...And the pursuit of national health: the incremental strategy toward national health insurance in the United States of America

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INTRODUCTION: ANOTHER EXCEPTION TO THE RULE

“If criminals have the right to a lawyer, I think working Americans should have a right to a doctor. ... I’m Harris Wofford, and I believe there is nothing more fundamental than the right to see a doctor when you’re sick.” By making health care reform the core issue of his campaign, Harris Wofford, a relatively unknown Democrat from Pennsylvania, won the seat in the Senate left vacant by the sudden death of Senator John Heinz in 1991. Wofford’s victory was unexpected, as the popular Republican Richard Thornburgh was considered to be most likely to win. Instead, health care reform proved to be an effective and perhaps even decisive campaign issue in this special senatorial election. At the Democratic National Convention of 1992, presidential candidate Bill Clinton followed Wofford’s example by promising the voters an “America in which health care is a right, not a privilege.”

Presenting health care as a right makes sense. America has always been a nation with a strong rhetorical emphasis on rights, ranging from civil rights, women rights, and gay rights, to the rights of the unborn, the right to bear arms, and “the right to remain silent.” Advocates of national health insurance have repeatedly pointed out that America is the only western welfare state that does not guarantee health insurance coverage as a right for all its citizens. Around forty million Americans do not have any health insurance coverage at all. Moreover, problems of incomplete coverage and inability to pay for health care are not limited to the underprivileged and the welfare poor alone. Even the middle-class Americans have begun to realize that their “right” to health care is indeed a privilege, as they worry about rising costs, higher premiums, limited coverage, and the decline of employer-based health insurance. To the advocates, the solution seems obvious. As Time columnist Barbara Ehrenreich

1 As quoted in Theda Skocpol, Boomerang: Clinton’s Health Security Effort and the Turn against Government in U.S. Politics (New York: W W. Norton & Company, 1996), 27.
pleads, "Why can't we have national health insurance — like just about everybody else in the civilized world, please?"

Then, on September 22, 1993, President Bill Clinton presented his long-awaited Health Security Plan to Congress. "At long last," he declared, "after decades of false starts, we must make this our most urgent priority: giving every American health security, health care that can never be taken away, health care that is always there." Initially, the plan was met with enthusiasm, but the euphoric mood changed rapidly as it came under serious attack from both the left and the right. The advocates of a single-payer national health insurance program complained that the plan did not go far enough; the opponents denounced the plan by creating a public image of fear that the individual would be lost in a bureaucratic health care hell. Even though a majority of the American public continued to favor universal coverage, the public support of the Clinton plan dwindled. What had started out as a promising attempt to reform health care became a symbol in the turn against government. Roughly a month before the congressional elections of November 1994, Senate majority leader George Mitchell pronounced the death of the Clinton Health Security Plan. When subsequently Harris Wofford lost his seat in the Senate, the failure of health care reform seemed complete.

The disappointing fate of the Clinton Health Security Plan came as no surprise to those historians who view the history of national health insurance in the United States as "a century of failure." Ever since the first unsuccessful attempt to include national health insurance in the Social Security Act of 1935, all succeeding efforts have failed: the Wagner bill of 1939, the Wagner-Murray-Dingell bills of the 1940s, President Harry S. Truman's National Health Plan of 1949, the 1970 Health Security Plan of Edward Kennedy and Martha Griffiths, President Richard Nixon's Comprehensive Health Insurance Plan of 1974, President Jimmy Carter's health insurance plan of 1979, and finally, the Clinton Health Security Plan. A comprehensive and universal health insurance program was never enacted. Instead, a combined system of private and government health insurance programs developed: private, employer-based health insurance for the working population, and government

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5 As quoted in Harold Bauman, "Verging on National Health Insurance since 1910," in Robert P. Huefner and Margaret P. Battin (editors), Changing to National Health Care: Ethical and Policy Issues (Salt Lake City: University of Utah Press, 1992), 29-49.


7 Hacker, The Road to Nowhere, 170-180; Skocpol, Boomerang, 92-98.

programs for those Americans who are the least likely to be insured. Enacted in
1965, Medicare provides health insurance for the elderly and the disabled,
Medicaid for the welfare poor and the medically indigent. Even though
policymakers believed that Medicare and Medicaid would eventually lead to
universal coverage, those Americans falling in between private insurance and
government programs remain uninsured.

THE AMERICAN EXCEPTION

The question why national health insurance was never enacted in America has
become a classic, reminiscent of the more famous one phrased by the German
sociologist Werner Sombart in 1906: “Why is there no Socialism in the United
States?”9 America is indeed the exception: all other western welfare states have
enacted national health insurance in some form or another. In the popular
view, this American exception is easily explained. National health insurance is
just plainly un-American, a product of those European nanny welfare states
where the people are pampered from the cradle to the grave. Americans don’t
want to be pushed around, as National Review columnist John C. Goodman
argues: “In Europe, people have been pushed around for centuries. In the U.S.
we have widespread access to information, about modern medical technology, a
legal system that encourages litigation, and a strong devotion to basic rights of
due process. National health insurance, as it operates in other countries, would
not survive the American cultural and legal system.”10

