Public Health Then and Now

Transformation in Defeat: The Changing Objectives of National Health Insurance, 1915–1980

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The persistence of a social movement over a long period sometimes obscures slow changes in its underlying purposes and sources of inspiration and support. The campaign for a government-sponsored program of health insurance in the United States has stretched over nearly three-fourths of a century, but insofar as it still continues it is no longer the same struggle it started out to be. As American political life and the economics of health care have changed, the objectives of reform have subtly shifted, and the idea of health insurance as a public program has undergone a complete transformation.

National health insurance[1] has always been concerned with relieving the economic problems of sickness. However, there are different types of cost associated with sickness, and reformers have gradually shifted their focus of concern from one type to another. The costs of sickness for individual households have two principal components: the cost of lost earning and disruption of family life (sometimes termed "indirect" costs), and the cost of medical care. These costs fall not only upon individuals, but also in their aggregate upon society at large, which experiences costs in diminished production and lost national income as well as a total medical bill. Accordingly, sickness creates costs of four general kinds: individual income and other indirect losses, the indirect social costs of sickness, individual medical costs, and the social costs of medical care.[2]

During the twentieth century, reformers have shifted their attention, at the individual level, from lost earnings to medical costs, as health insurance has become more concerned with health care financing than income maintenance. Second, they have dropped their initial emphasis on the indirect social costs of sickness, which they originally expected insurance would reduce, as health insurance has become increasingly divorced from public health. And, third, in recent years they have begun fundamentally to recast health insurance as a means of controlling and perhaps even reducing the social costs of medical care, as national health insurance has become increasingly viewed as an instrument of institutional reorganization and (social) cost containment.

These changes have taken place for two sorts of reasons—first, enormous changes in the economics of health and medical care; and second, more general changes in American society that inevitable affect the politics and ideology of reform. This history can be conveniently divided into three periods: 1) the early twentieth century, or Progressive era, when health insurance was introduced in America as a program of income maintenance for wage earners and, its advocates maintained, disease prevention and increased national efficiency; 2) the period from the 1930s to the 1960s, when health insurance became a program primarily of medical care financing to distribute individual risks and expand the access of lower- and middle-income groups to increasingly expensive services; and, finally, 3) the most recent period, beginning in the 1970s, when health insurance evolved into a program of cost control and institutional reform as well as universal coverage.

For convenience, I shall call these three phases Progressive Health Insurance, Expansionary Health Insurance, and Containment Health Insurance.

Progressive Health Insurance

The historical origins of health insurance as a public program are linked more to concerns about income maintenance, national economic power, and political stability than

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they are to the financing of medical care. Prior to any national programs, many workers in both Europe and America were insured through sickness funds sponsored by mutual societies, unions, and employers; the principal function of these funds was to provide cash benefits in sickness ("sick pay") to make up for lost wages. When European governments first made such insurance compulsory for wage earners or began subsidizing voluntary funds, compensating for individual wage losses was still their principal function; paying for medical care was secondary. Sickness insurance (as it originally was called) was instituted as part of a general program of social insurance against the chief risks that interrupted continuity of income: industrial accidents, sickness and disability, old age and unemployment (typically covered by governmental programs in that sequence).[3] Bismarck in Germany and other leaders elsewhere were consciously seeking to attach the loyalty of workers to the state and to deny socialism its sources of appeal; thus social insurance was a defensive program, inaugurated first by authoritarian and later by liberal regimes, to integrate workers into the society and stabilize the political order.[4] Political leaders also believed there would be a dividend in the increased health and efficiency of the labor force and the army. As England's Lloyd George put it in a memorable phrase, "You can not maintain an A-1 empire with a C-3 population."[5] For all these reasons—income maintenance, the preemption of socialism, increased efficiency and power—social insurance programs, including sickness insurance, were extended initially to wage earners and only later to their dependents and other people.

This background colored the campaign for health insurance in the United States, which began in earnest about 1915, after most of the major European countries had adopted either a compulsory program or subsidies to voluntary plans. As in Europe, interest in health insurance developed soon after the passage of insurance against industrial accidents. In America, however, reformers outside government, rather than political leaders, took the initiative in advocating health insurance. Some were socialists—indeed, the Socialist Party in 1904 was the first to endorse health insurance—and even those who were not, such as the members of the American Association for Labor Legislation (AALL), the leading organization in the campaign, generally supported the rights of trade unions. Hence the proposal did not come into political debate in America under anti-socialist sponsorship, as it had in both Germany and England. Yet the AALL's bill followed European precedent in placing an income ceiling on participation and aiming to improve workers' health on grounds of industrial efficiency as well as social equity. Its program applied only to manual workers and others, except for domestic and casual employees, earning less than $1200 a year. The benefits included both medical aid and sick pay (at two-thirds wages for up to 26 weeks, except during hospitalization, when it fell to one-third wages). Dependents were eligible for the medical benefits. The costs, estimated at four per cent of wages, were to be divided among employers and workers, each of whom was to pay two-fifths, and the state, which would contribute the remaining one-fifth. The employers' share increased for the lowest-income workers. A worker earning $600 a year, the AALL estimated, would pay eighty cents a month out of a premium of two dollars.[6]

The reformers formulated the case for health insurance in terms of two objectives. They wanted, first, to relieve poverty caused by sickness by distributing individual wage losses and medical costs through insurance. And, second, they wanted to reduce the social costs of illness by providing effective medical care and creating monetary incentives for disease prevention. This mixture of concerns was typical of the social Progressives. On the one hand, in emphasizing the relief of poverty, they made an appeal to moral compassion; on the other, in emphasizing prevention and increased national efficiency, they made an appeal to economic rationality.[7] Combining social meliorism with the ideals of efficiency fitted perfectly into Progressive ideology. It also reflected the political conditions of a democratic capitalist society, which made it incumbent upon reformers to gain the support of both the public and powerful business interests. Progressive health insurance was shaped by these political realities as well as the economics of sickness and health care of the time.

