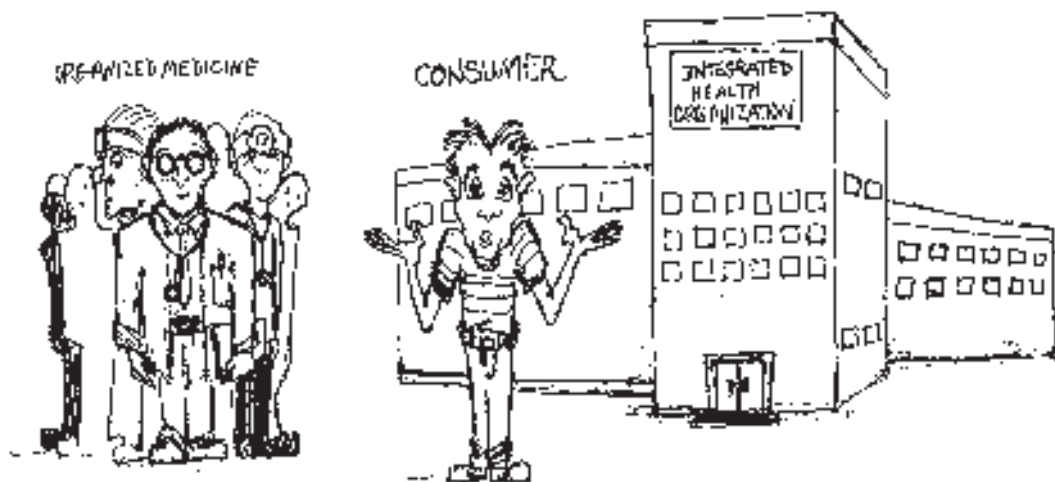


## Chapter 3

# The Evolution of Health Services in the United States

### Learning Objectives

- To discover historical developments that have shaped the nature of the US health care delivery system
- To evaluate why the system has been resistant to national health insurance reforms
- To explore developments associated with the corporatization of health care
- To speculate on whether the era of socialized medicine has dawned in the United States



*"Where's the market?"*

## Introduction

The health care delivery system of the United States evolved quite differently from the systems in Europe. American values and the social, political, and economic antecedents on which the US system is based have led to the formation of a unique system of health care delivery, as described in Chapter 1. This chapter discusses how these forces have been instrumental in shaping the current structure of medical services and how they are likely to shape its future. The evolutionary changes discussed here illustrate the American beliefs and values (discussed in Chapter 2) in action, within the context of broad social, political, and economic changes. Because social, political, and economic contexts are not static, their shifting influences lend a certain dynamism to the health care delivery system. Conversely, beliefs and values remain relatively stable over time. Consequently, in the American health care delivery experience, initiatives toward a national health care program have failed to make significant inroads. However, social, political, and economic forces have led to certain compromises, as seen in the creation of Medicare, Medicaid, and other public programs to extend health insurance to certain defined groups of people. Could major social or economic shifts eventually usher in a national health care system? It is anyone's guess. Given the right set of conditions, a national health care system could become a reality in the United States, as recently seen with the passage of the Patient Protection and Affordable Care Act (ACA) of 2010, which promises to reduce the number of uninsured by 32 million (Henry J. Kaiser Family Foundation 2011). Cultural beliefs and values are strong forces against attempts to initiate fundamental changes in the financing and

delivery of health care. Therefore, enactment of major health system reforms requires consensus among Americans on basic values and ethics (Kardos and Allen 1993). Ironically, American beliefs and values were not allowed a chance to play out in the political maneuvering that led to the passage of the ACA of 2010 (see Chapter 13).