Scholars have provided more subtle, though similar explanations. Seymour Martin
Lipset views the absence of national health insurance in the
United States as an example of American exceptionalism – the notion that,
because of its “unique” history, America is intrinsically different from other
western nations. America’s dominant public philosophy of individualism and
self-reliance, combined with a traditional aversion to state intervention, makes
national health insurance incompatible with American culture and politics.11
James A. Morone adds that, in the United States, the seemingly contradictory
combination of individualism and communal interest has enabled the medical
profession to maintain a strong influence on how health care policy is
administered.12 In his essay “Why Americans are Different,” Lawrence D.
Brown states that Americans are “aggressively moralistic” when it comes to
social policy. Americans are reluctant to commit to national health insurance

9 As quoted in Seymour Martin Lipset, American Exceptionalism: A Double-Edged
10 John C. Goodman, “National Health Insurance: An Expensive Way to Die,”
11 Lipset, American Exceptionalism, Chapter 1, 31-52.
12 James A. Morone, The Democratic Wish: Popular Participation and the Limits of
out of "the fear that the mythic [sic] prototypical recipient who uses his welfare benefits to buy a Cadillac or her food stamps for vodka is itching to charge the new government health insurance program for cosmetic surgery and such."\(^{13}\)

Other scholars have looked beyond the so-called exceptionally American cultural values and place a stronger emphasis on the structure and institutions of the American political system.\(^{14}\) First, the fate of health care reform in the United States is dependent on many different interest groups, including the medical profession, the pharmaceutical industry, insurance companies, consumer organizations, labor, and business. All these interest groups influence social policy through lobbying. Second, the complex combination of legislative and executive power, combined with the tension between federal and state politics, makes comprehensive federal legislation more difficult. While in most western welfare states, parliamentary and often coalition governments design social policy, American reformers see their efforts being obstructed by, in David Wilsford's definition, "the lobby, lobby, lobby system of the United States."\(^{15}\) To get national health insurance enacted, reformers need to lobby the administration, lobby the Congress, and lobby the governments of the individual states. Finally, compared to the debates in other western welfare states, the national health insurance debate in the United States has always been more ideological. All these influences have contributed to the exceptional position of American health care policy.

CHALLENGING THE QUESTION

To question the absence of national health insurance in the United States means making a comparison that is by definition problematic. Not only is

\(^{13}\) Lawrence D. Brown, "Why Americans Are Different," in Huefner and Battin (editors), Changing to National Health Care, 133-134. Brown implies that such stereotypes are "exceptionally" American. However, even though there may be a stronger political base for social welfare in the Netherlands, Brown's description sounds strikingly similar to the Dutch stereotypes of the Turkish immigrant on welfare who drives a brand-new Mercedes or the transsexual who uses the national health insurance program to pay for his sex change operation. There is no reason to assume that prejudice against and stigmatization of the less privileged are limited to the United States alone.


America much larger in size (in square miles and in population) than the other western industrialized nations, the complex relationship between federal and state governments makes American health policy more complicated. In comparative analyses, scholars tend to focus on the federal policy in America only, thereby ignoring policy on state level.\footnote{For example, in his table presenting "the degree of de-commodification" in several western welfare states in 1980, Gosta Esping-Andersen does not give a score for sickness benefits in the United States because, within his framework, such a program is "non-existent and therefore scored 0." Gosta Esping-Andersen, The Three Worlds of Welfare Capitalism (Princeton: Princeton University Press, 1990), 50.} Several American states have enacted health insurance programs to extend coverage to all or most of the population, or have initiated far-reaching health care reform.\footnote{Harry Nelson, Federalism in Health Reform: Views from the States That Could Not Wait (New York: Milbank Memorial Fund, 1994). See also Howard M. Leichter (editor), Health Policy Reform in America: Innovations from the States (Armonk, New York: M.E. Sharpe, 1992).} Why should a relatively small welfare state as the Netherlands be included in a comparative analysis, while American states as Florida or Minnesota – which have enacted health insurance programs on state level – are not? Comparisons between the United States of America and other western industrialized welfare states, especially those focused on cultural values, tend to be based on overemphasized differences and broad generalizations, while the American experiences on state level are often ignored.

The discussion becomes even more complicated when taking into account that national health insurance is not a singular entity meaning the same in all western welfare states at all times. If, in the definition of Edward D. Berkowitz and Kim McQuaid, "true" national health care means "health care paid for and provided by the government under a system in which doctors work for the government," then only a few national health care schemes fit the bill, most notably the British National Health Service (NHS).\footnote{Edward D. Berkowitz and Kim McQuaid, Creating the Welfare State: The Political Economy of 20th-Century Reform, revised edition (Lawrence, KS: University of Kansas Press, 1992), 211.} Compared to the national health care schemes of other western welfare states, the NHS can be called unique, as it is administered by the national government. In all other western welfare states, on the contrary, health care, whether or not supervised by the centralized government, is administered on local level. In this particular comparison, American health care policy complies to the rule, while Great Britain is the exception.\footnote{Rudolf Klein, The New Politics of the National Health Service, third edition (London: Longman, 1995), vii.}

Using broad definitions, national health care systems can be divided into three categories: 1) traditional sickness insurance, meaning the state finances the health care services for certain lower-income segments of the population,
predominantly through sickness funds consisting of contributions by employers and employees, 2) national health insurance, meaning the state functions as single-payer intermediary between health care provider and health care consumer, and 3) national health service, meaning the state both finances and provides for health care services. A fourth category includes national health care systems consisting of a mixture of the three. In practice, most health care systems overlap. Private health insurance co-exists with government health insurance programs. Systems based on social insurance (contributions by employers and employees) are combined with government health insurance programs for the non-working population financed by general revenue. Recent health care reforms have blurred the differences even further. Government programs have been partially privatized. Systems of managed care have strengthened the ties between private and government health insurance. Interestingly enough, these reforms are often defined as the “Americanization” of health care.

