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

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National health insurance arrived on the American political scene during the first two decades of the twentieth century. At that time, the belief in its inevitability was dominant. No one seemed to doubt, both advocates and opponents, that the United States would eventually follow the example set by European nations. First addressed in 1904 by the Socialist Party, national health insurance was soon included by former President Theodore Roosevelt in his Progressive Platform of 1912. By 1915, the American Association for Labor Legislation (AALL) was so convinced that national health insurance would be “The Next Great Step in Social Legislation” that it printed this conviction as slogan on its stationary. Even the American Medical Association (AMA), which later would become the most vocal opponent to national health insurance, cautiously supported the study of possible insurance schemes to protect the American worker against the costs of sickness and medical care.1

Over the years, national health insurance has become a synonym of universal coverage, meaning that such a program would guarantee basic health insurance coverage for all citizens. However, when historians state that Germany enacted national health insurance in 1883, Great Britain in 1911, the Netherlands in 1913, and France in 1928, it should be remembered that these government health insurance programs did not establish universal coverage in these nations. The programs merely provided health insurance for certain segments of the working population. Moreover, in Great Britain and the Netherlands, government health insurance did not pay for health care costs, but instead provided compensation for loss of income during sickness. Even though universal coverage was eventually established in all these nations, the timing differed greatly.2

American reformers did not advocate national health insurance in the literal sense of the word, as they, in the words of reformer Arthur Altmeyer, “never dreamed of the federal government having a role at the time. That was considered unconstitutional and outside the purview of federal power.”3 Instead, the focus was on state legislation. With the German compulsory health

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3 Interview with Arthur J. Altmeyer by Peter A. Corning, 14 September 1966, Columbia University Oral History Collection (microfilm edition, Roosevelt Study Center), 86.
insurance program for the lower-income industrial workers as model, the AALL had designed a draft compulsory health insurance bill for states to enact. By 1915, 13,000 copies of the draft bill had been printed and distributed. The AALL welcomed national health insurance as an interesting topic to be studied. The draft bill revived the reform movement and the interest in the AALL. All over the country, committees were established to study the draft bill. In several states, bills based on the AALL blueprint were introduced. In New York and California, health insurance legislation came close to being enacted. The movement went so well that reformer Isaac Rubinow stated: "One almost begins to feel that it is growing too fast."

Rubinow’s fear came true when toward the end of the 1910s the movement indeed slowed down. What exactly triggered this loss of momentum is not clear. Perhaps the reformers had expected too much of the revived interest and had underestimated the already existing opposition to national health insurance. Moreover, there were several different opponents. First, the insurance industry had opposed the AALL bill because it included funeral benefits, which would mean the loss of a profitable business. Second, the labor unions were either ambivalent about or simply against national health insurance. While the United Mine Workers supported the principle of social insurance, Samuel Gompers, president of the American Federation of Labor (AFL), considered national health insurance to be a paternalistic measure. It would not only enable the state to take over the role of the labor union as provider of social benefits, but could also undermine labor’s power in collective bargaining. Finally, the medical profession began to fear that national health insurance would endanger their income and their professional autonomy. Moreover, as Daniel M. Fox has pointed out, the medical profession objected to the possible reorganization of medical care into hierarchies that would be dominated by specialists.

At the end of the 1910s, the growing opposition to national health insurance had been enhanced by the American participation in World War I and by the Russian Revolution. With the outbreak of the war, national health insurance became “a dangerous device, invented in Germany, announced by the German emperor from the throne in the same year he started plotting and preparing to conquer the world.” The Red Scare following the Russian Revolution of 1917 added credibility to the claim that national health insurance was an un-American menace to the public health. One of the most effective

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5 As quoted in Numbers, Almost Persuaded, 60.
7 As quoted in Numbers, Almost Persuaded, 75.
arguments in favor of national health insurance—namely the successful precedents in Europe—lost its appeal. As Roy Lubove states, “The historical experience in Europe served as the only counterargument, but it was dismissed as invalid because of the uniqueness of American civilization and was used to discredit social insurance as an alien importation.” By 1918, only the AALL continued to believe that “there is a strong and rapidly growing demand for insurance against sickness.”

THE AALL AND THE “MATERNALIST” WELFARE STATE

Founded in 1906, the AALL was a male dominated organization with strong roots in the Progressive movement. The AALL believed that through labor legislation poverty could be reduced, providing the workers with better circumstances at work and at home. Moreover, the AALL was predominantly an academic organization. Many of its members had studied abroad in Germany. The AALL leadership consisted of professors from Columbia, Princeton, Wisconsin, and Yale. As a self-acclaimed objective and scientific organization, the AALL did not represent a particular political movement, but did advocate actual social insurance policy such as workmen’s compensation and compulsory health insurance for the working population. Its ideal (and rather paternalistic) picture of the American worker was the male breadwinner providing for his family in a working day consisting of three eight-hour shifts: “Eight hours for work! Eight hours for sleep! Eight hours for home and citizenship!” The ideal woman was (not surprisingly) expected to be the homemaker who took care of the children and provided a safe haven for the American worker to come home to.

The opponents to national health insurance recognized that the AALL leadership consisted of an academic elite. During the debate on the New York compulsory health insurance bill, the opposition, led by lawyer-physician John J.A. O'Reilly, charged:

Behind this Bill is an organization called the American Association for Labor Legislation, MADE IN GERMANY as part of the Infamous Kultur and imported to this Country by a Russian disciple of Bolshevism and I won’t workism; its Board of Officers contain the names of Hysterical men and women and vicious men and women who have no knowledge of or sympathy with the needs of the working people and who believe that the working man does not know what is good for him.

9 John B. Andrews (AALL) to Theodore Roosevelt, 30 March 1918, Theodore Roosevelt Papers, Reel 270 (microfilm edition, Roosevelt Study Center).
and THEY DO and they are willing to take lucrative positions under the [compulsory health insurance bill] to do him good and to DO HIM - good.\textsuperscript{11}

The AALL's movement for labor legislation did indeed fail to bridge the gap between the academic reformers and the American workers, thereby missing the support of a potentially powerful partner, the American labor movement. As stated earlier, the American Federation of Labor (AFL), which represented predominantly white male skilled workers, preferred voluntarism to state intervention. As AFL president Gompers believed, the AALL reformer used "rhetoric of disinterested benevolence," which "disguised a struggle for power between him and self-proclaimed friends of the working class."\textsuperscript{12}

In addition, a broad-based labor movement was absent in the United States. Enhanced by the American myth of a classless society, ethnic background and regional ties proved to be stronger than the common identity of being working class. Other groups demanding social legislation filled this vacuum. As Theda Skocpol explains, "During a period when intellectuals and workers' organizations could not work together to launch a paternalist U.S. welfare state, intellectuals and grassroots women's groups were able to cooperate to extend motherly concerns into new public programs claimed to be for the good of the entire nation."\textsuperscript{13} Subsequently, while in Europe social policy was focused on increasing the economic security of the male workers and their families, in the United States social policy was aimed at women and children. This American preference for a, in Skocpol's definition, "maternalist" welfare state to a paternalist welfare state reflected the distinction between social welfare and social insurance. Benefits as widow's pensions were based on social welfare, providing economic security to the "deserving poor" who – due to circumstances beyond their own control – could not provide for themselves. Social insurance programs such as workmen's compensation and compulsory health insurance, on the contrary, were attempts to prevent poverty before it had stricken.

