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

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Sometimes the best ideas come up at cocktail parties. One afternoon in late 1949, federal security administrator Oscar Ewing was having a drink with publisher William Randolph Hearst, Jr., when suddenly the conversation turned to national health insurance. “I'm very much in favor of your idea for national health insurance,” as Hearst told Ewing. “But the thing that worries me about it is that if anything went wrong, if it didn't work, the upheaval that would result would be catastrophic because we would have a completely different system of medicine.” Instead of a national health insurance program, Hearst suggested, Ewing should limit the program to hospital insurance. “If it works ... move into national health insurance. If it doesn't work, drop the whole idea.” Oscar Ewing liked Hearst's suggestion and subsequently discussed it with insurance expert Louis Pink of the New York Blue Cross/Blue Shield. Louis Pink added a suggestion of his own. “There is one phase of this whole problem where I think government might be very helpful. It's the over-65 group.” Back in Washington, DC, however, neither the social security policymakers nor President Harry S. Truman shared Ewing's enthusiasm for a 65+ hospital insurance program. As Oscar Ewing recalled, “I think the President rather thought it would be better to lose everything at that time and that future events would later force the adoption of some form of national health insurance. But he finally said ... that he'd follow my recommendations if I really thought it was the wise thing to do.”

The idea of hospital insurance for the elderly may have been new to Oscar Ewing, but the social security policymakers had been discussing such alternative strategies before. Already in 1937, during a meeting of the Interdepartmental Committee to Coordinate Health and Welfare Activities, surgeon general Thomas Parran had suggested to limit national health insurance to a program for social security beneficiaries. Seven years later, Merrill G. Murray of the Social Security Board made a similar suggestion in an internal memo. Even though both suggestions were ignored at the time, the social security policymakers did place them in their files. When, in 1949,
Oscar Ewing asked the social security policymakers to prepare an alternative proposal for national health insurance, they could build upon their earlier plans. As Wilbur Cohen recalled, “In view of Mr. Ewing's strong request for a legislative draft of the proposal I immediately got in touch with I.S. Falk ... and asked him to prepare a draft of the bill, an actuarial cost statement, and an explanation.”

The social security policymakers, however, remained skeptical about any proposal that would mean a compromise on national health insurance. “We do not regard these limited-benefit approaches as being necessary, preferable or even desirable,” as Falk told Oscar Ewing, “But they represent defensible proposals, and they are not fundamentally incompatible with the essential goals of comprehensive national health insurance.” Ewing, on the contrary, believed that the new strategy was “terrific,” cleverly using the existing sympathy toward the elderly and the advantages of the social security system. Opponents could hardly disagree that the elderly “deserved” medical care after working hard all of their lives. In addition, a limited program based on social security made the program financially more acceptable. At a press conference on June 25, 1951, Oscar Ewing announced his recommendation to include hospital insurance for the elderly in the legislative program. “These people as a whole need much more than the average amount of hospitalization, they have much less than average income with which to meet the costs of hospitalization and much less than average opportunity to obtain private insurance.”

Oscar Ewing’s enthusiasm for the 65+ hospital insurance proposal was partially motivated by his own personal political agenda. “Mr. Ewing seized upon it very vigorously,” as Falk remembered. “He had been displaying indications of presidential ambitions and was very much concerned with the possibilities of broadening the scope of the social insurance program, particularly with reference to what might be done in the health insurance field.” However, in spite of Ewing’s enthusiasm, President Truman did not show any interest in taking action. His advisors told Truman that, instead of programs would be for the American workers who paid social security tax – not for the retired elderly.

4 Falk to Ewing, 22 November 1949, Falk Papers, box 69, folder 710, Yale Library.
endorsing hospital insurance for the elderly, he could either "soft pedal the health issue" or establish a commission to study the need for health care legislation. Truman took the politically safe way out by establishing the President’s Commission on the Health Needs of the Nation. "Now, if somebody has got a better way than the one I propose, I am perfectly willing to accept it," Truman said in October 1951, referring to the failure of his national health insurance plans. He clearly kept his distance from the Ewing proposal. "On a number of occasions I have stated that I would be happy to consider suggestions which were better than the measures I have endorsed," Truman said, "But such counterproposals have not been forthcoming."

Without presidential support (yet with Truman’s permission), Oscar Ewing and the social security policymakers turned to the possible sponsors in Congress. Senators James Murray and Hubert Humphrey were interested in sponsoring hospital insurance for the elderly, though they believed that such a program should be seen as complementary, rather than as an alternative, to a national health insurance program. Representatives John Dingell and Emanuel Celler sponsored the House version of the bill. When, in spring 1952, the proposal was introduced in Congress, expectations were low. "Prospects for action this session appear remote," as the New York Times reported, and that prediction proved to be correct. Over the following years, Dingell annually reintroduced the bill in the House, which did not lead to any congressional action. In the Senate, James Murray and Hubert Humphrey introduced the bill only once more, though, in the words of James Sundquist, "even they appeared to have forgotten about it."

FOCUSING ON HOSPITAL INSURANCE FIRST

Inspired by the comments of the social security policymakers, historians have interpreted the shift toward hospital insurance for the elderly predominantly as

8 Monte M. Poen, *Harry S. Truman Versus the Medical Lobby* (Columbia: University of Missouri Press, 1979), 193. As stated before, Truman did not include Oscar Ewing in the commission, suggesting that the president did not give national health insurance high priority.
a strategy to circumvent the opposition of the medical profession as represented by the American Medical Association (AMA). This view is partially correct. As Oscar Ewing explained: “If physicians’ services were included in the payment, there might be objection on the ground that it is getting us in medical care, as distinguished from hospital care to which the proposal is deliberately restricted.” Hospital insurance would not interfere with the practice of the private physician. Moreover, unlike the AMA, the American Hospital Association (AHA) proved to be willing to discuss the possibilities of government programs, though without giving its endorsement. The social security policymakers, however, did not believe that such a move would be successful. Earlier attempts by the Social Security Board to limit health insurance to hospital care had failed as well. As I.S. Falk remembered:

You see, the bill that I gave Oscar Ewing in ’51 was not limited to hospitalization. That was comprehensive. He chopped it down to hospitalization on the same grounds that we and the White House and the Budget Bureau had used ten years before. That you say to the AMA: “There are no medical benefits in this thing. This is just to pay the hospital bill.” It didn’t work. The AMA said: “Oh, that’s just the camel’s nose, and it’s a hell of a big nose, getting under the tent. Sure, if you get hospitalization benefits, how long will it be before you tack on medical benefits?” And whenever anybody asked us that question, we said: “No comment.” Because that was the intent. This is why the President [Franklin D. Roosevelt] concurred in our trying it out, to see whether it would wash, but it didn’t. It got the AMA opposition just as strongly as though medical benefits had been in it. And after we got burnt on this series of bills in ’40, ’41, ’42, we said we’d had enough of that – “we don’t have to learn our lesson twice.” Ewing had to learn it, though.