As most of these health care systems are mixtures of different programs, often a combination of private and government health insurance, the American system appears to be less different than is generally assumed. The American federal government has always been an important partner in health care policy, not only through Medicare and Medicaid, but also through federal subsidies to extend medical care and through fiscal policies which encourage private, employer-based health insurance. By the end of the 1980s, the federal government spent more on health care than the private insurance companies did. The conclusion that any form of national health insurance – in its broadest definition – is absent in the United States of America can therefore not be sustained.

Several scholars have pointed out that, instead of explaining why national health insurance was never enacted in the United States, the focus should be on


22 Theodore R. Marmor, Jerry L. Mashaw, and Philip L. Harvey, America’s Misunderstood Welfare State: Persistent Myths, Enduring Realities, revised edition (New York: BasicBooks, 1992), 179. According to the authors: “By 1989, government financed about 40 percent of total health expenditures (nearly 70 percent of that total through Medicare and Medicaid), whereas private insurance covered only about 32 percent. Patients paid the rest out of pocket.”
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why the extension of medical care repeatedly been preferred to the extension of health insurance coverage? How is American health care financed? What role has the federal government played in the encouragement of private, employer-based health insurance? Why are certain groups of the population, such as the elderly, covered by government health insurance programs while others are not? These questions are indeed fundamental to understanding American health care policy and are in fact more relevant than merely questioning why the United States does not have a national health insurance program. This does not mean, however, that the issue of the absence of universal coverage in the United States can or should be ignored: in contrast to all other western welfare states, America has never enacted a government program, whether or not one of national health insurance, to guarantee basic health insurance coverage for all its citizens. To question the exceptionality of the American situation remains valid. Why did a nation, with a traditional aversion to governmental intervention, a well developed bill of individual rights, yet also with federally enforced policy on a broad range of issues from drinking to education, never guarantee access to medical care? In the study of American health care policy, the absence of universal coverage should also be included. By examining the options and the final decisions at specific moments in the national health insurance debate – thus focusing on the policy which was adopted, instead of on policy which was not – the question why America has been exceptional in not guaranteeing health insurance to all its citizens can be answered as well.

Conflict versus Consensus

In their attempt to explain the absence of national health insurance in the United States, historians have presented a “good guys versus bad guys” narrative – a struggle of reformers against the medical profession and the insurance industry. With the sole exception of Medicare, a rather moderate


success, the struggle repeatedly ended up in a defeat of the reformers. By viewing American health care policy as failed attempts to establish national health insurance, the emphasis has been placed on the conflict between two opposing poles, with a slight bias toward the reformers, instead of on the consensus which had been established among the remaining partners in American health care. As Daniel Fox poses the rhetorical question: "And why have professional historians who unlike frustrated reformers should have known better, emphasized the failure to achieve compulsory health insurance as the central issue in medical care policy in the United States?" Indeed, historians tend to ignore that, while national health insurance remained controversial, no one seemed to doubt, including the reformers and the medical profession, that the subsidizing of medical research and facilities would lead to better medical care.

"Believe it or not in the first two decades of this century, there was one instance in which the American Medical Association wanted a national health program, and the AFL-CIO opposed it," as President Clinton said at a health care rally on the day after he presented his Health Security Plan to Congress. The AMA had indeed in 1916, for a short period of time, cooperated with the social insurance experts of the American Association of Labor Legislation in the study of compulsory health insurance. The American Federation of Labor (AFL), on the contrary, was less cooperative. Its president Samuel Gompers denounced compulsory health insurance as paternalistic intrusion of the state. Over the years, the tables were turned. The AMA as main opponent and the AFL-CIO as main advocate became the two opposing poles in the debate on government health insurance.

Most historians of national health insurance in the United States have assumed that the direct cause of its failure was the opposition of predominantly the medical profession as mobilized by the AMA. The opposition of the medical profession convinced President Franklin D. Roosevelt's Committee on Economic Security that including national health insurance in the Social Security Act of 1935 would endanger the passage of the entire act. In 1949, the AMA launched an extensive and successful public campaign to counter President Harry S. Truman's National Health Plan. Even the enactment of

Medicare and Medicaid in 1965 can be seen as a victory of the medical profession. Not only did these programs prove to be a great financial benefit to the medical profession, the enactment of Medicare and Medicaid also reduced the political pressures pushing for universal coverage. When the opposition to government health insurance was taken over by other interest groups such as the Health Insurance Association of America, they could build upon a tradition of opposition initiated by the AMA.

The AMA’s strong opposition seemed illogical, as national health insurance could only benefit, not hurt, the medical profession. As President Harry S. Truman wondered, “I can’t get the doctor’s point of view because the objective is to help these people have a nest egg so the doctors and the hospitals can be paid.” However, the possible economic gain did not outweigh the fear that a government health insurance program would be the first step in the regimentation of the medical profession, the fear that the government would not only pay for medical care, but also determine how this care was supposed to be delivered. Government health insurance could also lead to a dominance of group practice, placing the medical profession under the regulations of hospital administrations. In addition, a joined fight against national health insurance enabled the AMA to maintain unity within the medical profession and strengthen its professional autonomy.