For the Progressives, the economic problem at the individual level involved both lost earnings and medical costs. Among individual workers, income losses appeared then to be greater than health care costs, but for families as a whole they were about the same. In a 1913 study, I. M. Rubinow—a doctor and actuary, a socialist, a founder of the AALL, and a leading authority on social insurance—put the average daily wage loss at $1.50 and average medical costs at $1.00 a day[8]; in 1916, B. S. Warren and Edgar Sydenstricker of the US Public Health Service estimated the daily wage loss at $2.00 and medical costs at $1.00.[9] The most exhaustive empirical investigation of the period, conducted for an Illinois health insurance commission, found that among wage earners sick one week or more, lost wages were four times the costs of medical care. However, for families with disabling illnesses in the course of a year, the difference was not as great because of the additional medical expenses of dependents: lost wages averaged $54.95 and direct outlays for medical care $43.03 (4.2 and 3.3 per cent, respectively, of average annual incomes of $1300). Among all families, including those that had no disabling illnesses, the wage loss and medical costs were about the same.[10]

The case for insurance rested on the unequal distribution of individual losses. The Illinois commission showed that a small proportion of families suffered large losses of income; one in seven men sick one week or more lost more than 20 per cent of annual earnings, not counting medical costs. Many such households were already at the edge of poverty when the breadwinner was healthy. The proportion who could not "make ends meet" increased to 16.6 per cent among families with serious illness, compared to 4.7 per cent among those without. Advocates of health insurance also cited data from charities indicating that sickness was the leading immediate cause of poverty; the Illinois commission, making one of the most conservative estimates, found it to be the chief factor in one-fourth to one-third of the charity cases in the state.[11]

To "eliminate sickness as a cause of poverty," as Rubinow defined the chief aim of health insurance, a compulsory system would distribute the losses not only among workers, but also among employers and the state since workers were not alone responsible for the conditions that caused sickness. Such a program had to be compulsory, he argued, to make it universal (that is, among low-income wage earners) and to secure contributions from employers and the public. A voluntary scheme would miss the majority of workers in need of income protection who simply could not afford the mutual benefit plans of fraternal societies and unions, much less the little commercial health insurance that was then available.[12] Yet most reformers were not advocating any radical transfer of income; they spoke of health insurance, like all social insurance, as a program primarily of income stabilization rather than income redistribution. The interest they claimed to represent was a public interest in preventing poverty and disease, not a special interest of labor. In fact, to their political embarrassment, the American Federation of Labor (though not all its member unions or state federations) opposed the program. Samuel Gompers, president of the AFL, repeatedly denounced compulsory health insurance as an unnecessary, paternalistic reform that would create a system of state supervision of the people's health. Gompers, who always insisted that workers had to rely on their own economic power rather than the state, was concerned that a government insurance system would weaken unions by denying them the function of providing social benefits, which in his own experience was a key to building trade union solidarity.[13]

There was, indeed, a solicitous, if not paternalistic, attitude implicit in the second half of the reformers' case for health insurance. In the language of the AALL's letterhead, health insurance had as its aim the "conservation of human resources," seen as analogous to conservation of natural resources. Irving Fisher, then one of the country's most eminent economists, argued in a presidential address to the AALL in 1916 that health insurance would have its greatest value in stimulating preventive measures and hence was needed not just "to tide workers over the grave emergencies incident to illness," but also "to reduce illness itself, lengthen life, abate poverty, improve working power, raise the wage level, and diminish the causes of industrial discontent."[14] Warren and Sydenstricker expected that by assigning insurance contributions to industry, workers, and the community, a compulsory insurance scheme would induce them to adopt public health measures to prevent disease and save money.[15] Reformers were, in short, suggesting that despite additional expenditures for treatment, prevention, and sick pay, health insurance would yield a net savings in social costs and accordingly greater economic efficiency.

This argument was meant to appeal to business. Earlier in the decade, many employers had concluded that the benefits of compulsory insurance against industrial accidents outweighed its costs. The increasing unpredictability of liability judgments had convinced them to accept a system of compensation that would limit and stabilize their losses. No such direct economic advantage interested them in health insurance, which they saw as a de facto rise in wages, and this difference decisively affected their response. The National Industrial Conference Board, a research organization established by major industrial trade associations, agreed that sickness was a serious handicap on the "social well-being and productive efficiency of the nation," but argued that direct investment in public health measures would have a higher return than investment in cash benefits for the sick. Compulsory health insurance would not "materially reduce the amount of sickness"; the incentives for prevention would not work because the responsibility for most sickness could not be fixed. Indeed, days lost from work might increase because sick pay encouraged malingering; the board cited statistics indicating days lost from work on account of sickness had increased in Germany after insurance was enacted. Nor would health insurance greatly reduce poverty. The figures suggesting sickness caused poverty ignored other causes; also, many charity cases would not have had health insurance because they were casual workers, self-employed, or unemployed. The large sums spent on health insurance would benefit only part of the population; in New York, the board calculated, the insurance bill would cover only one-third of the population.[16]

In response to criticism that health insurance was too costly, Progressive reformers answered that it involved no new cost at all. It merely distributed over society the income losses and medical costs that individual families already faced. Reformers did not talk of any need to spend more money or recognize any likelihood that health insurance might inadvertently increase social costs. They believed, however, that health insurance had to be properly designed to prevent abuses. In particular, sick pay represented a potentially serious cost-control problem. If patients were certified for sick pay by their doctor and had free choice of physician, certification might be all too easy to come by. Consequently, the AALL proposal recommended separating treatment from certification; the local funds charged with administering insurance were to employ physicians to do nothing but verify sick pay claims. In addition, reformers recommended that doctors be paid on a capitation basis rather than by visit; or, if paid by visit, that the local fund make such payments out of a fixed budget determined by the number insured in its area. European experience had clearly indicated that per capita arrangements were critical in maintaining limits on expenditures.[17]

The Progressive reformers also hoped to use health insurance to bring about even more radical changes in medical service than had been attempted elsewhere. Rubinow saw health insurance as an opportunity to encourage a shift from individual general practice to specialized group practice under governmental control.[18] Michael M. Davis, Jr., director of the Boston Dispensary, also advocated more specialism and organization. The initially positive response in 1915 of leaders of the American Medical Association to the AALL's approaches on health insurance encouraged Davis that America might be able to "improve on" Britain and Germany. In a letter to the AALL's John Andrews, he wrote that "we ought to aim to get started in such a way that we are not tied to a system of individualized private practice

without creating a definite opening for development along the lines of cooperative medical work in diagnosis and treatment." Davis added that he had "a good many ideas on organization" since visiting the Mayo Clinic.[19]

But physicians were unlikely to be enthusiastic about such ideas. They strongly objected to any form of "contract practice" (i.e., capitation payment) as a result of their experience with fraternal lodges and industrial firms that forced them to bid against each other for group business. Workmen's compensation had biased many of them against any kind of insurance. As private practitioners learned more about health insurance, their opposition mounted, and capitation payment, much less group practice, became politically unrealistic. Reformers attempted to placate professional opposition by surrendering to virtually all the physicians' demands, but the concessions were futile. The organized profession, which had shown an early interest in health insurance, became instrumental in its defeat.[20]