The question arises whether or not the emergence of a maternalist welfare state obstructed the AALL's objective of establishing a paternalist welfare state. As historian Charles Noble has suggested, "maternalism may have actually helped undermine efforts to establish a European-style welfare state in the United States."\textsuperscript{14} However, maternalism merely filled in some of the gaps that paternalism failed to cover. Even though the maternalist welfare state did increase the economic security of (arguably a small number of) women, it also reaffirmed the paternalistic ideal of the non-working mother. The maternalist

\begin{footnotes}
\item[13] Skocpol, \textit{Protecting Mothers and Soldiers}, 354.
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and paternalist welfare states did not contradict each other. In fact, the maternalist welfare state could have complemented the paternalist welfare state (if the latter had been established) by providing public assistance to those women and children who, due to the absence of a working male in their lives, were not protected by the social insurance programs targeted at the male workers and their dependents. In that perspective, the maternalist welfare state was not an alternative for the labor legislation advocated by the AALL, but merely a moderate attempt to achieve the “ideal” paternalist welfare state.

The importance of the emergence of this moderate maternalist welfare state, however, should not be underestimated. First, the emphasis on mothers and children led to the establishment of the U.S. Children’s Bureau in 1912. With this bureau, led by female federal officials, the influence of the federal government in public welfare and health increased. Second, the maternalist welfare state enhanced the preference for subsidizing the supply of medical care instead of introducing a system of social insurance. In the battle to fight infant mortality, for example, the improvement of public health services promised to be far more effective than the possible establishment of a national health insurance program. The influence of the maternalist welfare state is best shown by the Sheppard-Towner Infancy and Maternity Protection Act of 1921, one of the first major public health programs based on federal funding.\(^15\) Even though the act eventually proved to be temporary when federal funding was discontinued in 1929, it strengthened the position of the Children’s Bureau as a permanent federal agency. Moreover, the act reaffirmed the belief that the role of the federal government should be limited to the funding of the supply of medical care targeted at “deserving” mothers and young children only, instead of providing any form of (preventive) economic security to the American male worker. In addition, the eventual fate of the Sheppard-Towner Act shows that the opposition (most vocally by the medical profession as represented by the AMA) was not only based on a preference for voluntarism and non-governmental intervention, but also on gender and how medical care was organized. As Walter Trattner has pointed out, the final defeat of the act in 1929 was largely due to “a virulent campaign against the measure by the medical profession which sought (successfully) to wrest control of infant and maternal health from female-run public clinics and place it, instead, in the hands of private, male physicians.”\(^16\) In other words, the medical profession did not only oppose the increasing governmental influence on the provision of medical care, but also the resulting reorganization of medical care from private practice to public clinics and the increasing influence of non-medical professionals such as public health officials.

\(^{15}\) Skocpol, Protecting Mothers and Soldiers, 494-522.

The movement for national health insurance during the first two decades of the twentieth century was predominantly an intellectuals’ movement. There were no grass-roots organizations, nor representatives of workers who advocated such legislation. The movement was based on two intellectual centers, which can be described as “schools.” The first was formed around the labor economists of the University of Wisconsin, the second around the reformers and social workers in New York City. Both schools believed that through cooperation between the different social partners — employers, workers, and government — labor legislation could be enacted which would improve the conditions of the American worker without destroying the capitalist economy.

A central figure of the Wisconsin school was John R. Commons, the legendary economics professor from the University of Wisconsin. A whole generation of social security experts, including Arthur Altmeyer and Edwin Witte, was inspired by this “modern Socrates,” in spite of the complaints that his lectures were often incomprehensible or plain boring. Future leaders in social security would get together at Commons’ Friday night meetings where they discussed new ideas and began lasting friendships. Wilbur Cohen and Herman Somers, for example, who later would become Medicare specialists, defined themselves as “proud Friday Nighters.”

Professor Commons could be seen as the embodiment of the so-called Wisconsin Idea, a term introduced by Charles McCarthy in 1912. The Wisconsin Idea was based on the belief that society had the moral obligation to promote the well-being of all its citizens. All resources, including the university, were to be used to obtain that objective.

The Wisconsin school placed the strongest emphasis on prevention. Social insurance should prevent poverty, instead of providing relief after poverty had stricken. To achieve this goal, a strong cooperation between government, academia, and business was needed, working together in industrial commissions, the so-called “fourth branch of government.” These commissions would stand above politics, using scientific research to provide objective solutions to problems arising out of industrialism. Even though national health insurance was within the realm of interest (together with John Commons, Arthur Altmeyer had published a study on compulsory health insurance in 1919), the Wisconsin school’s main focus was on workmen’s compensation during unemployment.


The founding fathers of the Wisconsin Idea, including Commons and Richard T. Ely, tried to apply their theories to the contemporary political and economic situation. As Arthur Altmeyer explains:

None of these men ... disregarded theory or the historical approach, but they did believe very strongly that theory and history should be put to work in the solution of present-day problems. They believed in observing and analyzing the behavior of individuals and institutions under actual conditions; and on the basis of this observation and analysis they did not hesitate to make value judgments and suggest changes in — or propose the creation of — social institutions which would better promote the general welfare.\(^{19}\)

As a result, Wisconsin became one of the first American states to enact ground-breaking social security legislation, such as the workmen’s compensation act of 1911 and the unemployment compensation act of 1931. In the true spirit of the Wisconsin Idea, professor Commons and his students had actively been involved in the drafting of the latter bill.