Over the years, critics have pointed at the dominant influence of organized medicine in medical politics, depicting the AMA as “the world’s most hated union” and as a group of “demagogues ... who wave the flag to achieve selfish aims.” The image of the AMA as main obstructionist also became dominant in the popular literature. Books such as James Rorty’s American Medicine Mobilizes (1939) and Richard Carter’s The Doctor Business (1959) depicted the AMA as a group of ruthless doctors jeopardizing the public health in the pursuit of their own economic well-being. After Medicare was enacted, the AMA’s unsuccessful “multi-million dollar fight against public health legislation” was described by journalist Richard Harris in a series of four articles in The New Yorker. Harris’ account became a best-seller.

31 Fox, Health Policies, Health Politics, Chapter 3, 37-51.
when the articles were published in book form. The 1969 revised paperback edition featured a foreword by Senator Edward Kennedy, one of the most active advocates of national health insurance in the Senate. More recently, journalists Howard Wolinsky and Tom Brune published *The Serpent on the Staff: The Unhealthy Politics of the American Medical Association*, arguing that the AMA remains one of the most prominent obstructionists in health care reform.\(^{34}\)

The opposition of the AMA and the advocacy of the AFL-CIO did not stand on their own, but reflected a more general political and ideological division between conservatives and liberals in American politics throughout the twentieth century.\(^{35}\) As the division in opponents and proponents in the Medicare debate shows, government health insurance tended to be favored by representatives of the employed working population, and opposed by representatives of employers, independent professionals, and business.\(^{36}\)

Traditionally conservative interest groups such as the Chamber of Commerce supported the position of the AMA, while more progressive groups joined with the AFL-CIO. This division also reflected the political party alignments. With the notable exception of the 1974 Comprehensive Health Insurance Plan introduced by President Richard Nixon, a Republican, national health insurance appeared to be the prerogative of the Democratic Party. Politicians from both sides used their position on government health insurance to win political support and gain influence within their political parties.

During senatorial and presidential campaigns, Republican candidates used the AMA’s arguments against national health insurance in their own opposition to a more active role of the federal government in general. In 1948, right before the presidential elections, House Republicans established the Subcommittee on Government Publicity and Propaganda to investigate President Truman’s support of national health insurance, a political investigation which had more to do with the coming elections than with health care.\(^{37}\) In 1968, Ronald Reagan, then governor of California, strengthened his position within the Republican Party by claiming that “Medicare programs are

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in fact sicker than the people they are expected to aid."\(^{38}\) Three decades later, conservative House Republicans attacked the Clinton Health Security Plan as part of a larger political campaign against the Clinton administration. While health care reform was one of the main targets of attack, the issue did not reappear in the House Republicans legislative blueprint *Contract with America*.\(^{39}\)

However, politicians of the Democratic Party also took political advantage of the conflict situation in health care politics. President Harry Truman criticized the "do-nothing" Republicans for merely echoing the AMA propaganda: "Sorry. We can't do that. The medical lobby says it's un-American."\(^ {40}\) During the Medicare debates, President John F. Kennedy lashed out against the AMA, blaming the medical profession for the failure to enact health insurance for the aged, while he must have realized that Congress was the real obstructionist.\(^ {41}\) In 1992, presidential candidate Bill Clinton promised that "your government has the courage – finally – to take on the health care profiteers."\(^ {42}\) In the same manner as conservative Republicans have simplified the national health insurance debate by merely warning against "socialized medicine," liberal Democrats singled out the opposition of the medical profession as main obstacle to create a visible "enemy" in the fight for health care reform.

Even though the AMA's opposition was real, the overestimation of its influence reduces the history of national health insurance in the United States to a battle between idealistic reformers and opportunistic obstructionists. In this way, it tends to be forgotten that national health insurance (predominantly the issue of universal coverage) was not so much a "lost reform" as an option that was repeatedly not chosen. Efforts to reform health care were not merely failures but also political compromises, leading to the extension of medical care, cost containment, and health insurance coverage for certain segments of the population. Moreover, health care reform is a long political process that builds on both the successes and failures of the past. President Truman's "failed" National Health Plan, for example, eventually led to the enactment of Medicare and Medicaid. Even though Nixon's health insurance plan did not


\(42\) Bill Clinton, "A New Covenant," in Bill Clinton and Al Gore, *Putting People First*, 228.
succeed, the Nixon administration successfully introduced the Health Maintenance Organization (HMO) as an American solution to finance health care. The Clinton Health Security Plan led to the enactment of the Health Insurance Portability and Accountability Act of 1996. Introduced by Democrat Edward Kennedy and Republican Nancy Kassebaum, the act includes several aspects of the Clinton plan which increase the security of Americans already covered by health insurance. Not the failure of national health insurance in itself, but the preference for the extension of medical care, partial health insurance coverage, and cost containment instead of universal coverage should be the focus in studying American health care.