The growth of medical science and technology (discussed in Chapter 5) has also played a key role in shaping the US health care delivery system. Stevens (1971) points out that the technological revolution has been primarily responsible for bringing medicine into the public domain. Advancement of technology has influenced other factors, as well, such as medical education, growth of institutions, and urban development. Hence, American medicine did not emerge as a professional entity until the beginning of the 20th century, with the progress in biomedical science. Since then, the US health care delivery system has been a growth enterprise. Debates over issues such as methods of financing health care, quality improvement, and the appropriate role of government have also been rooted in the presumed importance of gaining access to ever-rising levels of scientific medicine (Somers and Somers 1977).

This chapter traces the evolution of health care delivery through three major historical phases, each demarcating a major change in the structure of the delivery system. The first phase is the preindustrial era from the middle of the 18th century to the latter part of the 19th century. The second phase is the postindustrial era beginning in the late 19th century. The third, most recent and current phase, is marked by the growth of managed care, organizational integration, the information revolution, and globalization, called the corporate era.

The practice of medicine is central to the delivery of health care; therefore, a major portion of this chapter is devoted to tracing the transformations in medical practice from a weak and insecure trade to an independent, highly respected, and lucrative profession. Delivery of medical services through managed care and the corporatization of physician practices, however, have made a significant impact on practice styles and have compromised the autonomy that physicians have historically enjoyed. The medical profession has also consolidated into larger organizational units, away from the solo practice of medicine that had once prevailed.

## Medical Services in Preindustrial America

From Colonial times to the beginning of the 20th century, American medicine lagged behind the advances in medical science, experimental research, and medical education that were taking place in Britain, France, and Germany. While London, Paris, and Berlin were flourishing as major research centers, Americans had a tendency to neglect research in basic sciences and to place more emphasis on applied science (Shryock 1966). In addition, American attitudes about medical treatment placed strong emphasis on natural history and conservative common sense (Stevens 1971). Consequently, the practice of medicine in the United States had a strong domestic, rather than professional, character. Medical services, when deemed appropriate by the consumer, were purchased out of one's private funds, because there was no health insurance. The health care market was characterized by competition among providers, and the consumer decided who the provider would be.

Thus, the consumer was sovereign in the health care market and health care was delivered under free market conditions.

Five main factors explain why the medical profession remained largely an insignificant trade in preindustrial America:

1. Medical practice was in disarray.
2. Medical procedures were primitive.
3. An institutional core was missing.
4. Demand was unstable.
5. Medical education was substandard.

## Medical Practice in Disarray

The early practice of medicine could be regarded more as a trade than a profession. It did not require the rigorous course of study, clinical practice, residency training, board exams, or licensing, without which it is impossible to practice today. At the close of the Civil War (1861–1865), “anyone who had the inclination to set himself up as a physician could do so, the exigencies of the market alone determining who would prove successful in the field and who would not” (Hamowy 1979). The clergy, for example, often combined medical services and religious duties. The generally well-educated clergyman or government official was more learned in medicine than physicians were at the time (Shryock 1966). Tradesmen, such as tailors, barbers, commodity merchants, and those engaged in numerous other trades, also practiced the healing arts by selling herbal prescriptions, nostrums, elixirs, and cathartics. Midwives, homeopaths, and naturalists could also practice medicine without restriction. The red-and-white striped poles (symbolizing blood and bandages) seen outside barbershops are reminders that barbers also functioned as surgeons at one

time, using the same blade to cut hair, shave beards, and bleed the sick.

This era of medical pluralism has been referred to as a “war zone” by Kaptchuk and Eisenberg (2001) because it was marked by bitter antagonism among the various practicing sects. Later, in 1847, the American Medical Association (AMA) was founded with the main purpose of erecting a barrier between orthodox practitioners and the “irregulars” (Rothstein 1972).

In the absence of minimum standards of medical training, entry into private practice was relatively easy for both trained and untrained practitioners, creating intense competition. Medicine as a profession was weak and unorganized. Hence, physicians did not enjoy the prestige, influence, and incomes that they later earned. Many physicians found it necessary to engage in a second occupation because income from medical practice alone was inadequate to support a family. It is estimated that most physicians’ incomes in the mid-19th century placed them at the lower end of the middle class (Starr 1982). It is estimated that in 1830 there were 6,800 physicians serving primarily the upper classes (Gabe et al. 1994). It was not until 1870 that medical education was reformed and licensing laws were passed in the United States.