While the social security experts of Wisconsin were economists, the New York reform movement consisted predominantly of social workers. Since the turn of the century, social work was going through a professionalization process. Encouraged by organizations such as the Association for Improving the Condition of the Poor and the National Council of Charities and Correction, social workers began to set standards for education and actual practice. The New York poor were no longer “charity cases” but became “case studies.” Important New York social workers included Homer Folks, John Kingsbury, and Harry Hopkins. They exchanged ideas and studies through Paul Kellogg’s magazine *Survey*. As historian Clarke A. Chambers, Paul Kellogg’s biographer, has described: “Such was the spirit in those years — guidance for skilled social service, a crusade for industrial justice, a move beyond preventive programs to constructive community measures.”\(^{20}\)

The distinction between social insurance and public assistance was reflected in the difference between the Wisconsin and New York school. While the Wisconsin social security experts focused on social insurance programs such as unemployment insurance, the New York reformers placed a stronger emphasis on public assistance programs. However, there was also an important similarity. The reformers of both schools approached their work in a scientific and professionally objective manner. In addition, the Wisconsin social security experts and the New York reformers were no strangers to each other, as they worked closely together in the AALL and similar organizations. Since both schools were relatively small, the professionals met each other regularly and some of them even considered each other friends. Moreover, their presence had a strong influence on the labor legislation in their home states. Both Wisconsin


and New York State were forerunners in labor and social legislation. As Arthur Altmeyer has stated, “One cannot help, if he compares the development of social legislation in Wisconsin and New York, but be struck by the fact that both states adopted the same sort of legislation at approximately the same time.” When in 1932 the governor of New York, Franklin D. Roosevelt, was elected president of the United States, the influence of the Wisconsin and New York intellectuals would reach beyond their home states and form the basis of federal social policy on national level.

**THE AMERICAN MEDICAL ASSOCIATION**

Another group of professionals that became more active on national level at the beginning of the twentieth century was the American Medical Association (AMA). When in 1847 the AMA was founded by a small group of prominent physicians gathered in Philadelphia, they could not have envisioned the AMA’s future political influence. At that time, American medicine was still a free and unprotected non-profession with practically no legal status. The physicians’ main objectives were improving medical education and setting standards of practice, thereby organizing the profession and reducing quackery. Physicians were spread out all over the continent, and in nineteenth century America, local governments differed from state to state, making the organization of a profession a slow and difficult process. At the turn of the century, however, the situation started to change. As the importance of American national politics grew, the AMA began to make its voice heard. As James Burrow has pointed out, “the AMA moved from political obscurity in the nineteenth century to carry through a major internal reorganization early in the twentieth, and to identify itself with the dynamic reform forces of the Progressive Era.”

During the first two decades of the twentieth century, the AMA supported — though often reluctantly — the increasing influence of the federal government in issues of public health, medical education, licensing physicians, and drug regulation laws. American medicine needed to be authorized and by governmental recognition the AMA could become the “official” mouthpiece of the medical profession. Gradually, more and more physicians joined the AMA and by 1920, sixty percent of the physicians was registered as member, thereby providing the AMA with the power of being “organized medicine.”

In theory, the formal structure of the AMA was based on democratic principles, modeled after the American political system of federalism. County physicians were united in local and state medical societies to which the AMA functioned as umbrella organization. Not the individual members, but the local governing bodies sent representatives to the AMA House of Delegates, the association's official legislative power. In practice, however, both the legislative and executive power were controlled by the AMA Board of Trustees. The House of Delegates met once annually, and in the remaining time, the Board of Trustees exercised its power by open mandate. During the first decades of the century, the ruling minority of the AMA did not shy away from rather devious tactics to maintain unity within the profession. Due to the AMA's strong influence in the education and licensing of the individual physician, openly opposing the association's official policies could mean professional suicide. The silencing of oppositional voices within the organization does not mean that the AMA did not represent the majority view of the physicians. Most AMA members showed little to no interest in active participation and left political questions up to the leaders of the association.

After the short period of cooperation with the AALL in the study of compulsory health insurance, the AMA soon became opposed to national health insurance. Since 1920, the AMA had officially opposed any form of compulsory health insurance "provided, controlled, or regulated by any state or the Federal government." By 1934, the anti-insurance sentiment had been deeply embedded in the official policies of the AMA. At that year's annual session of the AMA House of Delegates, AMA president-elect Walter Bierring expressed the fear that the medical profession was subject to a severe attack: "It is sad to relate, that mighty forces have been at work to sow the seeds of discontent in the ranks of organized medicine and to destroy the faith in that leadership which is based on the sacred traditions of sacrifice and devotion to the idealism of medical service."

Historians have explained the AMA's reversal of position from supporting the AALL's studies to rigid opposition to national health insurance by pointing out that by the 1920s the AMA had completed its task of reforming medical education. As a result, the more "academic" physicians became less involved in organized medicine, leaving the field open for more "pragmatic" physicians to guard the medical profession's economic interest. Elton Rayack disagrees: "The favorable attitude of the AMA toward health insurance prior to 1920 was essentially a reflection of the efforts of a very small number of influential

24 A highly charged account of the AMA's tactics can be found in James Rorty, American Medicine Mobilizes (New York: Norton & Company, 1939).
25 As quoted in Numbers, Almost Persuaded, 105.
leaders, particularly Dr. [Alexander] Lambert and Dr. [Isaac] Rubinow." However, as will be shown further on in this study, the tension between the specialists working in the hospital or medical school and the private practitioner strongly influenced the position the AMA. Even though the specialists did not favor national health insurance, they were less opposed to governmental intervention than the private practitioners were. The latter group, who dominated the AMA, opposed national health insurance not only out of economic interest, but even more out of the fear that such a government program would reorganize medical care and make the hospital the center of the profession.

An important factor in the unifying and strengthening of the AMA was the establishment of the *Journal of the American Medical Association* in 1883. An AMA brochure of 1940 defined the expansion of the AMA as "growing with the Journal." "In fact, prior to 1883 the Association was not active except during the few days of the annual meetings." Most important, the *Journal* was, in James Burrow's definition, "the AMA's most reliable breadwinner," providing the AMA with a dependable source of income and with a powerful voice. The main man behind the *Journal* was its editor Morris Fishbein, who conducted an almost personal crusade against national health insurance. Unlike the AMA's officers who rotated annually, Fishbein remained in function as the *Journal*’s editor for more than two decades, being largely responsible for its prevailing anti-insurance sentiment. Fishbein's influence within the medical profession was notorious; some even referred to the AMA as the American Fishbein Association. There was however no doubt in Fishbein's mind that he did represent the true voice of American medicine. When he and the *Journal* were attacked for not representing the majority view of the medical profession, Fishbein replied: "If it does not, then the Congress and the Senate and the President of the United States do not represent the people, because the American Medical Association has been since 1901 organized and conducted on a strictly democratic representative basis."

Over the years, national health insurance advocates (including those who eventually would work for the federal government) viewed the medical profession as their main opponent. As Isaac Rubinow remembered, "the national administration of the American Medical Association which, in the

beginning, was at least mildly objective, rapidly adjusted to what appeared to be the profession's attitude and their powerful Journal of the AMA has remained a bitter opponent.”31 Since the AMA was the most vocal of all opponents, this view was easily reaffirmed. However, other groups may have been less vocal than the AMA, that does not mean that they were in favor of national health insurance. In fact, only a small group of intellectuals advocated national health insurance, and they viewed the issue more as a scientific problem to be solved objectively than as a political program to be enacted.