Ironically, when the two traditionally opposing poles in the national health insurance debate finally tried to establish consensus, the politicians were the ones who chose to maintain conflict in health care reform instead. On July 21, 1994, the AMA and the AFL-CIO, together with the American Association of Retired Persons (AARP), published a joined advertisement in the national press in which they endorsed universal coverage. This action led to "reversed lobbying" by the conservative House Republicans, who sent a letter to the AMA delegates in which they expressed their discontent. According to the politicians, the AMA's recent position was "out of touch with rank and file physicians." Clearly, the fate of national health insurance in the United State cannot be explained by the opposition of the medical profession alone, but by the politics of conflict and consensus among the different partners in American health care.

THE RULE AND THE EXCEPTION

The emphasis on the absence of national health insurance coincides with the dominant view of America as a laggard in the development of its welfare state. The programs that were enacted, as is believed, are the result of the "Two Big Bangs," the two American attempts to catch up with the rest of the world: Franklin D. Roosevelt's New Deal of the 1930s and Lyndon B. Johnson's Great

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43 Even though the popularity of HMOs has decreased in recent years, during the early 1970s HMOs were seen as a positive solution to the problem of rising costs in health care delivery. The Nixon administration hoped that by the end of the 1970s, 90 percent of the American population would be enrolled in HMOs. As Paul Starr has stated, "The socialized medicine of one era had become the corporate reform of the next." Paul Starr, The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry (New York: BasicBooks, 1982), 396.


45 Skocpol, Boomerang, 161.
Society of the 1960s.\textsuperscript{46} This view is conform to Arthur Schlesinger's "Cycles of American History," the assumption that reform occurs in cycles of approximately thirty years. The New Deal reformers were inspired by the Progressives of the turn of the century, while presidents Kennedy and Johnson, in their turn, were inspired by the New Deal. In the 1990s, as Schlesinger predicted in 1986, new reforms by the generation inspired by the Kennedy presidency, a "Third Big Bang" did not occur.\textsuperscript{47} However, in spite of the promise of the Clinton presidency, a "Third Big Bang" did not occur. Instead of major health care reform establishing universal coverage, the Clinton administration ended "welfare as we know it."\textsuperscript{48}

Such a cyclical movement can certainly be detected, as the New Deal of the 1930s and Great Society of the 1960s were indeed major expansions of the American welfare state, particularly on the level of federal legislation. However, as Theda Skocpol has shown, the American welfare state before the 1930s was far from non-existent, with a comprehensive federal pension plan for Civil War veterans and social welfare policies for widows and mothers.\textsuperscript{49} In addition, the incremental extensions of the Social Security Act, specifically the inclusion of agricultural workers, domestic servants, and private employers in the group of beneficiaries in 1950 and the enactment of disability insurance in 1956, have been major expansions of the American welfare state.\textsuperscript{50} Most important, American social policymaking is a continuing political process that cannot be reduced to limited periods of intensified federal action alone.

In the attempt to identify an autonomous process which can explain the development of the western welfare state in general, scholars have applied the "logic of industrialism" approach. According to this approach, the welfare state has been developed to counter the side-effects of industrialism and rapid urbanization. With the shift from agriculture to industrialism, the economic insecurity of the working population increased. Families were no longer self-sufficient units within a close-knit social community, but became predominantly dependent on the wage-labor of the (male) breadwinner. The individualization of the worker ran parallel to the increase of dependency and vulnerability. Without personal savings to fall back upon, only charity could relieve the destitute among the workers and their families in case of

\textsuperscript{46} The term "Big Bang" in this context was introduced by Christopher Leman, as quoted in Theda Skocpol, Social Policy in the United States: Future Possibilities in Historical Perspective (Princeton: Princeton University Press, 1995), 13.


\textsuperscript{50} Berkowitz and McQuaid, Creating the Welfare State, Chapter 8, 165-192.
unemployment or sickness. Social welfare and social insurance programs, on the contrary, could provide economic security through wage compensation during those periods of loss of income.\textsuperscript{51}

However, the logic of industrialism approach cannot explain differences in the order and timing of social legislation among the western welfare states, a chronology that does not seem to correlate to the level of industrialization. In other words, those nations that were the first to industrialize were not by definition the first to enact comprehensive social welfare and social insurance programs. Scholars have provided a range of explanations for these differences, including class struggle and state formation. According to the class struggle approach, strong labor movements command social legislation, either as a political force outside the government or as a partner in social democratic coalitions. The relatively weak labor movement in the United States could therefore explain the relatively slow development of the American welfare state.\textsuperscript{52} The state formation approach focuses on the level of centralization and bureaucratization of the national government. Germany was the first to establish a broad welfare state due to its well organized bureaucracy. The United States, on the contrary, was relatively late in the centralization of the state. A governmental bureaucracy on federal level did not develop until the 1930s.\textsuperscript{53} Even though these explanations are valid and do partially explain the development of the American welfare state, they do not provide a single rule for the development of the welfare state in general.

In the attempt to explain the differences in timing and development of the American welfare state compared to other western welfare states, scholars have emphasized the exceptional character of American history, culture, and ideology. Such a cultural values approach confirms, rather than contradicts, the logic of industrialism approach, as America is presented as the exception that proves the rule. Moreover, this approach fits within a more general view of America as “unique and separate from the rest of the world because a virtually unchallengeable national myth identified it as a country created by removal from the corruptions and confinement of Europe.”\textsuperscript{54} To understand the “uniqueness” of the United States, scholars refer back to the classic studies of Alexis de

\textsuperscript{51} Theda Skocpol gives an elaborate overview of the different approaches in her essay “State Formation and Social Policy in the United States,” in Social Policy in the United States, 11-36.