The AMA’s opposition and the unwillingness of Congress to act on any kind of health insurance proposal had convinced the social security policymakers that no compromises on the scope of a national health insurance program should be made. As far as the social security policymakers were concerned, national health insurance had to be comprehensive and nation-wide.

There were, however, more practical reasons to focus on hospital insurance than the circumvention of the AMA’s opposition alone. The costs of hospital care were increasing at a higher rate than the costs of medical care. As I.S. Falk told Wilbur Cohen in June 1941, “For the longer run, it may be assumed [that] the volume of hospital services per capita will increase because of the aging of the population, its increasing urbanization, changing family

14 See for example Poen, *Harry S. Truman Versus the Medical Lobby*.
16 Cohen to Falk, 7 May 1951, Falk Papers, box 61, folder 541, Yale Library.
17 Interview with I.S. Falk by Peter A. Corning, 23 October 1968, Columbia University Oral History Collection (microfiche edition, Roosevelt Study Center), 228-229.
composition, and the trend toward increasing practice of medicine and surgery in hospitals.” Moreover, the hospital was becoming dominant in medical care, a development which the medical specialists had been emphasizing before. “We can be confident that in the future, even more than in the past, the hospital will be the center of coordinated services for the well and for the sick,” as social security policymaker Arthur Altmeyer stated. The social security policymakers believed that, “interlocked with the educational institutions of the universities and medical schools, the hospital of today is the health center of the future.” By doing so, the Social Security Board had incorporated the view of the medical specialists, who, unlike the AMA, supported group practice and federal subsidies for the extension of medical care. Without explicitly referring to the AMA, Altmeyer warned: “Those who would make of the hospital a building in which to furnish bed, nursing and only technical services and who propose to separate professional services from hospital care, are flying in the face of experience and progress. They would not merely stop the clock; they would turn it back. Their view cannot and should not prevail.”

The shift toward hospital insurance for the elderly started with hospital insurance for social security beneficiaries first, and only a decade later did the social security policymakers limit such a program to the elderly. The idea to focus on hospital insurance was an old one, already suggested by President Franklin D. Roosevelt. In his annual budget message to Congress on January 5, 1942, Roosevelt emphasized the incremental character of the Social Security Act. “From the inception of the social security program in 1935 it has been planned to increase the number of persons covered and to provide protection against hazards not initially included.” Among the proposed additions to the Social Security Act, Roosevelt suggested to add permanent and temporarily disability payments and hospital insurance. Based on the president’s wishes, the Social Security Board immediately developed a plan for hospital insurance for social security beneficiaries. Similar to health insurance programs in other western welfare states, the covered population would be the (male) industrial workers and their dependents. Moreover, hospital insurance would be presented “as a matter of right, without any means test.”

To discuss this hospital insurance plan, the Social Security Board organized a two-day conference, held in Washington, DC, in September 1942.

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18 Falk to Cohen, 11 June 1941, Cohen Papers, box 57, folder 4, State Historical Society of Wisconsin.
19 Arthur Altmeyer, “Financing Hospital Care Through Social Insurance,” 15 September 1943, Falk Papers, box 60, folder 537, Yale Library.
with representatives of the American Hospitals Association (AHA), the Protestant Hospital Association, and the Catholic Hospital Association. Also present were representatives of the Department of Labor and the Public Health Service (PHS). Even though the hospital associations did not endorse the Social Security Board’s proposal, the social security policymakers asked the representatives to discuss the objectives without arguing about the desirability of such legislation. The proposed plan would be national in scope and based on payments made through the social security system. The social security policymakers had estimated that by 1944, 47 million American workers would pay social security taxes, of which roughly 40 million would be eligible for the hospital insurance program. Coverage would also include the dependents of these workers, 18 million “wives” and 20 million “dependent children.” In addition, the plan could include the estimated 2 million retired workers who already received social security benefits. In total, depending on the scope of the program, the program could cover between 80 and 100 million workers.22

Similar to the health insurance programs in other western welfare states, the proposed hospital insurance program was foremost targeted at the actual working Americans and their dependents. The retired workers were not automatically included, but added as a possible option. The program would only apply to general hospitals providing acute care, as institutions for special care (such as hospitals for mental care or tuberculosis) and for the treatment of the chronically ill were not included. Even though the participants of the conference disagreed about how a government hospital insurance program would influence the role of voluntary health insurance programs, such as Blue Cross, they unanimously agreed that a government program should “encourage the growth and development of the Blue Cross plans on a voluntary basis.”23

Even though the conference on hospital insurance did not result in an endorsement by the hospital associations, a hospital insurance bill sponsored by Senator Murray was introduced to Congress in 1942.24 However, once the first

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22 "Hospital Payments Under Old-age and Survivors Insurance: Approved Summary of the discussion at a meeting of members of the staff of the Social Security Board with the Special Committee of the Board of Trustees, American Hospital Association, and the Joint Advisory Committee of the American Hospital Association, Protestant Hospital Association, and Catholic Hospital Association," 3 and 4 September 1942, Falk Papers, box 60, folder 537, Yale Library. I.S. Falk later added an undated note to the report, stating: “This paper reports a historically (little-known) important episode. It could have led to major legislative developments at the Congressional level, but it didn’t (war-time, domestic conflicts, etc).”

23 "Hospital Payments Under Old-age and Survivors Insurance;" 3 and 4 September 1942, Falk Papers, box 60, folder 537, Yale Library.

24 Daniel Hirshfield surprisingly states that “The President’s [hospital insurance] proposals were forgotten almost as soon as they were made, and no bills embodying them were introduced in the wartime Congress.” Daniel S. Hirshfield,
Wagner-Murray-Dingell bill was introduced to Congress in 1943, proposing a comprehensive national health insurance program, the issue of hospital insurance vanished in the background. The discussion on hospital benefits did not reappear until the implementation plans of President Truman’s National Health Plan of 1949. Since a comprehensive national health insurance program could not be implemented at once, the PHS had suggested to implement the program in several stages. I.S. Falk was against such a “staging” process. As far as he was concerned, staging was “not very good – impractical, geared to hospitalization & group-practice, but not adequate to meet [national] needs.” Nelson Cruikshank of the American Federation of Labor agreed. If staging was necessary, Cruikshank wanted “MD services first.”