THE COMMITTEE ON THE COSTS OF MEDICAL CARE

In 1927, a group of fifteen economist, physicians, and public health specialists established the Committee on the Cost of Medical Care (CCMC). Soon the word “Cost” was changed to “Costs” to emphasize that the CCMC focused on the larger field of medical care, not on the private practitioner alone. The name also reflected the importance of medical care as solution to the problems of public health.32 Financed by six private organizations, including the Milbank Memorial Fund and the Julius Rosenwald Fund, the CCMC planned a five-year research program to, as one of its publications stated, “provide a diagnosis of the ills in the present economic organization of medicine.”33 Chaired by Ray Lyman Wilbur, at that time secretary of the interior, the committee consisted of fifty specialists in medicine, public health, economy, and social work, including Michael M. Davis, Homer Folks, George E. Follansbee, Walton Hamilton, Edgar Sydenstricker, AMA secretary Olin West, and C-E.A. Winslow. By 1932, the CCMC had published twenty-eight reports, together representing a comprehensive empirical survey of the occurrence of sickness, the public access to medical facilities, and the way medical care was financed.

In 1929, Isidore S. Falk, a bacteriologist, joined the CCMC as executive secretary of the research staff.34 Falk had worked with professor Winslow at Yale University before accepting a position at the University of Chicago. Just a couple of weeks before he started working for the CCMC, Falk became

32 As Paul Starr has pointed out, if the CCMC had been established during the Progressive era, its name would probably have been the Committee on the Costs of Illness. 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), 261.
33 I.S. Falk, C. Rufus Rorem, and Martha D. Ring, The Costs of Medical Care, Publications of the Committee on the Costs of Medical Care No. 27 (Chicago: Chicago University Press, 1933), 578.
34 In most cases, both in primary documents and secondary literature, only the initials of Falk’s first and middle names are mentioned. When referring to Falk, I will do the same.
involved in a small scandal. After Falk had announced that he had isolated the virus which caused influenza, Morris Fishbein in the Journal of the American Medical Association questioned his findings and academic integrity. Falk decided to keep a low profile, since he just started his work for the CCMC. As he wrote Winslow, "My attitude has been to stay out of the picture so far as I could and to simply wait for this tempest in the teapot to quiet down." The controversy was never resolved, leaving the career of Falk blemished. Even though his activism and hard work was valued by his colleagues, Falk's reputation of having statistics "come out" his way was never cleared. As his colleague Barbara Armstrong stated, "I didn't want to undermine the only man that had charge of health insurance planning, because I care more about health insurance than I did about swatting Izzy [Falk]." Falk himself denied such accusations and blamed the AMA for trying to ruin his reputation.

The CCMC tried to approach the problem of costs of medical care in a scientific and objective manner. Through extensive empirical research, the problem would be defined and specific recommendations for solutions would be presented. Even though the researchers of the individual reports had the freedom to write their own opinions in the reports, the Committee's final recommendations were to be published in a single volume with the consent of all members. Initially the AMA had cooperated with the CCMC, but Morris Fishbein doubted the committee's integrity, predominantly because the involvement of I.S. Falk. As Fishbein would later recall: "He had written so much along the line that [the CCMC] felt that the only answer was nationwide, compulsory sickness insurance, ... you knew that was the answer that he would come out with."

In reality, the CCMC already decided in 1929 that national health insurance would not be included in its final report. Even the committee members known to favor such legislation expressed their doubts about the desirability and feasibility of national health insurance within the scope of the CCMC's studies. As the minutes of the CCMC's executive committee read:

Mr. [Walton] Hamilton suggested that our study of insurance will not reveal insurance as a comprehensive solution of the problems facing the committee but will show its limited usefulness. If it answers anything, it answers only a part of our problem, he said. Doctor [George E.] Follansbee said that insurance should be considered as only one of several alternatives. Mr. [Michael M.] Davis suggested

35 Falk to Winslow, 31 December 1929, Falk Papers, box 28, folder, 601, Yale Library.
36 Interview with Barbara Armstrong by Peter A. Corning, 20 December 1965, Columbia University Oral History Collection (microfiche edition, Roosevelt Study Center), 143.
37 Falk to Edwards A. Park, 30 April 1948, Falk Papers, box 45, folder 293, Yale Library.
38 Interview with Morris Fishbein by Charles O. Jackson, 12 March 1968, National Library of Medicine, History of Medicine Division, Bethesda, 68.
that insurance might solve the financial problem created by the uneven incidence of illness, but that the application of the insurance principle need have no direct connection with methods of medical practice. The two aspects of the question should be clearly differentiated.

Two years later, CCMC staff member Alden B. Mills presented the outline for a possible national health insurance program to be included as an appendix to the CCMC final report. However, it was unanimously decided that this appendix should not be included. "After some discussion, it was moved, seconded, and carried that ... to relieve the committee of the obligation of including any draft of proposed legislation on compulsory health insurance in the final report." 39

When in 1932 the CCMC published its final report Medical Care for the American People, the alarming situation it depicted had been intensified by the economic depression. The CCMC concluded that a large part of the population did not receive adequate medical care: "The amount of care which people need is far greater than that which they are aware of needing, and greater than that for which they are able to pay under present conditions." 40 However, the CCMC's final recommendations were vague on health insurance. Its majority report (signed by thirty-nine individuals, including seventeen physicians) called for a system of voluntary health insurance without explicitly recommending participation by the government. Instead, it stated that: "The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods." 41

The final report had created a schism which would haunt the national health insurance debate for years. While the lay reformers supported the CCMC's conclusions, a minority report was signed by conservative physicians backed by the AMA. The reformers, including Falk and fellow advocate Michael M. Davis, saw themselves as a vanguard in the battle for group practice and compulsory health insurance. The conservative physicians, in their turn, believed that these laymen were on an ideological mission, trying to undermine the quality of medical care. As a result, the national health

39 "Minutes of a meeting of the Executive Committee of the Committee on the Costs of Medical Care," 26 - 27 September 1932, Falk Papers, box 32, folder 55, Yale Library.

40 The final report of the CCMC proved to be so valuable that the Department of Health, Education, and Welfare (HEW) decided to issue a reprint in 1970. The Committee on the Costs of Medical Care, Medical Care for the American People (Washington DC: US Department of Health, Education, and Welfare, 1970), including a foreword by I.S. Falk.

41 The Committee on the Costs of Medical Care, Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care, Publications of the Committee on the Costs of Medical Care No. 28 (Chicago: The University of Chicago Press, 1932), 120.
And the pursuit of national health insurance debate was fixed between two rigid positions, with little willingness for constructive cooperation on either side. However, it is important to point out that the polarization of the CCMC was not merely based on the schism between lay reformers and physicians alone. The disagreement within the CCMC also reflected a schism within the medical profession itself. The majority report was signed by seventeen physicians, while the minority report was signed by eight physicians. The physicians who supported the majority report tended to be specialists favoring group practice; the physicians who supported the minority report private practitioners favoring individual practice. In other words, the CCMC was not so much divided on the issue of national health insurance, but on the issue of group versus individual practice.