### Primitive Medical Procedures

Up until the mid-1800s, medical care was based more on primitive medical traditions than science. In the absence of diagnostic tools, a theory of “intake and outgo” served as an explanation for all diseases (Rosenberg 1979). It was believed that diseases needed to be expelled from the body. Hence, bleeding, use of emetics (to induce vomiting) and diuretics (to increase urination), and purging with

enemas and purgatives (to clean the bowels) were popular forms of clinical therapy.

When George Washington became ill with an inflamed throat in 1799, he too was bled by physicians. One of the attending physicians argued, unsuccessfully, in favor of making an incision to open the trachea, which today would be considered a more enlightened procedure. The bleeding most likely weakened Washington’s resistance, and historians have debated whether it played a role in his death (Clark 1998).

Surgeries were limited because anesthesia had not yet been developed and antiseptic techniques were not known. Stethoscopes and X-rays had not been discovered, clinical thermometers were not in use, and microscopes were not available for medical diagnosis. Physicians relied mainly on their five senses and experience to diagnose and treat medical problems. Hence, in most cases, physicians did not possess any technical expertise greater than that of the mothers and grandparents at home or experienced neighbors in the community.

### Missing Institutional Core

In the United States, no widespread development of hospitals occurred before the 1880s. A few isolated hospitals were either built or developed in rented private houses in large cities, such as Philadelphia, New York, Boston, Cincinnati, New Orleans, and St. Louis. By contrast, general hospital expansion began much before the 1800s in France and Britain (Stevens 1971). In Europe, medical professionals were closely associated with hospitals. New advances in medical science were being pioneered, which European hospitals readily adopted. The medical profession came to be supremely regarded because

of its close association with an establishment that was scientifically advanced. In contrast, American hospitals played only a small part in medical practice because most hospitals served a social welfare function by taking care of the poor, those without families, or those who were away from home on travel.

### The Almshouse and the Pesthouse

In the United States, the *almshouse* was the precursor of hospitals, but it was not a hospital in the true sense. Almshouses, also called poorhouses because they served primarily the poor, existed in almost all cities of moderate size and were run by the local governments. These institutions served, primarily, general welfare functions by providing food and shelter to the destitute. Therefore, the main function of the almshouse was custodial. Caring for the sick was incidental because some of the residents would inevitably become ill and would be cared for in an adjoining infirmary. Almshouses were unspecialized institutions that admitted poor and needy persons of all kinds: the elderly, the orphaned, the insane, the ill, and the disabled. Hence, the early hospital-type institutions emerged mainly to take care of indigent people whose families could not care for them.

Another type of institution, the *pesthouse*, was operated by local governments to quarantine people who had contracted a contagious disease, such as cholera, smallpox, typhoid, or yellow fever. Located primarily in seaports, the primary function of a pesthouse was to isolate people with contagious diseases so disease would not spread among the inhabitants of a city. These institutions were the predecessors of contagious-disease and tuberculosis hospitals.

### The Dispensary

Dispensaries were established to provide free care to those who could not afford to pay. Urban workers and their families often depended on such charity (Rosen 1983). Dispensaries operated independently of hospitals, hence, medical practice in the United States was not legitimized because it lacked organizational affiliation.