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Tocqueville, *Democracy in America* (1840), and Louis Hartz, *The Liberal Tradition in America* (1955). As is believed, Americans are intrinsically different from those Europeans left behind in the Old World. They value individualism and self-reliance. They oppose a strong centralized state, but believe in voluntarism. As Roy Lubove has argued, “Americans assumed that their country was unique in assigning to private, voluntary institutions a wide range of responsibilities which in other nations were regulated to government or elite groups.”

In his studies on American exceptionalism, Seymour Martin Lipset argues that being an American is not only a matter of birth, but also of “ideological commitment.” Americans share the dominant public philosophy of Americanism: the American Creed constituted of liberty, egalitarianism, individualism, populism, and laissez-faire. Those who do not share these values are denounced as “un-American.” Anti-statism is deeply embedded in the American political system, which favors the division of power over a strong centralized government, enabling the dominance of laissez-faire liberal values. The two major political parties, Republican and Democratic, are both susceptible to populist movements and share the fundamental American values of individualism and egalitarianism, leaving little room for political parties based on other ideologies. Any political movement that appears to fall outside this set of values can easily be opposed by stressing its un-American character.

Lipset’s theory is tempting as it seems to explain many different exceptional aspects of American society, ranging from a relatively weak labor movement and the absence of national health insurance to a strong movement in support of the right to bear arms and the undying faith in religious revivalism. However, by placing the United States at the opposing pole in comparison to other western industrialized nations, differences are overemphasized while similarities are overlooked. For example, nineteenth century Great Britain also had a strong tradition of laissez-faire liberal values, but did nevertheless develop into a centralized welfare state. Moreover, there are too many exceptions in the history of American social policy itself which undermine the anti-statist argument. In spite of the popular belief in anti-statism, comprehensive social policy programs were established in the United States such as the Civil War pensions in the nineteenth century and Aid to Families with Dependent Children (AFDC) and Medicare and Medicaid in the twentieth century.


57 Skocpol, *Social Policy in the United States*, 16.
In his book *The Democratic Wish*, James A. Morone tries to explain this contradiction between anti-statism on the one hand and expanding government programs on the other by viewing the exceptions as the result of the "democratic wish." In addition to the fear of a strong centralized government, Americans share a "yearning" for communal democracy — "the direct participation of a united people pursuing a shared communal interest." The wish for collective action leads to the establishment of large public programs. Once these institutions and programs are growing into bureaucratic institutions, the fear of a strong centralized government curtails the actions of these programs. In the case of health care policy, as Morone argues, the contradiction was solved by channeling public action through private behavior. As Morone explains: "Politicians eager to legislate popular health care programs were provided uncontroversial options that reinforced the power and autonomy of the [medical] profession. The result made it easy to ascribe power to the industry and its lobbyists. Even a cursory history of American health care policy demonstrates the repetition of a political pattern: the ceding of public authority to the medical profession."

Without dismissing the arguments of Lipset and Morone altogether, Jill Quadagno adds race as a "key ingredient" in the development of the American welfare state. As she argues, with the initial exclusion of agricultural workers and domestic servants from the Social Security Act of 1935, racially-segregated programs were established, leading to separate welfare states in the North and the South. In this way, the Roosevelt administration could maintain the support of the conservative Southern Democrats. Race has undoubtedly been neglected in the history of national health insurance in the United States. Throughout the twentieth century, organizations such as the NAACP (National Association for the Advancement of Colored People) and the National Medical Association (the African-American counterpart of the AMA) have supported national health insurance. A national health insurance program could also change the racial relations in the South. The implementation of Medicare, for example, forced hospitals in the South to desegregate. Moreover, a disproportional large number of Medicaid recipients and the uninsured are ethnic minorities. Although race cannot explain American health care policy alone, racial inequality does have its influence on the national health insurance debate and should therefore not be ignored.

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58 Morone, *Democratic Wish*, 5.
59 Morone, *Democratic Wish*, 257.
Finally, American exceptionalism ignores the distinctive cultural and political histories of other western nations. By making America the exception, other western nations are grouped together under a single rule of uniformity, without recognition of the fundamental social and cultural differences of origin and development between those nations. In Germany, national health insurance was enacted in 1883 to counter the political threat of socialism and to maintain social control by providing basic economic security to the working population. The British National Health Service was enacted in 1948, after the experience of World War II made the establishment of a comprehensive centralized welfare state politically acceptable. In France, national health insurance was first introduced in 1930 when the state took over the previously privately run sickness funds for workers, yet it was not until the 1970s that the disabled, widows, and other uninsured were included. In the Netherlands, national health insurance was enacted in 1941, or, as one writer aptly phrased, “rolled in with German tanks during World War II.” Attempts to enact national health insurance before the German occupation had met strong opposition of the medical profession, resulting in the 1930 law that merely provided for income compensation during sickness. These diverse histories are exceptional in their own right and force us to question the validity of a general rule to which America is assumed to be the exception.