As Falk concluded:

In summary, “staging” is not necessary; it is not desirable; and it carries great dangers. It may be the original intention that partial benefits should rapidly become comprehensive; but if the change should be delayed, limited scope of benefits would gravely distort the proper content and organization of medical care. Merely announcing the intention of “staging” the benefits may strengthen the proposals for “contracting out” to voluntary plans; Blue Cross and Blue Shield provide limited and categorical benefits of the scopes contemplated in some of the advocated “staging” patterns. “Staging” may threaten to sacrifice the objectives of care early in the course of disease or illness, and the objectives of strengthening preventive services; it would weaken the status and the future opportunities of the general practitioners, especially those with limited or no hospital connections; and it would make more difficult the subsequent solution of administrative problems in paying for comprehensive services.

Moreover, Falk feared that any compromise on the scope of national health insurance would undermine the most important objective. “National health insurance is national because it undertakes to draw on the economic recourses of the whole nation in order to meet the health needs of people everywhere – whether they live in rich or poor areas, and whether they are urban or rural.”

Falk realized that the “most common” proposal of limited benefits – either as part of the staging process or as a separate bill – was the one focusing on hospital care first. In a memo to Oscar Ewing, he repeated the advantages of such a program, only to refute them with the disadvantages. The positive side

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of focusing on hospital care would be the relatively easy way to start such a program. Reimbursement procedures were easy to negotiate with hospitals. Hospital insurance would help to solve one of the more expensive problems of medical care. In addition to the patients, the hospitals would benefit from such a program, bringing in more money. Most important, the start of a hospital insurance program could be the stepping stone to further benefits. Nevertheless, Falk believed that there were important disadvantages. Hospital contracts would not necessarily be easier to negotiate that contracts with physicians. The insurance of hospital care would only lead to more usage of hospital care, at the cost of preventive care. If only hospital care was reimbursed, people would be encouraged to go to the hospital instead of the general practitioner. In addition, as Falk concluded, hospital insurance would "be illogical and unsatisfactory to the public, because, wherever there are hospitals and hospitalized patients there are attending physicians, and people would fail to understand why the insurance covers the hospital bill but not that of the attending physician."

In spite of the reluctance of the social security policymakers, the suggestion to achieve national health insurance by gradual steps gained support among the advocates of national health insurance. C-E.A. Winslow, Falk’s former mentor, published an editorial in the American Journal of Public Health, proposing to approach national health insurance in gradual steps, either by covering only a segment of the population, or by covering only a segment of the medical care, as would be the case with hospital insurance. Falk warned Winslow that such an approach would hinder rather than help the objective of national health insurance and he expressed his "concern over the danger of fragmenting medical services – by covering some under an insurance program while indefinitely postponing coverage for others." The views of the social security policymakers, however, did not prevail as political pressures – after the failure of the Wagner-Murray-Dingell bills and President Truman’s National Health Plan – called for a more limited approach.

The Elderly

Up to the 1940s, the national health insurance proposals of the Social Security Board were targeted at the industrial workers, similar to the programs in other western welfare states. Even the early proposals to provide hospital insurance for social security beneficiaries were meant for the working instead of the


29 C-E.A. Winslow, “Directed Gradualism in the Field of Medical Care” (draft version), 4 January 1950; Falk to Winslow, 16 December 1949, Falk Papers, box 65, folder 621, Yale Library.
retired Americans. The proposed programs which were specifically targeted at the elderly tended to be social welfare rather than social insurance programs, meaning that only the so-called medically indigent would be eligible. "It has been suggested that the proposals to extend hospitalization insurance to most of the population be laid aside for the present, and that, instead, Federal aid should assist in providing hospital care for the aged poor," as Arthur Altmeyer stated in 1943. The social security policymakers did not believe that such programs were desirable. "The insurance needs of 100 to 125 million self-supporting persons are not to be met by improving the provisions for a few million who are needy."

Before 1950, only relatively a few Americans, predominantly industrial workers, were included in the social security system. This changed with the social security amendments of 1950, which enabled the inclusion of agricultural workers, domestic servants, and the self-employed. Due to these amendments, the role of the federal government in social policy increased. While social welfare programs were predominantly federally funded programs on state level, social insurance programs were federally administrated. In 1951, for the first time, the amount of social security benefits outnumbered the amount of old-age assistance. The amendments of 1950 made the social security program dominant in the American welfare state, providing universal coverage to the majority of Americans. Linking a national health insurance program to the social security system made more sense than in the years before, since the number of Americans included within the system had increased.

As stated before, health insurance programs in most western welfare states were initially targeted at the (male) industrial workers. In the United States of America, however, the focus was shifted toward providing hospital insurance for the elderly. Such a shift seemed to be a logical step after limiting hospital insurance to social security beneficiaries. Hospital insurance for the elderly did fit within the incremental character of the Social Security Act. Starting with a relatively small number of elderly, the program would naturally grow along the lines with the growth of the population. "It is estimated that the number of persons, 65 and over, at the present time is 12.6 million. We estimate that 4,370,000 persons age 65 and over, or 35 percent of all aged persons, would be eligible for the hospitalization benefits if the plan were in

30 Historians often assume that the early proposals to provide hospital insurance for social security beneficiaries were meant for the elderly, which was not the case. See for example, Irving Bernstein, Promises Kept: John F. Kennedy's New Frontier (New York: Oxford University Press, 1991), 247.
31 Arthur Altmeyer, "Financing Hospital Care Through Social Insurance," 15 September 1943, Falk Papers, box 60, folder 537, Yale Library.
effect at the present time,” as the social security policymakers stated in 1951. “As a result of the growing number of persons receiving OASI [Old-Age and Survivors’ Insurance] benefits and the 1950 amendments, we estimate a total of about 5.5 million would be eligible at the present time. This number will grow to about 6.3 million on July 1, 1952, and to about 7.0 million on July 1, 1953. This number will continue to grow. We expect this number to increase to about ten million in 10 to 15 years from now.”