Starting with Philadelphia in 1786, dispensaries gradually spread to other cities. They were private institutions, financed by bequests and voluntary subscriptions. Their main function was to provide basic medical care and to dispense drugs to ambulatory patients (Raffel 1980). Generally, young physicians and medical students desiring clinical experience staffed these dispensaries, as well as hospital wards, on a part-time basis for little or no income (Martensen 1996), which served a dual purpose. It provided needed services to the poor and enabled both physicians and medical students to gain experience diagnosing and treating a variety of cases. Later, as the practice of specialized medicine, as well as teaching and research, was transferred to hospital settings, many dispensaries were gradually absorbed into hospitals as outpatient departments. Indeed, outpatient or ambulatory care departments became an important locale for specialty consultation services within large hospitals (Raffel 1980).

### The Mental Asylum

Mental health care was seen, primarily, as the responsibility of state and local governments. At this time, little was known about what caused mental illness or how to treat it. Although almshouses were used to



accommodate some mental health patients, asylums were built by states for patients with untreatable, chronic mental illness. The first such asylum was built around 1770 in Williamsburg, Virginia. When the Pennsylvania Hospital opened in Philadelphia in 1752, its basement was used as a mental asylum. Attendants in these asylums employed physical and psychological techniques in an effort to return patients to some level of rational thinking. Techniques such as bleeding, forced vomiting, and hot and ice-cold baths were also used. Between 1894 and World War I, the State Care Acts were passed, centralizing financial responsibility for mentally ill patients in every state government. Local governments took advantage of this opportunity to send all those with a mental illness, including dependent, older citizens, to the state asylums. The quality of care in public asylums deteriorated rapidly, as overcrowding and underfunding ran rampant (US Surgeon General 1999).

### The Dreaded Hospital

Not until the 1850s were hospitals similar to those in Europe developed in the United States. These early hospitals had deplorable conditions due to a lack of resources. Poor sanitation and inadequate ventilation were hallmarks of these hospitals. Unhygienic practices prevailed because nurses were unskilled and untrained. These early hospitals had an undesirable image of being houses of death. The mortality rate among hospital patients, both in Europe and America, stood around 74% in the 1870s (Falk 1999). People went into hospitals because of dire consequences, not by personal choice. It is not hard to imagine why members of the middle and upper classes, in particular, shunned such establishments.

### Unstable Demand

Professional services suffered from low demand in the mainly rural, preindustrial society, and much of the medical care was provided by people who were not physicians. The most competent physicians were located in more populated communities (Bordley and Harvey 1976). In the small communities of rural America, a spirit of strong self-reliance prevailed. Families and communities were accustomed to treating the sick, often using folk remedies passed from one generation to the next. It was also common to consult books and published pamphlets on home remedies (Rosen 1983).

The market for physicians' services was also limited by economic conditions. Many families could not afford to pay for medical services. Two factors contributed to the high cost associated with obtaining professional medical care: (1) The indirect costs of transportation and the "opportunity cost" of travel (i.e., forgone value of time that could have been used for something more productive) could easily outweigh the direct costs of physicians' fees. (2) The costs of travel often doubled because two people, the physician and an emissary, had to make the trip back and forth. For a farmer, a trip of 10 miles into town could mean an entire day's work lost. Physicians passed much of their day traveling along backcountry roads. Farmers had to cover travel costs and the opportunity cost of time spent traveling. Mileage charges amounted to four or five times the basic fee for a visit if a physician had to travel 5 to 10 miles. Hence, most families obtained only occasional intervention from physicians, generally for nonroutine and severe conditions (Starr 1982).

Personal health services had to be purchased without the help of government or

private insurance. Private practice and *fee for service*—the practice of billing separately for each individual type of service performed—was firmly embedded in American medical care. Similar to physicians, dentists were private entrepreneurs who made their living by private fee-for-service dental practice, but their services were not in great demand because there was little public concern about dental health (Anderson 1990).

### Substandard Medical Education

From about 1800 to 1850, medical training was largely received through individual apprenticeship with a practicing physician, referred to as a preceptor, rather than through university education. Many of the preceptors were themselves poorly trained, especially in basic medical sciences (Rothstein 1972). By 1800, only four small medical schools were operating in the United States: College of Philadelphia (which was established in 1756 and later became the University of Pennsylvania), King's College (which was established in 1768 and later became Columbia University), Harvard University (opened in 1783), and Dartmouth College (started in 1797).