Reformers ran into perhaps their most implacable opponent, the insurance industry, also partly because of their desire to achieve new efficiencies in social organization. Progressive health insurance plans included a death or "funeral" benefit, amounting to $50 or $100. Today, the inclusion of such a benefit must seem odd, but it was crucial at the time. In the early twentieth century, life insurance companies sold "industrial" policies to working-class families that provided lump-sum payments at death generally used to pay for funerals and the expenses of the final illness. This industrial life insurance was the backbone of commercial insurance; both Metropolitan Life and Prudential had risen to the top of the industry by successfully marketing industrial policies. Out of small payments of 10, 15, and 25 cents a week, two of the largest financial institutions of the day had been built. But because the premiums were paid on a weekly basis and lapses were frequent, industrial insurance had to be marketed by an army of insurance agents who visited their clients, usually the women of the family, as soon after payday as possible. Consequently, the administrative costs of industrial insurance were staggering; the workers who bought the policies received in benefits only about 40 cents of every dollar they paid in premiums.[21] Yet the fear of a pauper burial was so great that the policies were extremely popular. According to Warren and Sydenstricker, a 1901 Bureau of Labor study of 2,567 families disclosed that 65.8 per cent had annual expenditures for such insurance averaging $29.55 per family, while 76.7 per cent had expenditures for sickness and death averaging $26.78 per family. Compulsory insurance would have entirely eliminated the huge cost of marketing industrial policies, not to mention the profits. Hence reformers claimed that they could finance much of the cost of health insurance out of the money wasted on industrial insurance policies.[22] In effect, instead of paying insurance agents to visit them weekly, wage-earning families could pay for doctors and nurses to visit them in sickness. So the inclusion of funeral benefits was not an idiosyncratic choice by Progressive reformers; it was part of their general program for increased social efficiency. Probably no other measure stimulated more opposition, since compulsory insurance would have pulled the rug from under the multi-million dollar industrial life insurance business. Ironically, compulsory health insurance failed to win the support of business and financial interests, not only because they found unpersuasive the claims for an efficiency dividend from effective prevention and treatment, but also because the greater efficiency of compulsory insurance threatened to eliminate an important source of profit for the insurance industry and of investment capital for American business.

Expansionary Health Insurance

The economic objectives and rhetorical appeals, as well as the content of health insurance proposals, changed by the time the idea was revived during the New Deal and even more so after World War II.

Between the 1930s and 1960s, reformers made several distinct efforts to enact compulsory health insurance. During the early New Deal, the planners of social security tried to persuade President Franklin D. Roosevelt to include health insurance in the new system. In the late 1930s, many of the same people backed renewed proposals for federal sponsorship of health insurance at the state level, where campaigns were also in progress. Then with the Wagner-Murray-Dingell bill, first introduced in Congress in 1943, and President Harry Truman's health program of 1945, advocates of government health insurance moved to a genuinely national plan. Finally, limiting their efforts to the aged and the poor, they ultimately secured the passage of Medicare and Medicaid in 1965. But despite important changes in strategy and substance, the insurance proposals throughout this period rested on some common assumptions about individual and social costs that distinguish them from plans of the Progressive era and those that emerged later in the 1970s.

First of all, reformers dropped the funeral benefit, to which they attributed much of the responsibility for the defeat of health insurance in the Progressive era. It no longer seemed worth the fight.

Second, by the 1930s reformers had become more concerned with medical costs than lost wages. The creation in 1927 of the Committee on the Costs of Medical Care (CCMC) underlined the shifting emphasis, even in its name. I. S. Falk, a member of the staff, estimated that medical costs were 20 per cent higher than lost earnings for families with incomes under $1,200 a year and nearly 85 per cent higher for families earning between $1,200 and $2,500. The relatively higher cost of medical care was "a new condition, different from what prevailed in other times and in other countries when they faced the problem of planning for economic security against sickness."[23] Reformers such as Falk continued to advocate cash benefits in sickness, but they proposed that it be entirely separated from health insurance, which now became almost exclusively concerned with medical services. Writing in 1937, Michael Davis commented, "The development of health insurance has shown a steady but slow change from the economic to the medical emphasis." Not only was medical care now a bigger item in family budgets than wage losses, but "medical care is also more important than income protection because the provi-

sion of adequate medical service, curative and preventive, holds large possibilities for relieving suffering and for the positive promotion of health and economic efficiency."[24]

Such premises led to a somewhat altered justification for health insurance. Two considerations now prevailed—increasing medical costs and unmet medical "needs." The costs of services were rising to the point that not only wage earners, but also people of "moderate means," were finding them hard to meet. And as a result of this economic barrier, society was failing to meet individuals' health care needs.

The rise in medical costs had its origins before the Progressive proposals had been made, but the impact of change was not yet fully felt nor clearly understood until the 1920s. The increase came in the costs of both physicians' services and hospital care, but especially the latter. The rise in physicians' costs had two sources: improvement in the quality of services, as a result of scientific advance and increased investment in required education, and increasing monopoly power, as a result of licensing restrictions and other practices that by the 1920s were giving doctors significantly higher returns than their investment in education would have justified.[25] The rise in hospital costs had its origins in the complete transformation in the nature of hospital care. Before 1870, hospitals were caretakers for the chronically ill, operating on a low-budget basis as charities, but as they became centers for surgery and acute medical work, their construction and operating costs soared beyond the capacity of charity to support them. As hospital care became more common and as hospitals increasingly derived more of their income from services to patients, hospital charges grew.[26] But their cost was still relatively low when the insurance plans of the Progressive era were formulated. Among 211 families surveyed in 1918 in Columbus, Ohio, by the US Bureau of Labor Statistics, hospital costs averaged only 7.6 per cent of a total medical bill averaging $48.41 (of which about half went to physicians).[27] Consequently, the Progressives gave relatively little attention to hospital costs or the problems of hospital reimbursement. By 1929, according to the CCMC, hospital costs (not including doctors' and private nurses' hospital bills) were 13 per cent of a total family medical bill averaging $108.[28] In 1934, Davis put hospital bills and physicians' bills for in-hospital services at 40 per cent of total family medical costs. However, the key point, as Davis observed, was not just the growing average cost of medical care, but the increasing *variance* of costs as a result of exceptionally high hospital bills in a small number of serious illnesses. This new situation was responsible for the middle-class complaints that had focused attention on the problem of rising medical costs *before* the Depression. "In former years," Davis wrote, "when the range of sickness costs was lower, and few illnesses caused high expenditures, families with middle-class incomes felt financial pinch due to sickness much less frequently than today. Now, people who are economically secure, humanly speaking, are not secure against the costs of sickness. Thus, the economic problems of medical care now implicate not merely wage earners but the whole population, except the 5 per cent with the largest incomes."[29]

It was, of course, precisely in this period that voluntary insurance, primarily against hospital costs, began to emerge as the predominant form that health insurance would take in America—a far cry from what Progressive reformers had intended. But as hospital charges were rising for patients, the hospitals in the Depression faced a financial crisis of their own, and they actively cooperated in creating Blue Cross plans as a means of meeting it.[30] In fact, it might be said that while advocates of a government program were trying to improve the access of patients to medical care, the founders of Blue Cross succeeded in improving the access of hospitals to patients.