The main objection of the physicians as written down in the minority report was based on the reorganization of medicine. Instead of the traditional family doctor working in a private practice, physicians would be reorganized around the hospital within a hierarchy determined by science and technology. More important than the way how medical care would be financed was the way how it would be practiced. As one of the dissenting physicians explained, “We believe that the safe way for the future is by the development of the individual practice of medicine, making use of organizations where possible to eliminate waste and improve the service.” These physicians objected to national health insurance because they feared that such a financial scheme would encourage the reorganization of medicine. That the conservative physicians felt under attack by the CCMC final report was not surprising, as the CCMC seemed to single out the private practitioner as the main problem in medical care. The CCMC’s insistence that the current organization of medical care was the root of all problems implied that the private practitioner was not seen as a mediator but as a barrier between the patients and modern medical technology. In fact, the federal government was merely, in the words of Daniel Fox, “a surrogate enemy.” The real enemy was the modernization of medical care, represented by the medical specialists working within organizations established around the modern hospital.

At the National Conference on the Costs of Medical Care in November 1932, Dr. Nathan Van Etten repeated the objections written down in the minority report in plain language. Group practice was the main problem: “The minority objects to the large medical center as projected by the majority on the ground of exclusion of many physicians, of oppressive competition, of big business technique erecting machinery which eliminates personality and destroys personal relations by factory forms. Mere bigness is often a liability.”

42 Arthur C. Christie to Falk, 3 November 1932, Falk Papers, box 31, folder 40, Yale Library.
43 Fox, Health Policies, Health Politics, 51.
44 Nathan B. Van Etten, “The Minority Reports,” in The Committee on the Costs of Medical Care, The Significance of the Recommendations of the Committee on the
Falk and his fellow lay reformers, however, were convinced that the dissenting physicians merely wanted to protect their economic interests. The physicians’ worries were unnecessary, Falk believed, as group practice could increase the physicians’ income and simultaneously reduce the patients’ costs. “Both effects are obviously desirable.” Falk could just not accept that the physicians had other reasons to object to group practice. Regardless of whether or not their fears would prove to be correct, the physicians feared the modernization and the accompanying depersonalization of medical care. These fears seemed legitimate, as the CCMC was indeed trying to approach the issue in a scientific and objective manner. The lay reformers, most of them social scientists, tended to see patients as a percentage of a larger group, not as individuals. Group practice established around the hospital would only depersonalize medical care even more. Falk refused to take these objections seriously. As he wrote in the 1933 annual report of the Milbank Memorial Fund, “The inadequate and conflicting recommendations of the Committee [CCMC] were further confounded by emotional and obstructionist outbursts from a few so-called leaders of the medical and dental professions.” As Falk and his colleagues trivialized the physicians’ fears as merely economic interest, they enhanced the polarization of positions in the national health insurance debate.

Even though the American Medical Association had initially supported the CCMC studies, the AMA leadership decided to endorse the minority report. In its editorial (written by Morris Fishbein), the Journal of the American Medical Association attacked the CCMC final report with a line that has become a classic in the history of American health care policy. “The alignment is clear – on one side the forces representing the great foundations, public health officialdom, social theory – even socialism and communism – inciting to revolution; on the other side, the organized medical profession of this country urging an orderly evolution guided by controlled experimentation.” The lines were clearly drawn. The words “socialism and communism – inciting to revolution” were often quoted to prove the AMA’s antagonistic position. By 1932 the AMA no longer valued the work of the CCMC, but denounced the studies as merely a waste of money. The editorial ended with a typical Fishbein metaphor, comparing the CCMC to a “colored boy [who] spent a dollar taking

Costs of Medical Care: The National Conference on the Costs of Medical Care, New York Academy of Medicine, 29 November 1932, 26-29. Copy in Falk Papers, box 37, folder 98, Yale Library.
45 Falk to Christie, 1 November 1932, Falk Papers, box 31, folder 40, Yale Library.
twenty rides on the merry-go-round” with his “old mammy” commenting: “Boy, you spent yo’ money but where you been?”

In retrospect, I.S. Falk blamed the medical profession for the split in the CCMC. As he wrote in 1977, “The course of history was to show that the medical leadership of the time took the wrong path at the fork in the road and led the nation into a morass from which, even now, more than four decades later, it has not yet found a way out.”

By solely blaming the AMA for the split in the CCMC, Falk suggested that the CCMC represented a consensus which was only opposed by the AMA. In reality, the CCMC majority report could easily be interpreted as controversial by outsiders as well. “Not only the AMA treated the majority report as a radical document,” as Paul Starr states. “The New York Times headlined its front-page story ‘Socialized Medicine Urged in Survey,’ and then quoted [Ray Lyman] Wilbur as saying that medicine was on its way to some form of community organization and that the majority report was meant to keep the medical profession in control of such movements.”

Moreover, the intensified conflict can not be blamed on the medical profession alone. As Daniel Fox has pointed out, the lay reformers used the AMA’s opposition to the CCMC’s majority report to create the image of helpless reformers under attack by greedy doctors. “The myth that [the CCMC’s] majority, innocent of any fault but idealism, were bullied by selfish leaders of organized medicine sustained a coterie that had enormous influence in debates about policy over the next twenty years.”

THE MILBANK MEMORIAL FUND

One of the prominent private organizations with had financially supported the studies of the CCMC was the Milbank Memorial Fund. Founded in 1921, the Milbank Fund had as objective to promote public health through a cooperation with the medical professionals, voluntary organizations, academic scholars, and public officials. Important reformers worked together to obtain this objective. Members of the Milbank Fund technical board included New York reformer Homer Folks, physician Livingstone Farrand, AMA official James Alexander Miller, and future surgeon general Thomas Parran. Basically, the different voices in the national debate were represented on the technical board of the Milbank Fund.