American physicians later initiated the establishment of medical schools in large numbers. This was partly to enhance professional status and prestige and partly to enhance income. Medical schools were inexpensive to operate and often quite profitable. All that was required was a faculty of four or more physicians, a classroom, a back room to conduct dissections, and legal authority to confer degrees. Operating expenses were met totally out of student fees that were paid directly to the physicians (Rothstein 1972). Physicians would affiliate with a local college for the conferral

of degrees and use of classroom facilities. Large numbers of men entered medical practice as education in medicine became readily available and unrestricted entry into the profession was still possible (Hamowy 1979). Gradually, as physicians from medical schools began to outnumber those from the apprenticeship system, the Doctor of Medicine (MD) degree became the standard of competence. The number of medical schools tripled between 1800 and 1820 and tripled again between 1820 and 1850, numbering 42 in 1850 (Rothstein 1972). Academic preparation gradually replaced apprenticeship training.

At this point, medical education in the United States was seriously deficient in science-based training, unlike European medical schools. Medical schools in the United States did not have laboratories, and clinical observation and practice were not part of the curriculum. In contrast, European medical schools, particularly those in Germany, were emphasizing laboratory-based medical research. At the University of Berlin, for example, professors were expected to conduct research, as well as teach, and were paid by the state. In American medical schools, students were taught by local practitioners, who were ill-equipped in education and training. Unlike Europe, where medical education was financed and regulated by the government, proprietary medical schools in the United States set their own standards (Numbers and Warner 1985). A year of medical school in the United States, generally, lasted only 4 months and required only 2 years for graduation. In addition, American medical students customarily repeated the same courses they had taken during their first year again during their second year (Numbers and Warner 1985; Rosner 2001). The physicians' desire to keep their schools

profitable also contributed to low standards and a lack of rigor. It was feared that higher standards in medical education would drive enrollments down, which could lead the schools into bankruptcy (Starr 1982).

### Medical Services in Postindustrial America

In the postindustrial period, American physicians, unlike other physicians in the world, were highly successful in retaining private practice of medicine and resisting national health care. Physicians also became an organized medical profession and delivered scientifically and technically advanced services to insured patients. Notably, much of this transformation occurred in the aftermath of the Civil War. Social and scientific changes in the period following the war were accompanied by a transition from a rural, agricultural economy to a system of industrial capitalism. Mass production techniques used in the war were applied to peacetime industries. Railroads linked the east and west coasts, and small towns became cities (Stevens 1971).

The American system for delivering health care took its current shape during this period. Private practice of medicine became firmly entrenched as physicians grew into a cohesive profession and gained power and prestige. The well-defined role of employers in providing workers' compensation for work-related injuries and illnesses, together with other economic considerations, was instrumental in the growth of private health insurance. Rising costs of health care, however, prompted Congress to create the publicly financed programs, such as Medicare and Medicaid, for the most vulnerable members of the population. Cost considerations also motivated the formation

of prototypes for modern managed care organizations (MCOs).

### Growth of Professional Sovereignty

The 1920s may well mark the consolidation of physicians' professional power. During and after World War I, physicians' incomes grew sharply, and their prominence as a profession finally emerged. This prestige and power, however, did not materialize overnight. Through the years, several factors interacted in the gradual transformation of medicine from a weak, insecure, and isolated trade into a profession of power and authority. Seven key factors contributed to this transformation:

1. urbanization,
2. science and technology,
3. institutionalization,
4. dependency,
5. cohesiveness and organization,
6. licensing, and
7. educational reform.