Most advocates of health insurance regarded the social costs of medical care, estimated by the CCMC at about four per cent of national income, as not at all excessive.[31] Indeed, the reformers believed that people needed more medical care than they were receiving. Beginning with the CCMC, policy analyses typically began with estimates of the "need" for medical care or the "health needs" of the nation.[32] According to the CCMC, the need for medical care, as defined by professional standards, was higher than the rate of utilization even among the highest income group[33]; thus, presumably everyone needed more, and America would have to devote more of its resources to health care. In fact, instead of health insurance merely being a means of covering existing costs, as the Progressives had seen it, reformers now spoke of insurance as a way of budgeting larger expenditures. In the Introduction to the CCMC's final staff report, committee chairman Ray Lyman Wilbur wrote, "More money must be spent for medical care; and this is practicable if the expenditures can be budgeted and can be made through fixed, periodic payments—even as people are enabled to spend more for other commodities by installment than by outright purchase."[34] Falk, too, wrote that "the same procedures which will distribute sickness costs . . . will enable people to budget them and therefore spend more money for useful health and medical services, and will also provide larger and more assured incomes for those who render medical services."[35] And President Truman, introducing his program in 1945, cited the estimate that Americans spent four per cent of their income on medical care and declared, "We can afford to spend more for health."[36]

Thus health insurance was evolving from a means of distributing wage losses and medical costs into an expansionary financing measure. Its chief concern became increasing access to health care rather than income protection. And whereas the Progressives had been thinking of insurance for low-income workers, reformers now had in mind the middle class as well. By Truman's proposal, national health insurance was to cover salary as well as wage earners, self-employed businessmen, professionals, domestic and farm workers, and the poor in one comprehensive system.[37]

The proposals became expansionary in another sense: they dropped the cost-controls that the Progressives had wanted, such as capitation payment, and the earlier interest in organizational reform. Stung by the successful opposition of the medical profession in 1918–1920, reformers during the New Deal and after promised repeatedly that health insurance would not mean "socialized medicine." The Falk of 1936 did not sound like the Rubinow of 1916. Whereas

Rubinow openly suggested that a state-administered medical system was ultimately the best solution, Falk insisted that health insurance was antithetical to state medicine: "Health insurance is not a system of medical practice . . . It is always and everywhere consistent with the private practice of medicine."[38] Truman stated that under his plan "our people would continue to get medical and hospital services just as they do now." Hospitals and doctors would be permitted to choose whatever method of remuneration they desired; and, furthermore, doctors would have a right to expect higher average incomes.[39]

The desirability of expanding medical services and a general willingness to accommodate the interests of doctors and hospitals characterized almost all public and private programs in this period. National health insurance proposals only reflected the general climate. Especially after World War II, when the federal government began extensively subsidizing hospital construction and medical research, public policy took as its principal objective the expansion of needed medical resources. Rather than correcting distributional inequities, the policies favored growth—a characteristic of most American social policy, particularly in the postwar era.

The same expansionary premises characterized the private health insurance system and the policies the federal government adopted toward it. The government aided the spread of private insurance by excluding health insurance benefits from wage controls during World War II and by excluding employers' contributions to health insurance from taxable income. The tax exemption for employers' contributions (now worth about 40 per cent of the value of health insurance premiums to the average family, making it one of the largest federal expenditures on health care) became a growing insurance subsidy primarily for the middle class and unionized workers. The effect of the exemption was to encourage employees to take wage increases in fringe benefits for health insurance rather than cash; the exemption thus pumped money into medical care. Moreover, the private insurers, competing with one another, exerted no countervailing power against physicians and hospitals: antitrust laws forbade them from joining together to limit fees and rates. It was easier for insurance companies to raise their own rates than to pursue effective cost controls; besides, the higher the total volume of expenditures, the greater their profits. The long-run outcome was a system of health insurance that channeled a growing proportion of national income into health care and in no way infringed on the physicians' prerogatives to set prices and control their work.

Medicare and Medicaid did not fundamentally change this pattern. Although the government filled some of the gaps in the private insurance system, it followed the same pattern of accommodation to professional and institutional interests by not challenging the established payment system. Medicare, in particular, provided extremely favorable terms for reimbursing both doctors and hospitals. Payment to physicians was based on the history of their past charges and the level of fees in their communities; hence doctors had every incentive to push up their fees to raise the allowable levels of reimbursement. They could also choose to charge patients more than Medicare would pay. Medicare reimbursed hospitals on the basis of their costs, and allowed the hospitals to choose whichever of two means of computing their costs was most favorable to them. By paying hospitals according to their costs, Medicare did not discourage them from having higher costs, since higher costs would mean higher reimbursements.[40] Medicaid allowed nursing homes to figure depreciation into their costs and encouraged an elaborate legal game of buying and selling homes at increasingly extravagant prices to jack up their rates.[41] That such arrangements contributed to a huge surge in medical, hospital, and nursing home costs—from 5.9 to 9.1 per cent of the gross national product (GNP) between 1965 and 1979—should have surprised no one.[42]

Not all of the increase in social costs in the decades after World War II can be attributed to the insurance system. The new public investment programs in hospitals and research played a part, as did the general growth in technological development and public expectations. In the same period, almost all the major industrial nations saw dramatic increases in the share of their resources devoted to medical care. But two sources of evidence indicate that financial and organizational structures matter a great deal. The most dramatic exception to the inflationary pattern in medical costs has been Great Britain. With a national health service providing free care to its entire population, the British have nonetheless been able to hold medical costs to about five per cent of their GNP. (Nor does the existence of a private sector in British medicine contradict the pattern of containment: private services account for only about five per cent of the total.) The medical budget in Britain is set at the national level and must compete for funds with defense, education, and other areas; in America, medical expenditures are fragmented and even much of the public expenditure, under Medicare and Medicaid, is administratively uncontrollable.