CONSIDERING THE OPTIONS

As argued earlier, theories of American exceptionalism do not provide satisfactory explanations for the absence of national health insurance in the United States or for the American preference for the extension of medical care instead of universal coverage. Does this mean that American cultural values should altogether be ignored? Even though cultural values do not explain the assumed American exception, the notion that America is an exception is real and has a strong influence on debate. The opponents to national health insurance claim that America is exceptional in having the best medical care in the world. The advocates, on the contrary, claim that America is exceptional in having the relatively largest number of uninsured citizens among western welfare states. Even Daniel Fox, cynical when it comes to American exceptionalism, poses the hypothesis that “American ideology and politics

62 Starr, Social Transformation of American Medicine, 237.
64 Wilsford, Doctors and the State, 120.
made it easier for government to finance increases in the supply of medical care than to address inequities in demand for it.  

Even though (or perhaps because) national health insurance was never enacted, it continued to be a strongly debated issue throughout the twentieth century. From the start, the comparison to Europe and later Canada played a crucial part in the debate, enabling the claim that national health insurance is either un-American or—in an adapted way—uniquely American. The claim that national health insurance is un-English, un-French, or in fact typically Dutch is much harder to make. Not only the opponents but also the advocates of national health insurance have used so-called American values to justify their position. Both sides have tried to mobilize political power through rhetoric of personal interest, emphasizing the “Freedom of Choice” as a uniquely American value in the debate on this public issue. The personal interest is important, as a majority of the Americans support the public objective of universal coverage as long as the quality of their personal health care is not jeopardized. The social and economic aspects of American health care may have drastically changed during the course of the twentieth century, the rhetoric of the national health insurance debate has remained unchanged.

In his study *American Exceptionalism*, Seymour Martin Lipset argues that the European welfare states reflect “the values of noblesse oblige, the obligation of the leaders of society and the economy to protect the less fortunate.” Lipset fails to recognize the difference between social insurance and social welfare. While social insurance is based on compulsory insurance, increasing the economic security of the working population through employer and employee contributions, social welfare is based on relief, supplied only to those who are eligible. In most European welfare states the original programs were for the lower-income working population, for workers and their families only, not the poor. Coverage was later extended to include the entire uninsured population. In the United States, on the contrary, the working population was first covered by private, employer-based health insurance. The policymakers subsequently focused on those Americans who were the least likely to be insured: the elderly and the welfare poor. Basically, Lipset’s argument can be turned around. While in European nations government health insurance was initially based on occupational success (only workers were included), American government health insurance provides health insurance coverage for the

66 Fox, “History and Health Policy,” 350.
68 In France, government health insurance for the working population was established in 1928, but the extension to the non-working uninsured (the disabled, widows, and single parents) did not occur until the 1970s. Wilsford, 120. In Great Britain, the initial government health insurance program was for manual laborers. In 1948, the entire population was covered by the National Health Service. Klein, *The New Politics of the National Health Service*, Chapter 1, 1-27.
assumed deserving needy only. The elderly are considered to be deserving by age. The welfare poor and medically indigent “deserve” government assistance when they meet the eligibility rules. The notion of noblesse oblige can thus be more easily applied to the American system of providing assistance to those who are considered to be deserving than to the social insurance and social welfare systems in other western welfare states.

The distinction between social welfare and social insurance becomes clear in the “social division of welfare” theory of Richard Titmuss. In accordance with the logic of industrialism approach, Titmuss argues that industrialization has made the majority of the population dependent on wage labor – thus more vulnerable. The welfare state has been established to protect the individual against this vulnerability through several “methods” of welfare, which all share the aim to protect all citizens against the insecurity of modern industrial society, not only the “visible poor.” Along with social welfare (benefits provided directly by the state), the social services of the welfare state include fiscal welfare (benefits through tax deduction) and occupational welfare (benefits for employees provided by the employer, often indirectly subsidized by the state). Even though these benefits are not as “visible” as the benefits for the poor, together they form the “real” world of welfare.69

In the same manner as Richard Titmuss includes social, fiscal, and occupational welfare within his definition of the welfare state, the perception of “national health insurance” in the United States should include all forms of health insurance. In addition to those covered by Medicare and Medicaid (the most visible government health insurance programs in the United States), a large portion of the American population is covered by subsidized private and employer-based insurance. This system of indirect government subsidies is part of what Edward D. Berkowitz has defined as “the American model for social policy: the privately controlled behavior.”70 Such a combination of private and governmental health insurance is not “exceptionally American” in itself. Most western welfare states combine private and government health insurance programs. Again, the American exception is not the absence of national health insurance, but the absence of universal coverage, leading to a relatively large group of uninsured Americans.

With the exception of a few medical nihilists, most policymakers, politicians, and scholars view the promotion of health services as a positive development for the benefit of the public good. In the debate on national health insurance, the desirability of high quality health care in itself is not questioned. Instead the question is whether governmental programs will endanger or, quite the opposite, promote the quality of health care. While the opponents to

70 Berkowitz, America’s Welfare State, 160.
national health insurance argue that the American medicine is the most advanced and simply the best in the world, the advocates emphasize that the absence of a comprehensive national health insurance program constitutes a lack of quality, at least for the large group of uninsured and underinsured Americans.