### Urbanization

Urbanization created increased reliance on the specialized skills of paid professionals. First, it distanced people from their families and neighborhoods where family-based care was traditionally given. Women began working outside the home and could no longer care for sick members of the family. Second, physicians became less expensive to consult as telephones, automobiles, and paved roads reduced the opportunity cost of time and travel and medical care became more affordable. Urban development attracted more and more Americans to the



growing towns and cities. In 1840, only 11% of the US population lived in urban areas; by 1900, the proportion of the US population living in urban areas grew to 40% (Stevens 1971). The trend away from home visits to office practice also began to develop around this time (Rosen 1983). Physicians moved to cities and towns in large numbers to be closer to their growing markets. Better geographic proximity of patients enabled physicians to see more patients in a given amount of time. Whereas physicians in 1850 only saw an average of 5 to 7 patients a day, by the early 1940s, the average patient load of general practitioners had risen to 18 to 22 patients a day (Starr 1982).

## Science and Technology

Exhibit 3–1 summarizes some of the groundbreaking scientific discoveries in medicine. Advances in bacteriology, antiseptic surgery, anesthesia, immunology, and diagnostic techniques, along with an expanding repertoire of new drugs, gave medicine an aura of legitimacy and complexity, and the therapeutic effectiveness of scientific medicine became widely recognized.

When advanced technical knowledge becomes essential to practice a profession and the benefits of professional services are widely recognized, a greater acceptance and a legitimate need for the services of that

### Exhibit 3-1 Groundbreaking Medical Discoveries

- The discovery of anesthesia was instrumental in advancing the practice of surgery. Nitrous oxide (laughing gas) was first employed as an anesthetic around 1846 for tooth extraction by Horace Wells, a dentist. Ether anesthesia for surgery was first successfully used in 1846 at the Massachusetts General Hospital. Before anesthesia was discovered, strong doses of alcohol were used to dull the sensations. A surgeon who could do procedures, such as limb amputations, in the shortest length of time was held in high regard.
- Around 1847, Ignaz Semmelweis, a Hungarian physician practicing in a hospital in Vienna, implemented the policy of handwashing. Thus, an aseptic technique was born. Semmelweis was concerned about the high death rate from puerperal fever among women after childbirth. Even though the germ theory of disease was unknown at this time, Semmelweis surmised that there might be a connection between puerperal fever and the common practice by medical students of not washing their hands before delivering babies and right after doing dissections. Semmelweis's hunch was right.
- Louis Pasteur is generally credited with pioneering the germ theory of disease and microbiology around 1860. Pasteur demonstrated sterilization techniques, such as boiling to kill microorganisms and withholding exposure to air to prevent contamination.
- Joseph Lister is often referred to as the father of antiseptic surgery. Around 1865, Lister used carbolic acid to wash wound, and popularized the chemical inhibition of infection (antiseptis) during surgery.
- Advances in diagnostics and imaging can be traced to the discovery of X-rays in 1895 by Wilhelm Roentgen, a German professor of physics. Radiology became the first machine-based medical specialty. Some of the first training schools in X-ray therapy and radiography in the United States attracted photographers and electricians to become Doctors in Roentgenology (from the inventor's name).
- Alexander Fleming discovered the antibacterial properties of penicillin in 1929.

profession are simultaneously created. *Cultural authority* refers to the general acceptance of and reliance on the judgment of the members of a profession (Starr 1982) because of their superior knowledge and expertise. Cultural authority legitimizes a profession in the eyes of common people. Advances in medical science and technology bestowed this legitimacy on the medical profession because medical practice could no longer remain within the domain of lay competence.

Scientific and technological change also required improved therapeutic competence of physicians in the diagnosis and treatment of disease. Developing these skills was no longer possible without specialized training. Science-based medicine created an increased demand for advanced services that were no longer available through family and neighbors.