The other dramatic example of successful cost containment has, of course, been the American prepaid health plan (or "health maintenance organization"), where costs have run 20 to 30 per cent below fee-for-service medicine, primarily because of reduced hospitalization.[43] Like the British system, the prepaid plans have a single fixed budget that places constraints on professional decision-making; they also have to negotiate rates with large groups of subscribers. The evidence suggests that without the constraints provided by concentrated budgeting and countervailing power, whether at the national or organizational levels, costs are almost impossible to control.[44]

But America turned away from the type of system that would have provided these cost-control mechanisms. Earlier in the century there were alternatives to private insurance for spreading individual medical costs. The prepayment systems, such as contract practice in mutual benefit societies and later prepaid group practice plans, represented nongovernmental health services with fixed budgets. But these forms were bitterly opposed by private practitioners, partly because they gave organized consumers greater countervailing power in the market. "Contract practice" survived only as long as there were struggling young physicians willing to take positions. As the profession's market power increased

with the falling supply of doctors in the wake of the Flexnerian cutback in medical education, there were fewer practitioners willing to accept contracts with fraternal lodges and employers; the fraternal and company plans also suffered because of their status as second-class medicine. The prepaid group practice plans, which began in the 1930s as medical cooperatives, aroused boycotts and blacklists by local medical societies. Even though these actions resulted in a conviction of the AMA under the Sherman Antitrust Act, professional resistance generally succeeded in preventing prepaid plans from proliferating. The plans also faced difficulties in meeting start-up costs, as did Blue Cross. But Blue Cross plans had the aid of hospitals in underwriting their risks, cooperation from the medical profession, and favorable state legislation. Some states, under professional pressure, outlawed prepared group practice plans entirely.[45]

Whether national health insurance would have controlled costs more effectively than private insurance depends on when it might have been enacted and what direction it would have taken. A plan enacted along the lines of the earlier Progressive proposals, with capitation payment and/or fixed local budgets for medical services, might have held down physicians' costs. But like the English system, it would have later faced difficulties in its relations to hospitals; and only if the principle of fixed budgeting had been maintained might it have been able to control costs. On the other hand, the health insurance plans of the expansionary phase might well have landed us in as deep water as we are now, though such a system would have made the costs more politically visible earlier and might have prompted a more effective response.

The campaign for health insurance in America failed, in any event, because the political conditions that brought about its adoption in Europe were not replicated here. In Europe social insurance emerged from the conflict between socialist movements and conservative regimes with a paternalistic tradition of social legislation. In America, there was neither the powerful socialist movement from below nor the paternalistic or authoritarian regime above. And, indeed, the history of health insurance betrays a lack of both popular support from underneath and unified elite sponsorship from on top. The calculations of cost partly derive from political conditions: had there been more of a socialist challenge here, business might have changed its estimate of the benefits of health insurance.

But the repeated defeat of national health insurance did not prevent the United States from gradually adopting a national health insurance policy. By the end of the expansionary phase, the US had a program of tax subsidies for the middle- and upper-income employees with private insurance; a program of compulsory hospital insurance and subsidized voluntary medical insurance for the aged; and a noncontributory, federally subsidized state insurance program for the poor. This system was not universal, and it certainly was not progressive. Perhaps one-tenth of the population still had no insurance, and much of the private insurance provided inadequate coverage. Still, it was a system, and with only marginal changes it could cover the entire population. But before it could be made universal, it was overtaken by the problems of social cost that it had helped create.

Containment Health Insurance

In the mid-1970s, America entered a new stage in the history of health insurance. Many people may be puzzled by that remark. After all, no national health insurance program was adopted, nor was there any fundamental reorganization of medical services. One might well be impressed by the continuity of historical experience: the recurrence once again in the 1970s of campaigns for reform and the expectation that their triumph was inevitable, followed by their defeat and the persistence of existing institutions. This continuity is unmistakable. But while Americans continued discussing national health insurance and the economic problems of medical care, what they were discussing once again changed. The center of debate moved from distributing individual medical costs to controlling the social costs of medicine, and with that shift came fundamental changes in their assumptions and outlook for the future.

Until recently, there was little thought that the share of national income going to health care was excessive. Government and foundation reports well into the 1960s generally presumed the wisdom of increased investment in health care. Hospital construction, medical research, and medical education continued to receive subsidies for expansion. The problem of medical costs was understood fundamentally to be a problem of their uneven incidence over individuals and over time—the solution for which was insurance.

The dispute over the extent and control of insurance obscured a more basic consensus in the postwar period that third-party, fee-for-service payment was an appropriate and sufficient means of managing medical expenses. In the 1970s that belief broke down, and many concluded that the method we use to spread individual costs increases social costs unacceptably. Even though the problem of equitably distributing costs (and services) remains, the chief preoccupation now is how social costs may be limited.

It hardly needs pointing out that the concern with cost control reflects the condition of the economy and particularly the uneasiness over inflation. As one of the four most inflationary sectors of the economy (the others have been energy, food, and housing), medical care is an inevitable target of anti-inflation policies. But even if fiscal and inflationary pressures were to subside, the search for cost restraints in medical care would persist. For medical costs cause concern not only because of their magnitude, but also because of increasing skepticism about their legitimacy. The studies, frequently reported in the press, of unnecessary surgery, excess hospital capacity, duplication of technology, and so on reflect a crisis of confidence in the value of medical services and methods of resource allocation. Similar doubts now surround education, welfare programs and many other areas of social policy. Rising costs and diminished confidence set the debate about health insurance today in a new context: the old reformers, as well as the physicians, took the value of medical care for granted. They just wanted

more of it for everybody. Now reformers want less of some services, more of others, but most of all, control of what it all adds up to.