The shift toward providing hospital insurance for the elderly, however, was neither the direct result of the political attempt to circumvent the AMA’s opposition, nor the direct result of limiting hospital insurance to social security beneficiaries. In the early 1940s, the social security policymakers had already tried to circumvent the AMA’s opposition by focusing on hospital insurance, but to no avail. The AMA continued to oppose any form of government health insurance. Linking hospital insurance to social security beneficiaries did not necessarily mean that the elderly would receive benefits, as the first proposals focused on the American workers. Instead, the move toward targeting the elderly was the answer to a consequence of a typical aspect of the American welfare state: the governmental encouragement of privately controlled social benefits. The increase of private, employer-based health insurance undermined the drive for national health insurance. As the elderly were excluded from such fringe benefits the need for government health insurance for the elderly increased.

Through collective bargaining, employer-based health insurance became the norm for the American worker, leaving the retired worker uninsured. Employer-based private health insurance grew after World War II, encouraged by the federal government which, through tax policy, indirectly subsidized the American worker’s fringe benefits. By the early 1950s, labor unions such as the Congress of Industrial Organizations (CIO), United Mine Workers, and the United Auto Workers had succeeded in obtaining health insurance benefits for their members. These labor unions, which members were predominantly industrial workers, realized that fringe benefits were far more important to the workers than government national health insurance. In 1948, national health insurance advocate Michael Davis of the Committee for the Nation’s Health (CNH) told Arthur Altmeyer that the United Mine Workers no longer endorsed President Truman’s National Health Plan. As Davis reported, the national health insurance objective received “a very serious blow” when the support of the labor movement was lost. The AFL, on the contrary, continued to support national health insurance. Unlike the other labor unions, the majority of the

33 Cohen to Ewing, 19 June 1951, Cohen Papers, box 30, folder 5, State Historical Society of Wisconsin.
35 Berkowitz and McQuaid, Creating the Welfare State, 167.
36 As quoted in Berkowitz and McQuaid, Creating the Welfare State, 167.
AFL members were not employed by large industrial companies and thus less likely to obtain private, employer-based health insurance through collective bargaining. "This Is a BIG FIGHT," as AFL president William Green stated in a fund-raising pamphlet for the CNH, "Life and Health Are at Stake." Even though the AFL continued to support a national health insurance program for the entire population, it also immediately backed the shift toward targeting the elderly. At its 70th annual convention in 1951, the AFL adopted the recommendation that Congress should enact a "medical aid" program for all social security beneficiaries. In addition, the AFL recommended that spouses were admitted to the pension rolls at the age of 60 (after all, "Facts have clearly shown that men marry women who are generally five years younger than they are") and that disabled workers would automatically receive social security benefits. As the AFL argued, the elderly "usually have maladies requiring lengthy treatment" and "are now required to depend on relatives, who may not be in a position to aid." Hospital insurance for the elderly could provide an effective solution without submitting the elderly to "a humiliating pauper's oath, as well as a minimum of medical aid." 38

Another motivation for the switch of focus toward the elderly was the growth of private, voluntary (both commercial and nonprofit) health insurance. The need for a national health insurance program for the entire population decreased as more and more Americans were covered by private health insurance. The elderly, however, were often excluded from such schemes. Even nonprofit health insurance organizations as Blue Cross and Blue Shield were forced to raise the premiums once their clients turned 65. The American Hospital Association (AHA) recognized the special problems of the elderly. As AHA official James Hague remembered, "The AHA quickly accepted the need of the aged for health care help and the need for federal assistance in the solution. The AHA's approach was to be via a Blue Cross card for everyone, destroying the differential between those who couldn't pay because everyone would have a Blue Cross card." 39 The AHA wanted this link to Blue Cross, as the hospitals had a large control over this nonprofit hospital insurance

37 As reprinted in Alan Derickson, "Health Security for All? Social Unionism and Universal Health Insurance," *Journal of American History* 80 (March 1994): 1333-1356. William Green was also the honorary vice-president of the Committee for the Nation's Health.

38 "Resolutions On Social Security, Referred to the Committee on Social Security by 70th Convention of the American Federation of Labor," 17-25 September 1951, Nelson Cruikshank Papers, box 16, State Historical Society of Wisconsin. Derickson states that "Finally, in 1957 organized labor retreated from advocacy of universal coverage to a narrower proposal to cover only the recipients of Social Security pensions." Derickson, "Health Security for All?" 1354. Even though the AFL did indeed continue to push for national health insurance, it also endorsed already in 1951 hospital insurance for the elderly.

organization. After the establishment of the first Blue Cross group payment program in 1929, the Blue Cross program grew rapidly. By 1945, 19 million Americans were insured by Blue Cross, and 2 million by Blue Shield (nonprofit health insurance initiated by the physicians).\(^{40}\) In spite of its recognition of the special problems of the aged and its continuous support of the studies of possible hospital insurance plans, the AHA did not endorse Ewing’s hospital insurance for the elderly proposal.\(^{41}\) This refusal was partly because the social security policymakers did not want to use the Blue Cross/Blue Shield programs as intermediaries. The use of the Blues (as they were often referred to) could lead to a dominance of the medical profession in the administration of the insurance schemes. In addition, some of the Blue Cross programs were in competition with each other and several states had more than one Blue Cross program.\(^{42}\)

Recognizing the need for federal legislation on the one hand, the AHA continued to oppose governmental intervention on the other. According to I.S. Falk, the hospital associations had always been “schizophrenic” — politically preferring voluntarism to governmental intervention, financially in favor of some form of state subsidized health insurance. “The hospital associations never made up their minds which end was up. ... They hoped against hope year after year (and for a while were very confident) that they had solved their problem without having to invoke government compulsory insurance through the development of the Blue Cross plans.”\(^{43}\)

Even though the social security policymakers initially questioned the desirability of hospital insurance for the elderly, once FSA administrator Oscar Ewing had presented his proposal, the Social Security Administration heralded the advantages of such a program:

- There is a great need of hospital insurance for old-age and survivors beneficiaries.
- An increase in the monthly old-age and survivors insurance benefits would not meet the need for protection against hospital bills.
- Private insurance does not and cannot meet the need for protection against hospital costs.
- The plan would not adversely affect existing insurance plans.
- The plan would not interfere with the independence of private hospitals.
- The plan would help the hospitals as well as the patients.
- The plan would not interfere in any way with medical practice.
- The plan would be an insurance – not an assistance plan.


\(^{41}\) Cohen to Falk, 7 May 1951, Falk Papers, box 61, folder 541, Yale Library.