Physicians' cultural authority was further bolstered when medical decisions became necessary in various aspects of health care delivery. For example, physicians decide whether a person should be admitted to a hospital or nursing home and for how long, whether surgical or nonsurgical treatments should be used, and which medications should be prescribed. Physicians' decisions have a profound impact on other providers and nonproviders alike. The judgment and opinions of physicians even affect aspects of a person's life outside the delivery of health care. For example, physicians often evaluate the fitness of persons for jobs during pre-employment physicals many employers demand. Physicians assess the disability of the ill and the injured in workers' compensation cases. Granting of medical leave for sickness and release back to work require authorizations from physicians. Payment of medical claims requires physicians' evaluations. Other health care professionals,

such as nurses, therapists, and dietitians, are expected to follow physicians' orders for treatment. Thus, during disease and disability, and sometimes even in good health, people's lives have become increasingly governed by decisions made by physicians.

### Institutionalization

The evolution of medical technology and the professionalization of medical and nursing staff enabled advanced treatments that necessitated the pooling of resources in a common arena of care (Burns 2004). Rapid urbanization was another factor that necessitated the institutionalization of medical care. As had already occurred in Europe, in the United States, hospitals became the core around which the delivery of medical services was organized. Thus, development of hospitals as the center for the practice of scientific medicine and the professionalization of medical practice became closely intertwined. Indeed, physicians and hospitals developed a symbiotic relationship.

For economic reasons, as hospitals expanded, their survival became increasingly dependent on physicians to keep the beds filled because the physicians decided where to hospitalize their patients. Therefore, hospitals had to make every effort to keep the physicians satisfied, which enhanced physicians' professional dominance, even though they were not employees of the hospitals. This gave physicians enormous influence over hospital policy. Also, for the first time, hospitals began conforming to both physician practice patterns and public expectations about medicine as a modern scientific enterprise. The expansion of surgery, in particular, had profound implications for hospitals, physicians, and the public. As hospitals added specialized facilities and staff, their

regular use became indispensable to physicians and surgeons, who earlier had been able to manage their practices with little reference to hospitals (Martensen 1996). Affiliation with establishments symbolizing the scientific cutting edge of medicine lent power and prestige to the medical profession.

Hospitals in the United States did not expand and become more directly related to medical care until the late 1890s. However, as late as the 1930s, hospitals incurred frequent deaths due to infections that could not be prevented or cured. Nevertheless, hospital use was on the rise due to the great influx of immigrants into large American cities (Falk 1999). From only a few score in 1875, the number of general hospitals in the United States expanded to 4,000 by 1900 (Anderson 1990) and to 5,000 by 1913 (Wright 1997).

### Dependency

Patients depend on the medical profession's judgment and assistance. First, dependency is created because society expects a sick person to seek medical help and try to get well. The patient is then expected to comply with medical instructions. Second, dependency is created by the profession's cultural authority because its medical judgments must be relied on to (1) legitimize a person's sickness; (2) exempt the individual from social role obligations, such as work or school, and (3) provide competent medical care so the person can get well and resume his or her social role obligations. Third, in conjunction with the physician's cultural authority, the need for hospital services for critical illness and surgery also creates dependency when patients are transferred from their homes to a hospital or surgery center.

Once physicians' cultural authority became legitimized, the sphere of their influence

expanded into nearly all aspects of health care delivery. For example, laws were passed that prohibited individuals from obtaining certain classes of drugs without a physician's prescription. Health insurance paid for treatments only when they were rendered or prescribed by physicians. Thus, beneficiaries of health insurance became dependent on physicians to obtain covered services. More recent, the referral role (gatekeeping) of primary care physicians in managed care plans has increased patients' dependency on primary care physicians for referral to specialized services.

### Cohesiveness and Organization

Toward the end of the 1800s, social and economic changes brought about greater cohesiveness among medical professionals. With the growth of hospitals and specialization, physicians needed support from each other for patient referrals and for access to facilities to admit their patients. Standardization of education also advanced a common core of knowledge among physicians. They no longer remained members of isolated and competing medical sects. Greater cohesiveness, in turn, advanced their professional authority (Starr 1982).