The rising costs of medical care have also now begun to disturb some powerful institutions that feel the brunt of them. Corporations object to the burgeoning costs of fringe benefits for health care; General Motors, for example, has been widely (though mistakenly) publicized as paying more to Blue Cross than to any steel manufacturer or other supplier. Unions, too, are uneasy: they find it harder to secure pay increases for their members because the "fringes" soak up so much of their gains. Faced by these pressures, both corporations and unions have been agitating for effective cost controls. The federal government has also faced fiscal pressures as a result of soaring costs in uncontrollable health programs. Medicare and Medicaid both provide an entitlement to coverage without limitation as to total cost. By fiscal year 1977, for example, Medicare and Medicaid outlays were double what they had been only three years earlier. Nor was the problem restricted to the federal government. In Los Angeles County, medical costs to the indigent increased from 24 to 42 per cent of property tax revenues between 1968–69 and 1975–76. The rise of medical costs thus played a part in the California tax revolt of the late 1970s. State after state was forced to make cutbacks in health programs as medical costs increased.[46]

In the debate on national health insurance, which revived at the close of the 1960s, the social costs of medical care became a dominant concern only during and after the 1974–75 recession. The early '70s saw a profusion of expansionary health insurance proposals. Sensing public pressure, the Nixon Administration presented its own alternative to the comprehensive public insurance system advocated by Senator Edward M. Kennedy. The Nixon plan would have mandated coverage by private employers—a regulatory approach to expanding health insurance that relied on copayments and other benefit limitations to control expenditures. Even the AMA felt obliged to advance a proposal for income-scaled tax credits to cover the premium cost of the "catastrophic" portion of health insurance. Unlike the Administration's proposal, the AMA approach would have kept private insurance voluntary. This plan, as well as a proposal supported by the American Hospital Association, had few significant cost controls.[47]

With all sides acknowledging the need for change, observers widely believed that passage of some plan was imminent and that the only question was which kind. There appeared to be clear progress toward a political compromise. Between 1971 and 1974, the Nixon Administration moved toward a plan that was significantly more liberal in its benefits. By 1974, the estimated cost was about equal to the plan proposed by Senator Kennedy. "I consider the total [cost] as not a very significant figure," said Caspar Weinberger, Secretary of Health, Education, and Welfare (HEW), at a press conference in February 1974.[48] For his part, Senator Kennedy had joined with Representative Wilbur Mills, then the powerful chairman of the House Committee on Ways and Means, to support a plan that was more accommodating to the private insurance industry. In June 1974 Senator Kennedy announced, "A new spirit of compromise is in the air" and suggested a bill could reach the President's desk by the fall.[49] But the Watergate crisis prevented its enactment and soon the careers of both President Nixon and Representative Mills ended in political scandal. In addition, Kennedy had been unable to swing labor behind the Kennedy-Mills proposal; without any support from its natural constituency, the compromise plan had no chance in Congress.

During the second half of the 1970s, a stalling economy also stalled the movement for national health insurance. In 1975, President Gerald Ford did not resubmit the Nixon health insurance plan on the grounds that it would exacerbate inflation. That same year, the AMA withdrew its support for the tax credit proposal. Labor and other supporters of a public insurance system decided to pass up opportunities for incremental legislation (e.g., to cover the unemployed) in the hope of a breakthrough after the next election. But even though presidential candidate Jimmy Carter had pledged himself to a universal health insurance plan, President Carter was reluctant to press for a specific proposal because of inflation and slow economic growth. Ambivalent and timid, the Carter Administration let health insurance get backed up behind its proposals for welfare reform and hospital cost containment.[50]

However, during these years of impasse, the positions of liberals and conservatives underwent further evolution. On both sides there emerged proposals to combine national health insurance with a more general reorganization of the medical industry in the interests of cost control. In 1979, Senator Edward Kennedy—this time with the support of the AFL-CIO and other liberal organizations—introduced a compromise proposal that would have provided universal coverage while retaining private insurance plans. The new Kennedy initiative—basically a voucher system—incorporated many of the suggestions of market-oriented critics of the health industry aimed at fostering greater competition and rational decision-making. Yet it also retained redistributive and planning mechanisms to achieve equity as well as cost containment. Introducing the proposal, Senator Kennedy predicted a "cross-over point" four years after enactment when the new system would cost less than if Congress allowed the present, incomplete insurance system to continue.[51]

Unwilling to accept Kennedy's leadership and under pressure to come up with its own plan, the Carter Administration finally adopted an incremental proposal to phase in national health insurance gradually as economic conditions permitted. It also included new regulatory and incentive mechanisms to contain costs, but there was a basic difference in outlook from the Kennedy plan. Kennedy saw national health insurance as an opportunity to reconstitute the health system on a new framework of incentives and bargaining relationships; improvements in cost control would accompany improvements in access. Hence national health insurance could resolve problems of individual and social cost simultaneously. Carter, on the other hand, regarded national health insurance as an onus the system could bear only if cost controls preceded it and the economy prospered. Hence the Administration approached a plan

reluctantly and never actively sought its enactment.

A more strictly market approach to national health insurance was meanwhile presented by Alain C. Enthoven, a Stanford economist and member of the Reagan transition team who developed his proposal originally as a consultant to HEW Secretary Joseph Califano. The basic principles of the Enthoven proposal—modeled after the Federal Employees' Health Benefits Program—are: 1) multiple choice among competing private insurance and prepayment plans; and 2) "fixed-dollar" public subsidies to consumers through vouchers and tax credits. "The subsidy might be more for the poor than for the nonpoor, for old than for young, for families than individuals, but not more for people who choose more costly health plans," Enthoven wrote in his book *Health Plan,* modestly subtitled "The Only Practical Solution to the Soaring Cost of Medical Care."[52] Indeed, so vigorous have Enthoven's efforts been to associate the proposal with cost containment that some who have heard of it may not realize it is a national health insurance plan which, in its basic assumptions, is not significantly different from Kennedy's most recent proposal and from analogous "voucher" plans for education often favored by left-wing critics of the public schools.

At the end of the 1970s, all the major new national health insurance proposals were almost inseparably plans for cost containment. In the early '70s, conservative proposals either echoed trade association views or offered limited additions to private insurance. By the late '70s, some conservative health advisors adopted a market model of national health insurance that involved extensive structural change in the health industry. And, whereas at the beginning of the decade Senator Kennedy had favored a public insurance system with regulation from the "top" to control costs, by the decade's end he too accepted a system of private plans with a greater emphasis on incentives.

But while a new conception of national health insurance was emerging at the close of the 1970s, the bottom dropped out of the movement's political support. In the wake of Ronald Reagan's election, all such plans are off the national agenda. Conservatives no longer feel obliged to propose any version of national health insurance, and a good part of the progressive coalition has abandoned the idea in favor of a national health service. Ironically, both conservatives and many radicals agree that national health insurance would be unable to restrict cost increases. The conservatives see more health insurance as likely to reduce the cost-consciousness of patients, while the radicals lay the blame not on patients, but on the power and profit-mindedness of the providers. Between these convergent antagonists are the weary and divided advocates of national health insurance, trying to redefine the movement for an era of cost containment and conservative skepticism of social reform.