\(^{42}\) Cohen to Falk, 10 January 1951, Falk Papers, box 61, folder 540, Yale Library; "Blue Cross and OASI Hospitalization," no author, Falk Papers, box 70, folder 726, Yale Library.

\(^{43}\) Interview with Falk, 23 October 1968, 233.
The plan would help to reduce relief costs to Federal, State and local governments and to private charities.

The plan provides for decentralized administration.

The plan can be put into operation without increasing the insurance contributions.

The plan can be administered simply and economically.\(^{44}\)

The arguments were strong and could be politically effective. However, the recent failure of President Truman’s National Health Plan made health insurance an unpopular issue. In the 1952 presidential elections campaign, liberal Democrats deliberately kept their distance from the issue. The social security policymakers, in the meantime, focused on another issue within the field of social security and medical care, namely disability insurance.

**THE EISENHOWER ADMINISTRATION AND DISABILITY INSURANCE**

The American view on social security underwent important changes during the early 1950s, as more and more Americans were included within the system. In addition, the number of actual retirees receiving social security benefits was rapidly increasing as well, making the issue of increasing benefits important in elective politics. Social security was becoming more popular and for the first time received bipartisan support. The social security policymakers tried to include medical care within the social security system by making small steps. The 1950 social security amendments included a program of federal public assistance for medical care, enabling direct payments to hospital and medical care providers, or so-called vendor payments.\(^{45}\) Such programs were essential as first steps toward national health insurance.\(^{46}\)

When in 1952 new social security amendments were proposed, the social security policymakers had included the so-called disability freeze. Workers who had become disabled before they retired would still receive the same amount of social security as they would have if they had continued working. The AMA opposed the inclusion of the disability freeze, claiming that it would lead to “socialized medicine.” Action in Congress stalled because of the controversy surrounding the disability freeze.\(^{47}\) To end the impasse, social security policymaker Wilbur Cohen proposed a curious compromise, which can be named the disability freeze that never was, a measure which had already ended before it went into effect. Even though the disability freeze was included in the

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44 "Major Arguments in Favor of Providing Hospitalization Benefits for Old-Age and Survivors Insurance Beneficiaries," 21 August 1951, Cohen Papers, box 30, folder 8, State Historical Society of Wisconsin.


bill, the measure would end on June 30, 1953, while no applications would be excepted before July 1, 1953.\textsuperscript{48} This seemingly useless compromise was important as it was the first step toward disability and health insurance within the law. As Wilbur Cohen explains:

The importance and significance of the disability freeze provision of 1952, which was in effect the last legislative achievement of President Truman before he retired, was that this was the beginning step in getting a medical examination made of the disabled individual, which proved to the [American Medical Association], over their objections, that medical examinations could be made for eligibility purposes, under Social Security, without causing socialized medicine. The whole opposition of the AMA to both health insurance, disability insurance, almost anything, was that it was the entering wedge to socialized medicine. What I wanted to prove was that there could be a medical examination that did not adversely affect the doctor's responsibility to diagnosis and treat medical care and that the federal government could administer it in a fair and honest, intelligent and efficient [way].\textsuperscript{49}

Right before the Eisenhower administration would take over and in the midst of the Korean War, Wilbur Cohen succeeded in securing a constructive step toward national health insurance within the law.

The election of President Eisenhower in 1952 drastically changed the political environment of social security. For the first time since the enactment of the Social Security Act, a Republican president headed the nation. Eisenhower's views on social security were notorious. His statement to the House Committee on Ways and Means in 1958 spoke for itself. "If all that Americans want is security, they can go to prison. They'll have enough to eat, a bed, and a roof over their heads."\textsuperscript{50} The AMA realized it had found a friend in President Dwight Eisenhower. Already in March 1953, two months after his inauguration, Eisenhower addressed the members of the AMA House of Delegates. "I have found, in the past few years, that I have certain philosophical bonds with doctors," as he declared. "I don't like the word 'compulsory.' I am against the word 'socialized.' Everything about such words seems to me to be a step toward the thing that we are spending so many billions


\textsuperscript{49} Interview with Wilbur Cohen by James Sargent, 18 March 1974, Columbia University Oral History Collection (microfiche edition, Roosevelt Study Center), 48-49.

to prevent; that is, the overwhelming of this country by any force, power, or idea that leads us to forsake our traditional system of free enterprise.”  

President Eisenhower’s views on national health insurance were also notorious. After the president had been hospitalized, advocates of national health insurance repeatedly referred to Eisenhower’s own use of government health insurance. As Leon Keyserling remembered: “I mean you know the story about Eisenhower when he had this operation he woke up from his coma and he said, ‘By golly, ... I’ve got to get well so that I can fight health insurance,’ forgetting that all his life he had been protected by health insurance and was in a government hospital. He never paid a penny for medicine in his life, but it wasn’t right for other people.”

Eisenhower, undoubtedly aware of these stories about his alleged hypocrisy, continued to denounce national health insurance as “socialized medicine,” stating “I don’t believe in it and I want none of it myself, I don’t want any of it.”

In spite of President Eisenhower’s personal dislike of social security, the American public began to appreciate its welfare state. As Edward D. Berkowitz and Kim McQuaid have pointed out, the fact that the Eisenhower administration did not try to end social security is an important success of the system in itself. The Eisenhower administration did, however, try to break the power of the Social Security Administration by pressuring the old school social security policymaker such as Arthur Altmeyer, I.S. Falk, and Wilbur Cohen to resign. Oveta Culp Hobby replaced Oscar Ewing as FSA administrator. Soon Hobby became the secretary of the newly created Department of Health, Education, and Welfare (HEW), which included the Social Security Administration. As Cohen remembered, “Mrs. Hobby was a determined woman. Once she recommended something, she stuck with it. This was her great strength – and weakness.”

Hobby announced that HEW would follow an “AMA administration, fully committed to the wishes of the AMA.” However, when the AMA claimed that it was solely responsible for Eisenhower’s election, Eisenhower was not amused.