Initially, the Milbank Fund’s main focus was on health demonstrations to promote the prevention of tuberculosis. As these health demonstrations needed to be supported by statistics, the Milbank Fund started a research division headed by Edgar Sydenstricker, the older brother of writer Pearl S. Buck. Sydenstricker had been the first public health statistician of the U.S. Public Health Service (PHS). In 1926 he had come to work for the Milbank Memorial Fund. I.S. Falk, who became Sydenstricker’s assistant in 1932, described him as “a very mild-mannered person, rather slow of speech.” Most of all, Sydenstricker “was a scientist, every inch of him.”\footnote{Interview with I.S. Falk by Peter A. Corning, 28 July 1965, Columbia University Oral History Collection (microfilm edition, Roosevelt Study Center), 79.} The Milbank Fund’s participation in the CCMC, however, encouraged both executive secretary John Kingsbury and Edgar Sydenstricker to obtain a more active role in social policy. Especially Kingsbury was an idealist who regarded national health insurance as the ultimate solution to the problems in American medical care. He had written extensively on the issue, including the study \textit{Red Medicine}, which he had co-authored with Sir Arthur Newsholme. This study, written after a visit to the Soviet Union, undoubtedly made the more conservative members of the Milbank technical board uneasy. As Clyde V. Kiser explained the differences between John Kingsbury and Edgar Sydenstricker:

\begin{quote}
Sydenstricker, surely no less dedicated a man than Kingsbury, chose to deal with the problems as a scientist rather than an activist. Evidently realizing that the topic was “charged with emotional dynamite,” he wanted first to collect and analyze objective data that would be needed for guiding efforts at reform. Kingsbury’s philosophy, on the other hand, was that of a social worker, an activist, and a reformer. He had a high regard for Sydenstricker’s scientific approach and placed considerable reliance upon it. However, Kingsbury was impatient to get reforms started, and it was in relation to some of his activities that objections [among members of the Milbank Memorial Fund’s technical board] emerged and grew.\footnote{Clyde V. Kiser, \textit{The Milbank Memorial Fund: Its Leaders and Its Work, 1905-1974} (New York: Milbank Memorial Fund, 1975), 55.}
\end{quote}

Even though Sydenstricker had indeed a strong belief in the scientific and objective approach, his advocacy of national health insurance equaled, if not surpassed, Kingsbury’s. However, instead of using the language of an activist as Kingsbury did, Sydenstricker used his professionalism to enable the continuation of the Milbank Memorial Fund’s role in the national health insurance debate.

In addition to the minority report written by the conservative physicians, the CCMC also included two dissenting views, written by respectively Walton Hamilton and Edgar Sydenstricker. They both felt that the recommendations of the CCMC did not go far enough. As Sydenstricker stated, “As a member of the Committee [CCMC], I regret that I cannot see my way clear to sign the
final report of the Committee for the reason that the recommendations do not, in my opinion, deal adequately with the fundamental economic question which the Committee was formed primarily to study and consider.” In later articles, Sydenstricker expanded on the reasons why he could not support the CCMC majority report. “The Committee apparently was more concerned with improvement in the quality of medical care than with the heart of the problem,” he wrote in 1933, adding that “improvement in medical care is, of course, highly important but the pressing problem is making what medical we now have available to all people.” Sydenstricker believed that the costs of medical care should be distributed over the entire population according to ability to pay. Even though he did agree with most of the findings of the CCMC, he wanted more than merely to study the facts: Edgar Sydenstricker wanted to make policy that could make medical care available to those who could not afford it.

Even before the CCMC final report had been published, the Milbank technical board had come to the conclusion that the Milbank Memorial Fund’s participation in the study of health insurance should be continued. On May 19, 1932, professor C-E.A. Winslow (who was also a member of the Milbank advisory board) was present at the meeting of the Milbank technical board to inform the members about how the work of the CCMC was getting along. After Winslow had explained the CCMC’s majority recommendations, the technical board agreed that medical care could be best organized around the hospital, a “typical American development.” Only James Alexander Miller expressed a concern similar to the ones expressed by the minority report. As he stated, any plan that “would hamper the individual practitioner in building up his private practice and which might lessen his incentives to develop his abilities to their fullest extent” was a “step in the wrong direction.” Similar to the disagreement among the CCMC members, the Milbank technical board disagreed on the preference for group practice instead of private practice. Nevertheless, unanimous agreement was reached on the scientific value of the studies and the need for the Milbank Fund to continue its involvement in the issue.

After the CCMC majority report had been published, the technical board of the Milbank Fund second Sydenstricker’s opinion that the CCMC had been a “failure” or at least a “disappointment.” Accordingly, Edgar Sydenstricker convinced the technical board to continue the study of national health insurance. His argument was simple: not continuing the studies which were started by the CCMC would be a waste of money. Up to May 1932, the

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53 Edgar L. Sydenstricker, “Statement,” in The Committee on the Costs of Medical Care, Medical Care for the American People, 201.
55 “Minutes of the meeting of the Technical Board,” 19 May 1932, Milbank Memorial Fund Records, box 11, folder 79, Yale Library.
Milbank Fund has invested a total of $260,000 in the studies of the CCMC.\textsuperscript{56} Moreover, Sydenstricker argued that the CCMC had not been a complete failure. Experts, professionals, and the lay public had been made aware that there was a problem, opposing views had been brought to the surface, and, most important, a large amount of data had been collected on which further study could be based. Sydenstricker suggested to continue to study national health insurance, resulting in "the drafting of an actual plan of a state system of compulsory insurance."\textsuperscript{57} Even though national health insurance was not the only topic of study, Sydenstricker explicitly stated that the Milbank Fund studies should focus on "the applicability of the insurance principle to the distribution of medical care." As far as Sydenstricker was concerned, national health insurance was the only "solution" to solve the problem of inadequate access and unequal distribution. One important criticism of the CCMC report expressed by the Milbank technical board was that it excluded the European experiences with national health insurance. Therefore, Sydenstricker suggested to send "two or three open-minded physicians" to Denmark, England, and the Soviet Union to study the national health insurance schemes in those countries.\textsuperscript{58}

In the 1933 annual report of the Milbank Fund, I.S. Falk stated that "The Fund has not been content, nor would its social conscience permit it, to be merely a casual observer of the American scene."\textsuperscript{59} That same year, in spite of the disagreement among the members of the Milbank technical board, Albert Milbank publicly endorsed national health insurance during the Fund’s annual dinner, prompting the \textit{New York Times} to report: "HEALTH INSURANCE URGED BY MILBANK."\textsuperscript{60} At the dinner, Milbank explicitly explained what the Milbank Fund expected of a national health insurance scheme. "Sickness insurance – or more precisely insurance against the costs of medical care – is needed. This, as you know, is recommended by the Committee on the Costs of Medical Care as a voluntary and local measure. But, in my opinion, such insurance will not produce the results contemplated unless the scheme is compulsory and at least state-wide in scope."\textsuperscript{61}

\textsuperscript{56} "Minutes of the meeting of the Technical Board," 19 May 1932, Milbank Memorial Fund Records, box 11, folder 79, Yale Library.
\textsuperscript{57} Sydenstricker to John A. Kingsbury, "Suggestions for a continuation project in problems of medical care," 5 December 1932, Falk Papers, box 41, folder 178, Yale Library.
\textsuperscript{58} "Minutes of the meeting of the Technical Board," 18 January 1933, Milbank Memorial Fund Records, box 11, folder 79, Yale Library.
\textsuperscript{59} Falk, "Annual Report [Milbank Memorial Fund]," 3 February 1934, Falk Papers, box 39, folder 131, Yale Library.
\textsuperscript{61} Press release Milbank Memorial Fund, 17 March 1933, Milbank Memorial Fund Records, box 22, folder 177, Yale Library.
GROUP PRACTICE OR HEALTH INSURANCE

At a joint meeting of the College of Physicians of Philadelphia and the American Academy of Political Science held on February 7, 1934, the conflict between the lay reformers and the conservative physicians became even more apparent. I.S. Falk read a paper written by Edgar Sydenstricker, who could not attend due to health reasons. In the paper, Sydenstricker questioned the role of the medical profession as the only authority in medical care: “The principle taboo which we must discard is that the provision of medical care is a mysterious and sacrosanct realm into which only the physician may enter and at whose portals all others must genuflect.” While recognizing the medical profession’s responsibility of safeguarding the quality of medical care, Sydenstricker emphasized that guaranteeing access to medical care was a responsibility of the society as a whole, not solely of the medical profession. The designated power to provide that guarantee would therefore be the (federal) government. In this point of view, the physicians should be regarded as merely “a necessary servant of society,” subject to the public need, but also “given full opportunity to render his service in the best possible way.”