From the beginning, advocates of health insurance have tried to make a case for its economic rationality. In the Progressive era, the case rested on promised reductions in the social costs of illness and insurance and improvements in the productive efficiency of labor. This argument did not win reformers the support they anticipated. During the expansionary phase of health insurance, reformers still referred to the gains in efficiency from improved health, but the point became less central and the gains were expected to come from better treatment of illness rather than financial incentives for public health or the elimination of industrial insurance. Recently, health insurance supporters have revived the notion that reform will yield savings, but the savings now are to come primarily from eliminating unnecessary medical services rather than a more efficient and healthy population.

This new phase, however, creates its own distinct tensions. To make national health insurance into an instrument of cost containment—or, to use the voguish term, "rationing"—threatens its popular appeal. For however important questions of efficiency have been, questions of equity have always been the true moral basis of health insurance as a social movement. Today, however, health insurance seems less like a moral cause than an argument about economic management. What once would have been a statement of social equality is now, if carried out, likely to be an effort of financial rationalization. Like some of its advocates, the idea of national health insurance has passed from an idealistic youth to a kind of grim maturity.

FOOTNOTES

1. I use the current term "national health insurance" in a generic sense to cover the various government-sponsored health insurance programs proposed since the Progressive era, even though the earliest plans were introduced into state legislatures rather than Congress.
2. These terms require some explanation.

   1) "Individual income and other indirect losses" should ideally include the unpaid time of family members lost in caring for the sick as well as income lost during sickness and from diminished earning capacity thereafter; however, estimates cited below include only lost wages. Moreover, individual losses, as usually conceived, include only those losses from sickness in an individual's own household, not the indirect losses from sickness in other households. Consequently, the sum of individual income losses does not equal the social costs of sickness. The costs to society would include reduced productivity among temporarily sick workers who nevertheless receive their customary wages. On the other hand, there is no social cost if one worker loses income on account of sickness but is replaced by another, otherwise unemployed, unless the new worker needs to be trained or is less productive.

   2) Most estimates of individual medical costs cited below include only private medical expenditures (i.e., payments out of pocket and for insurance), whereas estimates of the social costs of medical care also include tax revenues spent on medical services. A more complete estimate of the social cost might include the opportunity cost of capital invested in the health sector that might be more productively invested elsewhere.
3. See Flora P, *et al:* "On the Development of the Western European Welfare States," paper prepared for the International Political Science Association, Edinburgh, August 16–21, 1976, p. 22.
4. Rimlinger GV: Welfare Policy and Industrialization in Europe, America and Russia (New York: John Wiley, 1971).
5. Gilbert BB: British Social Policy, 1914–1939 (London: B.T. Batsford, 1970), p. 15; see also Gilbert's earlier book, The Evolution of National Insurance in Great Britain (London: Michael Joseph, 1966), chapters 6 and 7.
6. For the AALL's "standard bill," see American Labor Legislation Review 6 (1916), 239–268. On the background of the AALL, see Irwin Yellowitz: Labor and the Progressive Movement in New York State, 1897–1916 (Ithaca, NY: Cornell University Press, 1965), pp. 55–59. For a general treatment of the entire Progressive social insurance movement, see Roy

Lubove: The Struggle for Social Security 1900–1935 (Cambridge: Harvard University Press, 1970).