While Arthur Altmeyer and I.S. Falk resigned, Wilbur Cohen refused to leave the Social Security Administration. Subsequently, he was demoted to

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52 Interview with Leon H. Keyserling by Ed Edwin, 15 February 1979, Columbia University Oral History Collection (microfiche edition, Roosevelt Study Center), 43.
54 Berkowitz and McQuaid, Creating the Welfare State, 175.
56 As quoted in Harris, A Sacred Trust, 65.
Falk's former position, head of the Research and Statistics Division. In 1954, Cohen suggested to attach a health care program to the public assistance laws. The social security policymakers estimated that 30 million Americans could not afford voluntary health insurance. Instead of including health insurance in the social security program, paying the health care costs of the poor would become a part of the social welfare programs. As Cohen believed, such a program could enable a compromise between the advocates (AFL-CIO) and opponents (AMA) of national health insurance. Medical care for the low-income groups would be a joint federal-state program, adding medical care to the existing old age and public assistance laws.\(^{57}\)

The Eisenhower administration recognized the power of the argument that the elderly in particular had difficulties to find adequate coverage under private insurance. Instead of a government health insurance program, the Eisenhower administration suggested the enactment of a subsidy program that would encourage the private health insurance industry to provide coverage for the elderly. This proposal, however, did not receive support from either the conservatives or the liberals. To the advocates of a government health insurance, the proposal was a "puny and totally inadequate 'gimmick' ... which can accomplish virtually nothing," while the AMA denounced it as "socialized medicine."\(^{58}\) President Eisenhower was disappointed by the opposition of both sides and by the failure of the private industry to participate. At a press conference, he stated: "There is nothing to be gained, as I see it, by shutting our eyes to the fact that all of our people are not getting the kind of medical care to which they are entitled. I do not believe there is any use in shutting our eyes to the fact that the American people are going to get that medical care in some form or another." Ike was not willing to give up on the issue. "This is only a temporary defeat; this thing will be carried forward as long as I am in this office."\(^{59}\)

When, in 1955, Marion Folsom of Eastman Kodak, replaced HEW secretary Oveta Culp Hobby, the advocates of national health insurance hoped that social security would return to the legislative agenda. However, as Arthur Altmeyer warned Wilbur Cohen, even though Folsom had supported the principles of social security since the early 1930s, he would probably turn out to be another "Secretary of not too much Health, Education, and Welfare."\(^{60}\)


\(^{58}\) As quoted in Sundquist, Politics and Policy, 291.


\(^{60}\) As quoted in Berkowitz, Mr. Social Security, 96.
No longer working with his fellow social security policymakers, Cohen was starting to get frustrated. "I had weathered the 1953-4-5 storms of the new Republican Administration but Mrs. Hobby's opposition to disability insurance in 1955 made me very unhappy," as Cohen remembered. "The 2½ years under the Eisenhower Administration had been a great emotional and intellectual strain for me." In 1956, Wilbur Cohen accepted a position at the University of Michigan, though he remained an important advisor and advocate of social security legislation.

Even though the Eisenhower administration opposed disability insurance, chances to get such legislation enacted increased after the congressional elections of 1954, giving the Democrats a majority in Congress. Disability insurance had been included in the National Health Program proposed by the Interdepartmental Committee to Coordinate Health and Welfare Activities in 1938. In later years, Arthur Altmeyer expressed his regret that the social security policymakers had not pushed for disability insurance at that time, as the AMA seemed willing to accept the Interdepartmental Committee's proposals on the condition that the plans to encourage national health insurance programs on state level be dropped. Instead, disability insurance continued to be one of the programs to be studied by the Social Security Administration. After the failure of the health insurance proposals, disability insurance was an attractive political issue for the Democratic Party. With the presidential elections of 1956 in sight, Senator Lyndon B. Johnson rounded up support for disability insurance and the bill was passed that same year. The enactment of disability insurance was a victory of labor. The AFL had merged with the CIO in 1955, thereby increasing the political influence of labor's social security expert Nelson Cruikshank. Wilbur Cohen, as an independent advisor, had worked closely together with Cruikshank, proving that the bond between labor and the social security policymakers remained strong. The enactment of disability insurance was also a trying ground for the enactment of hospital insurance for the elderly. According to several participants, the only reason why the efforts to enact hospital insurance for the elderly had been postponed to 1957 was because the social security policymakers waited for the enactment of disability insurance. The American Medical Association, in the

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meantime, understandably warned that the enactment of disability insurance was the next step toward a "total national compulsory sickness program."65

CONSENSUS ON HOSPITAL INSURANCE FOR THE ELDERLY

Even though Wilbur Cohen, I.S. Falk, and Arthur Altmeyer had left the federal government, they continued to influence the social security developments. In 1957, Cohen suggested to Altmeyer that they should present "something bright, new and shiny to challenge people and to serve as a goal for the Liberals and Progressives in the decades ahead." As he explained:

If we are going to make any headway in the hospitalization or medical care field, I think we have to reluctantly admit that the only way we can get it is by accepting "contracting out." ... I think that there is no reasonable hope for even such a modest program as hospitalization insurance unless you are willing to, in some way or another, recognize the existence of existing coverage. ... One further bombshell. It seems to me that we will sooner or later have to admit that the only way to approach the medical care program is by some catastrophic plan or major medical approach. I have been against this in the past, but I must, reluctantly, admit that it is the approach that has the appeal. A final proposal is to approach the problem of hospitalization and medical care insurance on some type of Federal-State basis, even possibly through use of the credit offset device. As you can see, my thinking goes so far as to use the States, the credit offset method and "contracting out" and could be a big reversal in our entire approach. It would be a major problem to sell Nelson Cruikshank on such a reversal, yet I believe that if we are going to make any further progress in the immediate future, we will have to give greater recognition to the use of the States and to nonprofit agencies.66

Cohen's search for alternatives was not surprising, as during the 1950s the issue of national health insurance had vanished from the political arena. Even the Democratic Party refused to endorse national health insurance. Adlai E. Stevenson, Democratic presidential candidate in 1952 and 1956, clearly distanced himself from the national health insurance plans of the Truman administration. As Adlai Stevenson stated in 1955, "There is emerging impressive evidence of agreement that the most promising approach to this problem of distribution of medical service lies in the development of voluntary, private, prepayment health insurance programs."67

By 1957, however, the situation had changed. Almost unnoticeably, the idea of hospital insurance for the elderly as an alternative for (instead of complementary to) national health insurance had been crystallized. While the

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65 As quoted in Berkowitz and McQuaid, Creating the Welfare State, 172.
66 Cohen to Altmeyer, 9 September 1957, Cohen Papers, box 6, folder 3, State Historical Society of Wisconsin.
issue of national health insurance seemed to have vanished in the background, the issue of the elderly and their specific problems had received high priority on the political agenda. In March 1956, President Eisenhower established the Federal Council on Aging, which was to explore the possibilities for programs targeted at the elderly. Even though the discussions on the problem of the elderly did not primarily focus on their inability to obtain private health insurance coverage, soon the proposal for a health insurance program for the elderly became the main issue in the debate. This was largely due to the efforts of the AFL-CIO. Nelson Cruikshank, head of the labor union’s social security department, worked closely together with Wilbur Cohen in the drafting of a new proposal.