Even though Sydenstricker believed the American system to be “characterized by a grossly unequal distribution of wealth,” he recognized that “any program of action which may be given serious consideration at the present must assume the continuance of the economic system under which we now live.” Therefore, Sydenstricker proposed the establishment of a system of medical care which would combine government and private medicine. Only in cooperation with the medical profession, a solution to the problem of medical care could be reached. However, he did add that, to succeed, the debate had to be sacred from those “peculiarly inane ... shibboleths,” explicitly referring to Morris Fishbein’s famous words “socialism and communism – inciting to revolution.”

Sydenstricker presented a vision of national health insurance which would go further than the European systems and which would also combine the insurance principle with the already existing American public health services.

The great majority of the people – those who earn their livelihood in the American way of living and who want to pay for their medical care – are not in a position to budget individually the unpredictable costs of medical care. ... For this class, the principle of insurance must be combined with a program of public or state medicine. We should go beyond the health insurance systems of Great Britain and Europe which provide medical care to employed individuals only, and we should go further than to provide public medical service for infants, children,

and mothers, or for tuberculosis and mental diseases. All kinds of medical care, at home or in institutions, should be provided, and those who are eligible to receive this care should include not merely those who are employed, but all persons and their families having incomes below an amount sufficient to purchase medical services in any contingency.\textsuperscript{64}

In fact, the system proposed by Sydenstricker would bring together the maternalist welfare state and the paternalist welfare state. In addition to a social insurance based national health insurance program that would provide security to the American male industrial workers and their dependents (paternalism), Sydenstricker suggested the establishment of services for mothers and children, regardless of marital or employment status, based on public assistance and public health services (maternalism).

In his reply, Morris Fishbein reaffirmed the AMA's position that the medical profession was the only authority that was "really entitled to say how medicine shall be practiced." Again, national health insurance was seen as part of the reorganization of medical care. Recognizing that the state had the right to interfere in case the community was threatened (such as during epidemics), Fishbein complained that the state was in fact trying to go much further than that. The extension of free clinics and the establishment of student health services at state universities were seen as examples of how the state was expanding its influence. "It is not surprising to hear Dr. Sydenstricker ... insinuate that our entire economic, social and political system needs reorganizing," as Fishbein stated. "It is annoying however to have him center his attention on medicine and want to begin all the reorganization with the medical profession." According to Fishbein, this could only be explained by Sydenstricker's function as spokesman of the Milbank Memorial Fund. "That foundation is pledged to a program for socialization of medical care and its executive secretary Mr. Kingsbury has become enamored of what was shown to him in a personally conducted tour of Russia."\textsuperscript{65}

The criticism of the medical profession was not entirely unjustified. Sydenstricker and Falk did envision the reorganization of medical care. According to Sydenstricker, the fear of a "medical hierarchy" as result of group practice was based on a misunderstanding. The reorganization of medical care should enable to bring the overhead costs down. As far as Sydenstricker was concerned, there was "no necessary incompatibility between integration of services and retention of desirable, non-financial personal relations between doctor and patient." In fact, group practice and health insurance could strengthen the individual relation between the doctor and patient, as the economic situation no longer played a dominant role. The only question that remained was what had to come first: group practice or health insurance. "We have, in effect, been asked to choose between an evolutionary policy and a

\textsuperscript{64} Sydenstricker, "Medical Practice and Public Needs," 29.

\textsuperscript{65} Fishbein, "The Doctor and the State," 95.
program of definite action; between voluntary efforts to develop facilities for medical care through group action and a business-like application of a well-tried method of distributing costs over that part of the population which is now unable to budget medical costs."\(^{66}\) While the CCMC final report had opted for the first option, Sydenstricker and Falk clearly favored the latter one.

At the joint meeting of the College of Physicians of Philadelphia and the American Academy of Political Science of February 1934, the AMA opposed national health insurance by attacking the integrity of the advocates, Edgar Sydenstricker in particular. However, the medical profession realized that some action was needed to counter possible compulsory health insurance schemes. Accordingly, in June 1934, the AMA House of Delegates passed the so-called "Ten Principles" describing the conditions on which voluntary health insurance should be based:

1. Medical sponsorship and control of all medical service plans
2. No third-party intrusion in physician-patient relationship
3. Free choice of physician
4. Physician-patient relationship
5. Separate administration of hospital and medical plans
6. Cost of medical service to be determined by the income of the patient
7. Medical benefits and disability benefits to be under separate administration
8. Plans to be open to all qualified physicians on a voluntary basis
9. Medical relief to be limited to families below "comfort level"
10. Rules governing medical care to be established only by the medical profession\(^{67}\)

These ten principles may have implied the endorsement of health insurance in theory, they merely endorsed voluntary initiatives by local medical societies to experiment with limited forms of group payment controlled by the medical profession. Any initiative outside of organized medicine was perceived as an attack on the medical profession. As Paul Starr has pointed out, the ten principles also showed that the AMA would only accept health insurance plans based on indemnity, with the exception of plans for the welfare poor.\(^{68}\) By maintaining a direct financial relation between doctor and patient, the position of the private practitioner would be strengthened. Even though the reformers agreed with most of the AMA’s ten principles (and falsely believed that the AMA was becoming more willing to accept national health insurance), Sydenstricker and Falk wanted exactly the opposite, namely to break down the direct financial obstacle between doctor and patient.


