiest states and only a miniscule portion was going to the states in which the needs were greatest.

I mentioned the catastrophies of the Kerr-Mills program because through the early

1960s its failure led to expediting, augmenting, and accelerating the acceptability of the paid-up insurance concept that was going to become Medicare in 1965.

[Shortly before his death in October 1984, Falk read a draft copy of this chapter. He added a note at this point: "The Clements story is particularly moving to me. I had spent more years on the design of disability insurance–since 1936–than on any subject other than health insurance. I was particularly piqued at the insurance industry for their opposition, because, after some early bad experiences with it, they lost money on it and had no intention to take it up. Theirs was a dog in the manger opposition to it. It pained me greatly for years."]

The Kerr-Mills program lasted less than five years and was succeeded by Medicaid in 1966. Kerr-Mills did not solve the problems it set out to correct (unless it was meant to delay the passage of Medicare, which it may have done).

Looking back at the Eisenhower years, we might summarize by saying that, even though not much seemed to be happening in the health field, there was some simmering under the surface that would bubble over in the mid-1960s. Action picked up during the Kennedy and Johnson years and culminated in the passage of Medicare and Medicaid in 1965. That action is described in the next chapter.

Notes

(Transcripts of the oral histories cited here are housed in the library of the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. The Oral History Collection is a joint project of the Hospital Research and Educational Trust and the AHA.)

1. Commons was a professor at the University of Wisconsin from 1904 to 1932.

2. Henry F. Pringle, *Theodore Roosevelt* (New York: Harcourt, Brace, 1956), pp. 396-97.

3. For background reading see Peter A. Corning, *The Evolution of Medicare* (Washington, D.C.: Office of Research and Statistics, Social Security Administration, U.S. Department of Health, Education, and Welfare, 1969).

4. The act was not renewed in 1929.

5. See Odin W. Anderson, *Blue Cross Since 1929* (Cambridge, Mass.: Ballinger, 1975).

6. Nathan Miller, *FDR: An Intimate History* (Garden City, N.Y.: Doubleday, 1983), pp. 306-25.

7. For a description of the utopian movement in the United States in the 1930s, see George Creel, *Rebel at Large* (New York: Putnam's, 1947).

8. Altmeyer later became one of the three members of the first Social Security Board.

9. Quoted from Arthur J. Altmeyer, *The Formative Years of Social Security* (Madison: The University of Wisconsin Press, 1968), pp. 8-9.

10. Frances Perkins, *The Roosevelt I Knew* (New York: Viking Press, 1946), p. 286.

11. *Wilbur Cohen, In the First Person: An Oral History.* See Profiles of Participants, in the center of this book, for biographical information.

12. *1. S. Falk, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

13. *Cohen, Oral History.*

14. Ibid.

15. J. Joseph Huthmacher, *Senator Robert F. Wagner and the Rise of Urban Liberalism* (New York: Atheneum, 1968), p. 292.

16. Robert H. Ferrell, ed., *Off the Record: The Private Papers of Harry S. Truman* (New York: Harper & Row, 1980), pp. 165-66.

17. Ibid., p. 262.

18. Ibid., p. 303.

19. Robert J. Donovan, *Conflict and Crisis: The Presidency of Harry S. Truman, 1945-1948*

(New York: Norton, 1977), p. 125.

20. Altmeyer, Formative Years, p. 163.

21. Falk, Oral History.

22. *Cohen, Oral History.*

23. Altmeyer, *Formative Years, pp.* 237-38.

24. Grants totalling $556,000 for the support of the Commission on Financing of Hospital Care were forthcoming from the Blue Cross Commission, the Health Information Foundation, the John Hancock Mutual Life Insurance Company, the W.K. Kellogg Foundation, Michigan Medical Services, the Milbank Memorial Fund, the National Foundation for Infantile Paralysis, and the Rockefeller Foundation.

25. See Profiles of Participants for biographical information.

26. *Robert Sigmond, In the First Person: An Oral History.*

27. See Profiles of Participants for biographical information.

28. *James Hague, In the First Person: An Oral History.*

29. *Nelson H. Cruikshank, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

30. *Cruikshank, Oral History.*

31. Ibid.

32. *Falk, Oral History.*