Three factors played an important role in making hospital insurance for the elderly a top priority on the political agenda of the Democratic Party and the labor movement. First of all, the number of Americans over 65 was growing rapidly. Most of them were excluded from private, employer-based health insurance, which provided health insurance coverage to the working Americans. Even though the elderly were not the only segment of the population that was excluded, they were the most visible. Second, hospital insurance for the elderly had also a strong appeal to the non-elderly. Not only were most Americans expecting to grow old themselves, but a large amount of the health care costs of the elderly were carried by their grown children. In this way, as the argument went, working Americans were often forced to choose between the health care costs of the aged parents and the college education of their children. Finally, and perhaps most important, the liberal Democrats recognized the political power of hospital insurance, which could be an effective issue to compete with the rather popular Eisenhower administration. This revived enthusiasm for hospital insurance for the elderly (which would become known as Medicare) hid the fact that still a large number of the younger American population did not have any health insurance coverage either. The appeal of the new Medicare ideal erased any plans for national health insurance. Even I.S. Falk, who remained active as advisor in the background, had to recognize that focusing on hospital insurance for the elderly first was “tactically the best for getting initial enactment and for providing a basis for evolution of comprehensive care on a sound pattern.”

The appeal of Medicare was however not immediately recognized. In search of a sponsor in Congress, the AFL-CIO finally found a willing Democrat in Representative Aime Forand, the fourth ranking Democrat in the House Committee on Ways and Means. Even though Wilbur Cohen had

68 Sundquist, Politics and Policy, 295-296.
70 Falk to Frank F. Furstenberg, 12 July 1958, Falk Papers, box 159, folder 2296, Yale Library.
already discussed the issue with him back in 1951, Forand was not well informed about health insurance for the aged.\textsuperscript{71} He depended on the AFL-CIO for actual information and speeches. Once the issue, to Forand’s surprise, proved to be a large political success, Forand became one of the most ardent advocates of health insurance for the elderly. As AFL-CIO social security expert Nelson Cruikshank remembered: “From then on, Aime Forand thought he invented the whole idea. We didn’t bother to disillusion him. He was a great friend. That’s the way it was done.”\textsuperscript{72} The introduction of the Forand bill in Congress almost went unnoticed. Senator Paul Douglas would later remember a meeting in southern Illinois, when “a bedraggled oldster with many missing teeth asked me about the chances of passing the Forand bill.” Much to his own embarrassment, Douglas admitted, “I had to ask him to tell me what it was. He gave me the rough outlines of the measure. Then he said, ‘I need that badly,’ and the little band of aged courthouse loungers nodded gravely, although without much hope.”\textsuperscript{73} While the politicians seemed to ignore the issue, however, the public and the press began to notice the issue. Part of this revised interest was caused by the opposition of the American Medical Association. “I want to pay tribute to the AMA for the great assistance they have given me in publicizing this bill of mine,” as Aime Forand jokingly announced, “They have done more than I ever could have done.”\textsuperscript{74}

**The Kerr-Mills Program**

The main obstacle to get health insurance programs enacted was not so much the opposition by the medical profession, but the unwillingness of the committees in Congress to let the health insurance proposals come to a vote on the floor. The Finance Committee was responsible for health insurance proposals in the Senate, the Committee on Ways and Means in the House of Representatives. Health insurance proposals met the most opposition in the House, prompting the advocates of national health insurance to speak of the House In No Way and by No Means Committee.\textsuperscript{75} Pressure to enact some form of health insurance increased, however, when, in 1959, the Senate Subcommittee on the Problems of the Aged and Aging, chaired by Senator Patrick McNamara, a Democrat from Michigan, started hearings all throughout the nation. The testimonies of the elderly had a strong impact on public

\textsuperscript{71} Cohen to Aime Forand, 28 June 1951, Cohen Papers, box 30, folder 5, State Historical Society of Wisconsin.

\textsuperscript{72} As quoted in Weeks and Berman (editors), *Shapers of American Health Care Policy*, 72.


\textsuperscript{74} *Congressional Record – House*, 22 June 1960, 86th Congress, 2nd session, volume 106, 13819.

\textsuperscript{75} Harris, *A Sacred Trust*, 107.
opinion and received a lot of attention from the media. “I don’t care whether you call it socialized medicine or free medicine, or what, but something should be done,” as one senior citizen exclaimed. “The cost of hospitalization is enormous. It can wipe out all that we have in a short period of time.”

In addition to the hearings of the McNamara subcommittee, pressure on Congress increased because of the coming presidential elections. Democratic presidential candidate John F. Kennedy had made Medicare an important campaign issue. While Congress had ignored the Forand bill since its introduction in 1957, three years later action was required. Three different proposals were introduced. The Kennedy Medicare bill was the Senate version of the Forand bill, proposing hospital insurance for the elderly based on the social security system. The Javits bill, a counterproposal by the moderate Republicans, proposed a voluntary system of health insurance, also based on the social security system, which left the retiree the choice between a health insurance benefit or a cash payment. The final choice was Kerr-Mills, a public welfare bill which would give financial aid to the so-called medically indigent over 65. This joint federal-state program left the initiative to start a medical assistance plan to the states. While Medicare was based on the principle of social insurance, Kerr-Mills was based on social welfare, merely providing benefits once poverty had stricken. Addressing the House of Representative for the last time before his retirement, Representative Aime Forand stated that the Kerr-Mills program would do no harm, but not any good either. “Personally, I think it is a sham. I think it is a mirage that we are holding up to the old folks to look at and think they are going to get something.”