Throughout the twentieth century, the American federal government has designed policies to promote the availability and quality of medical care, with an emphasis on acute care. Daniel Fox recognizes two different strategies in policy: the first influencing the supply of health services (the extension of medical care), the second influencing the demand for care (the extension of health insurance coverage). This distinction is important, because throughout the national health insurance debate, the tension between these strategies has influenced the outcome. All efforts to enact a national health insurance program also included plans to extend medical care. In the end, the extension of medical care has been repeatedly preferred to the extension of coverage.

In addition to the strategies of influencing the supply of and demand for health care, Lawrence D. Brown recognizes strategies to influence the organization of health care and the behavior of health care providers:

1. **Supply of health care and resources.** The federal government subsidizes medical research and education, public health services, and the construction of hospitals. Most notable examples are the establishment of the National Institutes of Health in 1930 and the Hill-Burton hospital construction program of 1946.

2. **Demand for health care.** The federal government enacts health insurance programs to assist in the payment of medical care, including Medicare and Medicaid.

3. **Organization of health care.** The federal government promotes and funds certain forms of group practice such as Health Maintenance Organizations (HMOs).

4. **Behavior of health care providers.** The federal government tries to contain health care costs through Professional Standards (PS), Rate Setting (RS), and Prospective Payment System (PPS) programs.

As Brown argues, these strategies appeared in chronological order: the first two from the 1930s to the 1960s in an attempt to extend health care services and insurance coverage, the second two in the 1970s and 1980s in an attempt to curtail rising health care costs.

Historians of national health insurance have primarily focused on the second strategy, and predominantly on the relatively marginal success of the American federal government to influence the demand for health care. As Brown argues, “The European norm is universal national health insurance; in the United States the

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major programs are Medicare (for the old, the disabled, and those in need of renal dialysis) and Medicaid (for the welfare poor and the medically indigent).”

However, subsidies and fiscal welfare schemes of the federal government to encourage private health insurance coverage should also be included in the strategy of influencing the demand for health care. Also, as stated before, not national health insurance in itself but universal coverage is the “European norm.” Among the options available to American policymakers and politicians, universal coverage has been the first to be compromised.

AMERICAN NATIONAL HEALTH INSURANCE

To understand American health care policy, certain moments in its history need to be examined, moments when the extension of health care services and the coverage of certain parts of the population were favored over universal coverage. Instead of presenting a struggle between reformers and the medical profession, this study tries to see American health care policy from the early 1930s to the late 1960s as a series of options available to policymakers and politicians operating within a framework of interest groups, including labor unions and the medical profession. The core of this study is based on the working papers, the personal papers, the presidential papers, and the oral histories of the policymakers and politicians involved. In this way, I will try to show how and why certain options were chosen while others were discarded. Two decisions are central in this study. First, the choice for the extension of medical care instead of including national health insurance in the Social Security Act of 1935. Second, the choice to target government health insurance at the elderly and the welfare poor instead of the working Americans.

In the first chapter, I will discuss the intellectual background of the policymakers, the development of the Committee on the Costs of Medical Care (CCMC), and the developments leading up to the cooperation with the Roosevelt administration. In the second chapter, I will focus on the work of President Roosevelt’s Committee on Economic Security and its decision to exclude national health insurance from the Social Security Act of 1935. With this act, the foundation of the American federal welfare state was established. As the policymakers believed, the Social Security Act was only the beginning. Over time the act would be amended to eventually constitute a safety-net which would provide economic and social security to the entire population during old-age, unemployment, and sickness. In the third chapter, I will describe the growing power of the Social Security Board, the plans to add national health insurance to the Social Security Act, and the preference for the extension of medical care to health insurance coverage. Also included is a description of the emergence of private, employer-based health insurance.

73 Brown, Health Policy in the United States, 2.
In the fourth chapter, I will discuss the decision of the social security policymakers to let go of a universal program and focus on hospital insurance for the elderly and the welfare poor instead. This change of strategy occurred around 1951 and is a crucial turning point in the development of American national health insurance. In the fifth chapter, I will discuss the enactment and the implementation of Medicare and Medicaid, particularly focusing on the distinction between social insurance for the elderly and social welfare for the poor. Special attention will be given to the role of the American Hospital Association (AHA) and Blue Cross/Blue Shield. In the sixth chapter, I will discuss the “hidden agenda” of the policymakers to extend the coverage of Medicare and Medicaid to eventually include all uninsured Americans. Contrary to their own public claims that Medicare and Medicaid would not lead to any system of national health insurance, the policymakers clearly intended to expand the programs to include those of the population who were not insured through private and/or employer-based health insurance. However, the costs of these programs, particularly Medicaid, grew faster than was anticipated. The programs were no longer seen as solutions but rather as the source of a new problem: the acceleration of health care costs. This study ends in the late 1960s, when the focus in health care policy shifted from extending medical care and insurance coverage to cost containment.

Initially my research was started to understand why a national health insurance program was never enacted in the United States of America. Instead, the question has become how and why the contemporary health care system of combined government and private programs has developed. The answer to the latter question, of course, also implies an answer to the first one. Choices made in the past do influence the choices made today. The American system should not be seen as an exception but as one of the diversities among western welfare states. Ideally, this study would also include in-depth descriptions of the choices that led to the other western health care systems. Recognizing that America is not an exception means also recognizing the differences among other western welfare states. In the end, the American experience is not the exception to the rule, but an experience that challenges the rule.

74 Marmor, Political Analysis and American Medical Care, 149.