\(^{68}\) Starr, *The Social Transformation of Medicine*, 300.
MILBANK GOES TO WASHINGTON

The national health insurance advocates of the Milbank Memorial Fund were delighted when in 1932 Franklin D. Roosevelt was elected president of the United States. President Roosevelt knew the Milbank Memorial Fund and its executive secretary John Kingsbury from his time as governor of New York. In 1930, Roosevelt had appointed Kingsbury on the New York State Health Commission. In addition, Kingsbury was a good friend of Harry Hopkins, who had been appointed by President Roosevelt as the federal emergency relief administrator. Kingsbury had been Hopkins' personal mentor in the 1910s and the two men had stayed in contact ever since. Hopkins had worked together with Kingsbury in the Association for Improving the Condition of the Poor, and later, when Harry Hopkins was affiliated to the New York Tuberculosis Association, he again worked closely together with John Kingsbury and Edgar Sydenstricker. When Roosevelt became president, the Milbank Memorial Fund followed the actions of the Roosevelt administration with interest. Especially the foundation of the Temporary Emergency Relief Administration (later changed in the Federal Emergency Relief Administration or FERA) had the Milbank Fund's interest. Even though the provision of work and home relief was top priority of the FERA, Hopkins had come to discuss the possibilities of free medical care under the existing relief laws. By 1933, the FERA had started a health program on local level, providing funds for emergency medical care for the poor. Even though the program was meant to be temporary, its successful attempt to work together with the local medical societies convinced the reformers that a national health insurance program could be possible.

When Roosevelt went to Washington, Kingsbury sent him an outline of a national health insurance program designed by Sydenstricker and Falk. Expanding on the studies of the CCMC, Sydenstricker and Falk argued that group budgeting through compulsory health insurance could guarantee access to medical care for at least the lowest-income segment of the population. Roosevelt thanked Kingsbury for his "interesting" letter and invited him to come to Washington to discuss the plans with secretary of labor Frances Perkins and other cabinet members. "I'm inclined to think that by next winter it will be time for us to take up the general health problem from the national

point of view.”  

When Kingsbury and Sydenstricker were in Washington, not all cabinet members reacted favorably. As Kingsbury reported to the technical board of the Milbank Memorial Fund, Frances Perkins “exhibited a clearer comprehension of the entire question” than secretary Harold Ickes and surgeon general Hugh Cumming, while Harry Hopkins “expressed not only interest but willingness to do everything in his power to bring about Executive action.”  

After meeting with Perkins and Hopkins, Kingsbury received a call from Hopkins with the request to send Sydenstricker and Falk to Washington.

Back in New York, the technical board of the Milbank Fund developed a “growing uneasiness” about Kingsbury activism. Especially James Alexander Miller believed that Kingsbury’s actions went too far. The technical board decided that “future assistance in clarifying [a national health insurance] program should be given privately and confidentially rather than in ways which might lead to further public discussion.”  

In spite of this uneasiness, however, the Milbank reformers continued to push national health insurance. In May 1934, Edgar Sydenstricker met with surgeon general Cumming while attending a meeting of the League of National Health Committee in Geneva. Even though Cumming was known to be “conservative,” he reacted favorably to Sydenstricker’s suggestion that “health should become a recognized national policy.” If the Public Health Service (PHS) would not work together with leading reformers, Sydenstricker warned, then the PHS would alienate itself from the developments in health care. Without explicitly stating that national health insurance should be included in a national plan, Sydenstricker stressed that cooperation was necessary for any plan to succeed.

Before Franklin D. Roosevelt had been elected president of the United States, the Milbank Fund had focused its attention on state legislation. As I.S. Falk explained, the reformers were “doomed to frustration,” as their plans seemed to be nothing more than “a useful intellectual exercise in developing our own thinking.” Sydenstricker and Falk wanted to work on national level and their chance came in 1933. “That was about the stage at which we were when FDR, Harry Hopkins, Frances Perkins and a number of other people with whom we were having close working relationships, moved to Washington.”

The prospects looked good. Harry Hopkins told John Kingsbury in 1934 that “with one bold stroke we could carry the American people with us, not only for

71 Kingsbury to Roosevelt, 24 November 1933; Roosevelt to Kingsbury, 4 December 1933, PPF 1031, FDR Library.
72 “Minutes of the meeting of the Technical Board,” 18 January 1934, Milbank Memorial Fund Records, box 11, folder 79, Yale Library.
73 “Minutes of the meeting of the Technical Board,” 13 March 1934, Milbank Memorial Fund Records, box 11, folder 79, Yale Library.
75 Interview with I.S. Falk by Peter A. Corning, 28 July 1965, Columbia University Oral History Collection (microfiche edition, Roosevelt Study Center), 73-74.
unemployment insurance but [also] for sickness and health insurance.” In the meantime, the AMA watched the developments with suspicion. “The New Deal was about to engulf Washington,” as Morris Fishbein, by then the embodiment of opposition to national health insurance, wrote in his autobiography.

CONCLUSION

The early years of the national health insurance in the United States are significant, as two important factors are brought forward: a) the American preference for the extension of medical care to national health insurance, and b) the dominance of intellectuals who approached the issue in an allegedly scientific and objective manner. While the intellectual drive for an insurance scheme failed to get sufficient support, maternalistic policies to extend public health measure were accepted. This preference was also present in the work of Edgar Sydenstricker and I.S. Falk, though not as an alternative but as a complementary measure. As Falk explains, they were initially requested to work out plans for loss of earnings during sickness, disability insurance, and the costs of medical care (meaning national health insurance). According to Falk, “We ... proposed a broader perspective to the Cabinet Committee, embracing not only the traditional elements in the European models of social insurance, but also all major elements required for an adequate health program – extending to the recourses needed for preventive as well as curative medicine and for protections against their costs.”

The difference between national health insurance and the extension of medical care reflected not only the difference between the paternalist and maternalist welfare state, but also the difference between social insurance and public assistance. As Sydenstricker and Falk believed, the differences could and should be combined. Their ideal welfare state would be both paternalist and maternalist, providing national health insurance and public health services. While conflict existed about the need of national health insurance, there was little disagreement about the need of extending medical care. Nevertheless, to the advocates, national health insurance was the obvious and logical solution. Therefore they were prone to dismiss opposition by the medical profession as merely economic interest. They failed to recognize that the medical profession opposed national health insurance out of a fear that such a program would reorganize the way medical care was delivered.

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Several scholars have argued that the polarization caused by the CCMC's final report made national health insurance a controversial issue. Daniel Hirshfield states that, in addition to a large amount of scientific data, the CCMC "produced only dissension, controversy, and conflict." According to Paul Starr, the CCMC controversy convinced the Roosevelt administration that "health insurance was an issue to be avoided." Even though the CCMC studies undoubtedly polarized the positions of the advocates and the opponents, the CCMC was fundamental for the inclusion of national health insurance in the studies of the Roosevelt administration. During the economic depression of the 1930s, health insurance was not the most urgent issue. Unemployment compensation and welfare benefits seemed to be far more pressing. The Roosevelt administration could have avoided the issue altogether. Instead, the Roosevelt administration used the CCMC studies and the work of the Milbank Memorial Fund in its studies on economic insecurity. Because of the studies done by Sydenstricker and Falk, plans had already been developed. President Roosevelt only needed to bring the policymakers to Washington.

79 Hirshfield, *The Lost Reform*, 32.