The Kerr-Mills program was enacted and subsequently signed into law by President Eisenhower. Representative Wilbur Mills, who chaired the House Committee on Ways and Means, would later remember: “We could pass Kerr-Mills because there was no objection to it.” Some action had to be taken, and to the opponents of Medicare, Kerr-Mills was the most acceptable alternative. Even though the Medicare proposal lost, the occasion was historic, as for the first time, a national health insurance proposal had come up for a vote in the Senate. The Medicare advocates, however, feared that the enactment of Kerr-Mills would mean the end of Medicare, as pressure was taken off Congress to enact a health insurance program. They could not understand why Wilbur Cohen, the Medicare expert, had assisted Senator Robert Kerr in the drafting of the Kerr-Mills program. Wilbur Cohen, however, had three important reasons to support the Kerr-Mills legislation. First, he wanted to strengthen the already existing public assistance medical programs. Second, he believed that the Kerr-

76 Sundquist, Politics and Policy, 287-290.
Mills program could provide medical assistance to those Americans who would not be covered by existing and future social security programs. Third and finally, he wanted to avoid the enactment of an alternative program that could make the future enactment of Medicare unlikely. As far as Wilbur Cohen was concerned, the Kerr-Mills program was not an alternative for Medicare, but a complementary program which would eventually help to get Medicare enacted. “There were many persons in 1960 who felt strongly that the Kerr-Mills proposal should not be enacted. They believed it would retard the movement for hospital insurance thru SS,” as Wilbur Cohen remembered. “I did not share this view and was strongly criticized by many of the supporters of hospital insurance. I believed then – and I believe now – that this was the right decision – it was both pragmatically as well as tactically sound and was in accord with good program development to meet existing needs.”

Wilbur Cohen realized early on that private, employer-based health insurance for the workers and a government health insurance program based on the social security system for the elderly would leave a segment of the population uninsured. A social welfare program, providing medical assistance when needed, was necessary to fill in that gap. As Cohen explained, “The Kerr-Mills program is a necessary underpinning to all other programs so that any individual who does not have private insurance or social security will still be able to have his medical needs met.” The main problem with the Kerr-Mills program was, however, that the initiative to start a medical assistance was left to the individual states. “There are two directions that Kerr-Mills can take and both are dangerous,” as Cohen warned Senator Clinton P. Anderson. “In the wealthy States, it can become a political poker game, which each side upping the ante to win the approval of the elderly. In the poorer States, as the financial burden becomes unbearable, wholesale cutbacks are ordered, and the bills of doctors and hospitals will remain unpaid.”

During the first three years after its enactment, Kerr-Mills proved to be rather ineffective. By 1963, only a few states had started a Kerr-Mills program. Moreover, roughly three-quarters of the federal money spent on Kerr-Mills had gone to three states alone, namely California, Massachusetts, and New York State. The AMA, however, decided to support the Kerr-Mills program, even

though initially organized medicine had opposed its enactment. The physicians argued that there was no use for Medicare as the elderly in need were already taken care off by Kerr-Mills. Moreover, the AMA accused the Department of Health, Education, and Welfare (HEW) of deliberately sabotaging the Kerr-Mills program, in an attempt to prove its ineffectiveness. These allegations were echoed by Representative Thomas Curtis from Missouri, an ardent opponent of social security. Wilbur Cohen, who had returned to HEW in 1961, was furious about these allegations. “Let me say something, Mr. Curtis, that you may not know,” as Cohen wrote in a reply of eight pages. “As a consultant to Senator Kerr I redrafted the House version of the bill (the Mills bill) for Senator Kerr.” Moreover, not HEW but many of the state medical societies were obstructing the implementation of the Kerr-Mills program. “I wonder how much you have done to urge State officials and legislators to take advantage of Kerr-Mills,” as Cohen concluded, “What did you do in Missouri?” In spite of Cohen’s denial, however, the rumors that HEW was boycotting Kerr-Mills continued for the years to come.

CONCLUSION

Historians have explained the change of strategy to focus on hospital insurance for the elderly as an attempt to circumvent the opposition of the AMA. By limiting insurance to hospital costs and focusing on the “deserving” elderly, policymakers undermined the AMA’s argument that Medicare would destroy the sacred doctor-patient relationship or undermine the American worker’s individualism and self-reliance. Even though the policymakers indeed hoped that hospital insurance for the elderly would be more acceptable to the medical profession, they realized that this probably would not be the case. During the early 1940s, the AMA had also opposed President Roosevelt’s proposals for hospital insurance. Most important, the social security policymakers, particularly I.S. Falk, were initially against limiting the program to hospital insurance for the elderly. They preferred the proposal of a comprehensive national health insurance program, realizing that the AMA would oppose all proposals regardless of focus or size. To the social security policymakers, limiting the program to hospital insurance for the elderly was an unacceptable compromise. Only after FSA administrator Oscar Ewing, with President Harry

83 Cohen to Thomas B. Curtis, 9 November 1961, Cohen Papers, box 133, folder 4, State Historical Society of Wisconsin.
S. Truman's permission, continued to push for this strategy, the social security policymakers went along and became active promoters of the program that would become known as Medicare.

The social security policymakers had to admit that limiting the program to hospital insurance for the elderly did make sense. As the elderly were part of the non-working population, they tended to be excluded from the private, employer-based health insurance programs. Moreover, as the elderly were considered to be a high-risk group, health insurance coverage was far more costly. Subsequently, the elderly became the logical target of government health insurance. Targeting the elderly also had an ideological advantage: no opponent would dare to argue that the elderly did not deserve adequate medical care. As a result, the discussion on hospital insurance for the elderly was not perceived as part of the national health insurance debate, but as part of the debate on the problems of the elderly.

With the election of President Dwight Eisenhower, the movement for hospital insurance for the elderly came to a temporarily hold. The forced resignations of Arthur Altmeyer and L.S. Falk, later followed by Wilbur Cohen, undermined the insurance movement in the Social Security Administration. At that time, the importance of labor increased. The AFL and CIO merged in 1955 and became the main architect of the Medicare bill. However, labor refrained from action until the enactment of disability insurance. To both the social security policymakers and the labor movement, the inclusion of the disability freeze in 1952 and the enactment of disability insurance in 1956 were small but important steps toward a government health insurance program.

The establishment of the Federal Council on Aging in 1956 created a platform that could be used for the launching of Medicare. Even though President Eisenhower had always been against "socialized medicine," he realized that something needed to be done for the elderly. Subsequently, the debate focused on the distinction between social insurance and public assistance. While the social security policymakers (at that time working as independent advisors) and the labor movement preferred the inclusion of health insurance within the federal system of social security (social insurance), the opponents of Medicare preferred either a program of voluntary health insurance or a public assistance program on a joint federal-state level. The resulting Kerr-Mills program may have been an unsatisfying compromise, its enactment was an important step toward Medicare and Medicaid.