7. Yellowitz: Labor and the Progressive Movement, p. 85. Progressivism contained quite divergent tendencies, of which the "social Progressives" represent only one—and even they are difficult to characterize. For some major accounts of the Progressive period, see Hofstadter R: The Age of Reform: From Bryan to F.D.R. (New York: Random House, 1955); Mowry GE: The Era of Theodore Roosevelt and the Birth of Modern America, 1900–1912 (New York: Harper & Row, 1958); and Weinstein J: The Corporate Ideal in the Liberal State: 1900–1918 (Boston: Beacon Press, 1968); and for a contentious essay arguing that Progressivism was too diverse to be described as a movement, see Filene PG: An Obituary for 'The Progressive Movement,' American Quarterly 22 (1970), pp. 20–34.
8. Rubinow IM: Social Insurance (New York: Henry Holt, 1916), p. 214.
9. Warren BS, Sydenstricker E: Health Insurance: Its Relation to Public Health, Public Health Bulletin, No. 76 (March 1916), p. 6.
10. Report of the Health Insurance Commission of Illinois, May 1, 1919, pp. 15–17, 204–211.
11. Ibid., pp. 18–22.
12. Rubinow: Social Insurance, pp. 264, 248–49, 281–298.
13. For an acrimonious confrontation between the socialist and conservative union viewpoints, see the testimony of Rubinow and Gompers and the exchanges between them in US Congress, House Committee on Labor, Hearings Before the Committee on H.J. Resolution 159 . . . April 6 and 11, 1916, 64th Cong., 1st sess., pp. 36–45, 122–189. For Gompers' position, see also Samuel Gompers: Trade Union Health Insurance, America Federationist 23 (November 1916), 1072–74; Compulsory Sickness Insurance, The National Civic Federation Review 5 (April 1, 1920), p. 8; and Philip Taft: The A.F. of L. in the Time of Gompers (New York: Harper and Row, 1957), pp. 364–365.
14. Fisher I: The Need for Health Insurance, American Labor Legislation Review 7 (March 1917), pp. 17–23.
15. Warren and Sydenstricker: Health Insurance: Its Relation to Public Health, p. 5. For the suggestion that the costs of sickness be calculated on the basis, not of lost earnings and medical expenses, but of the cost of "the services and equipment that suffice to prevent sickness," see Haven Emerson: The Social Cost of Sickness, American Labor Legislation Review 6 (March 1916).
16. National Industrial Conference Board: Sickness Insurance or Sickness Prevention? Research Report No. 6, May 1918. For similar arguments, see Frank F. Dresser: Suggestions Regarding Social Insurance, An Address Before the Conference on Social Insurance, Washington, DC, Dec. 4–9, 1916, National Association of Manufacturers pamphlet 46.
17. Alexander Lambert, medical advisor to the AALL and chairman of the AMA's social insurance committee, favored payment by visit under a fixed budget for physicians' services. See Lambert: Organization of Medical Benefits and Services Under the Proposed Sickness (Health) Insurance System, *in*: US Department of Labor, Proceedings of the Conference on Social Insurance (Washington, DC: Govt Printing Office, 1917), pp. 655–659. The California insurance commission recommended capitation payment. See Report of the Social Insurance Commission of the State of California, March 1919 (Sacramento: California State Printing Office, 1919), p. 11.
18. Rubinow: Social Insurance, pp. 271–272.
19. Davis MM Jr, to Andrews JB, July 21, 1915, *in* Papers of the American Association for Labor Legislation, 1905–1945 (Glen Rock, NJ: Microfilm Corporation of America, 1973), Reel 14.
20. See Numbers R: Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912–1920 (Baltimore: John Hopkins University Press, 1978).
21. Rubinow: Social Insurance, p. 420; Marquis James: The Metropolitan Life: A Study in Business Growth (New York: The Viking Press, 1974), pp. 73–93. As of 1915, Metropolitan held 34 per cent and Prudential 38 per cent of all industrial business. James, pp. 171–172.
22. Warren and Sydenstricker: Health Insurance, p. 54; Rubinow: Social Insurance, p. 420.
23. Falk IS: Security Against Sickness (Garden City, NY: Doubleday, Doran & Co., 1936), pp. 14–16.
24. Davis MM Jr, preface to Millis HA: Sickness and Insurance (Chicago: University of Chicago Press, 1937), p. v.
25. Friedman M, Kuznets S: Income from Independent Professional Practice (New York: National Bureau of Economic Research, 1945); for an analysis of the process by which physicians transformed their growing cultural authority into economic power—a much more complex process than just limiting entry into the market—see my analysis in The Social Transformation of American Medicine (New York: Basic Books, forthcoming 1982).
26. For a contemporary account of rising costs, see Goldwater SS: The Cost of Modern Hospitals, National Hospital Record 9 (November 1905), pp. 39–48.
27. Ohio Health and Old Age Insurance Commission: Health, Health Insurance, Old Age Pensions (Columbus, Ohio, 1919), p. 116.
28. Falk IS, Rorem R, Ring MD: The Cost of Medical Care (Chicago: University of Chicago Press, 1933), p. 89. The estimate was only for private expenditures; figuring in tax money spent on hospital care, the proportion of social costs for hospital care rose to 23 per cent (p. 19).
29. Davis MM Jr: The American Approach to Health Insurance, Milbank Memorial Fund Quarterly 12 (July 1934), p. 211, 214–215.
30. Reed LS: Blue Cross and Medical Service Plans (Washington, DC: Federal Security Agency, 1947).
31. e.g., Falk, Security Against Sickness, p. 20.
32. See Falk, Rorem and Ring: The Cost of Medical Care, pp. 25–58, 70–79; Reed LS, Health Insurance: The Next Step in Social Security (New York: Harper and Brothers, 1937), pp. 21–33; Interdepartmental Committee to Coordinate Health and Welfare Activities: A National Health Program: Report of the Technical Committee on Medical Care, *in* Proceedings of the National Health Conference, Washington, DC, July 18–20, 1938 (Washington, DC: Govt Printing Office, 1938), 29–64; National Health Assembly, America's Health: A Report to the Nation (New York: Harper and Brothers, 1949), passim.
33. Falk, Rorem and Ring: The Cost of Medical Care, pp. 73–76; Committee on the Cost of Medical Care, Medical Care for the American People (Chicago: University of Chicago Press, 1932), p. 7.
34. Introduction, *in* Falk, Rorem and Ring: The Cost of Medical Care, pp. vi–vii.
35. Falk: Security Against Sickness, p. 358.
36. A National Health Program: Message from the President, Social Security Bulletin 8 (December 1945), p. 8.
37. Ibid.
38. Falk: Security Against Sickness, p. 359.
39. National Health Program, p. 11; Altmeyer AJ: How Can We Assure Adequate Health Service to All the People? Social Security Bulletin 8 (December 1945), p. 15.
40. On the accommodation of the hospitals and doctors, see Marmor TR: The Politics of Medicare (Chicago: Aldine, 1973), pp. 85–88; and Feder JM: Medicare: The Politics of Federal Hospital Insurance (Lexington, MA: Lexington Books, 1978).
41. See Vladeck B: Unloving Care: The Nursing Home Tragedy (New York: Basic Books, 1980).
42. Worthington NL: National Health Expenditures, 1929–74, Social Security Bulletin 38 (1975), p. 5; the estimate for 1979 was a preliminary figure from Rice D, National Center for Health Statistics, October 1979. On the general origins of health care inflation, see Enthoven AC: Consumer-Choice Health Plan, N Eng J Med 298 (March 23, 1978), pp. 650–658. For an expanded version of the argument presented here, see Starr P and Esping-Andersen G: Passive Intervention, Working Papers for a New Society (July/August 1979), pp. 15–25.
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dispute. For views on the question, see Roemer MI, Shonick W: HMO Performance: The Recent Evidence, Health and Society 51 (September 1973), pp. 271–318; Gaus C, Cooper BS, Hirshman CG: Contrasts in HMO and Fee-for Service Performance, Social Security Bulletin 39 (May 1976), pp. 3–14; and Luft HS: How Do Health Maintenance Organizations Achieve their 'Savings'; Rhetoric and Evidence, N Eng J Med 298 (June 15, 1978), pp. 1336–1343.

44. For more on this point, see my discussions in The Undelivered Health System, The Public Interest (Winter 1976), pp. 66–85; and Controlling Medical Costs Through Countervailing Power, Working Papers for a New Society 5 (Summer 1977), 10 ff.
45. On the aid to Blue Cross, see Reed: Blue Cross and Medical Service Plans; on prepaid group practice, Hansen HR: Group Health Plans: A Twenty-Year Legal Review, Minnesota Law Review 42 (1958), 527–548.
46. Enthoven: Consumer-Choice Health Plan, p. 650; Iglehart J: The Rising Cost of Health Care—Something Must be Done, But What? National Journal (October 16, 1976), 1458–65.
47. Davis K: National Health Insurance (Washington, DC: The Brookings Institution, 1975), ch. 5.
48. The New York Times, Feb. 8, 1974.
49. Insuring the Nation's Health, Newsweek, June 3, 1974. See also Rivlin AM: Agreed: Here Comes National Health Insurance, The New York Times Magazine, July 21, 1974.
50. For an inside account, see Heineman BW Jr, Hessler CA: Memorandum for the President (New York: Randon House, 1980), 266–301.
51. Press conference, May 14, 1979.
52. Enthoven AC: Health Plan (Reading, MA: Addison-Wesley, 1980), xxii.
53. A proposal for a national health service was introduced in the US House of Representatives in March 1979 by Rep. Ronald Dellums and eight cosponsors. See HR 2969, 96th Congress, 1st Session, and Congressional Record, March 19, 1979, H1453–1457.

Editor's Note: Due to the unusual nature and completeness of the author's Footnotes, we are publishing them as submitted, realizing that they do not follow the usual reference format of the Journal for articles and public health briefs. The Journal is grateful to Professor Starr for this historical review of national health insurance.

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