For a long time, physicians' ability to remain free of control from hospitals and insurance companies remained a prominent feature of American medicine. Hospitals and insurance companies could have hired physicians on salary to provide medical services, but individual physicians who took up practice in a corporate setting were castigated by the medical profession and pressured to abandon such practices. In some states, courts ruled that corporations could not employ licensed physicians without engaging in the unlicensed practice of medicine,

a legal doctrine that became known as the “corporate practice doctrine” (Farmer and Douglas 2001). Independence from corporate control enhanced private entrepreneurship and put American physicians in an enviable strategic position in relation to hospitals and insurance companies. Later, a formally organized medical profession was in a much better position to resist control from outside entities.

The AMA was formed in 1847, but it had little strength during its first half-century of existence. Its membership was small, with no permanent organization and scant resources. The AMA did not attain real strength until it was organized into county and state medical societies and until state societies were incorporated, delegating greater control at the local level. As part of the organizational reform, the AMA also began, in 1904, to concentrate attention on medical education (Bordley and Harvey 1976). Since then, it has been the chief proponent for the practitioners of conventional medicine in the United States. Although the AMA often stressed the importance of raising the quality of care for patients and protecting the uninformed consumer from “quacks” and “charlatans,” its principal goal—like that of other professional associations—was to advance the professionalization, prestige, and financial well-being of its members. The AMA vigorously pursued its objectives by promoting the establishment of state medical licensing laws and the legal requirement that, to be licensed to practice, a physician must be a graduate of an AMA-approved medical school. The concerted activities of physicians through the AMA are collectively referred to as *organized medicine*, to distinguish them from the uncoordinated actions of individual physicians

competing in the marketplace (Goodman and Musgrave 1992).

## Licensing

Under the Medical Practice Acts established in the 1870s, medical licensure in the United States became a function of the states (Stevens 1971). By 1896, 26 states had enacted medical licensure laws (Anderson 1990). Licensing of physicians and upgrading of medical school standards developed hand in hand. At first, licensing required only a medical school diploma. Later, candidates could be rejected if the school they had attended was judged inadequate. Finally, all candidates were required to present an acceptable diploma and pass an independent state examination (Starr 1982). Through both licensure and upgrading of medical school standards, physicians obtained a clear monopoly on the practice of medicine (Anderson 1990). The early licensing laws served to protect physicians from the competitive pressures posed by potential new entrants into the medical profession. Physicians led the campaign to restrict the practice of medicine. As biomedicine gained political and economic ground, the biomedical community expelled providers such as homeopaths, naturopaths, and chiropractors from medical societies; prohibited professional association with them; and encouraged prosecution of such providers for unlicensed medical practice (Rothstein 1972). In 1888, in a landmark Supreme Court decision, *Dent v. West Virginia*, Justice Stephen J. Field wrote that no one had the right to practice “without having the necessary qualifications of learning and skill” (Haber 1974). In the late 1880s and 1890s, many states revised laws to require

all candidates for licensure, including those holding medical degrees, to pass an examination (Kaufman 1980).

### Educational Reform

Advanced medical training was made necessary by scientific progress. Reform of medical education started around 1870, with the affiliation of medical schools with universities. In 1871, Harvard Medical School, under the leadership of a new university president, Charles Eliot, completely revolutionized the system of medical education. The academic year was extended from 4 to 9 months, and the length of medical education was increased from 2 to 3 years. Following the European model, laboratory instruction and clinical subjects, such as chemistry, physiology, anatomy, and pathology, were added to the curriculum.

Johns Hopkins University took the lead in further reforming medical education when it opened its medical school in 1893, under the leadership of William H. Welch, who trained in Germany. Medical education, for the first time, became a graduate training course, requiring a college degree, not a high school diploma, as an entrance requirement. Johns Hopkins had well-equipped laboratories, a full-time faculty for the basic science courses, and its own teaching hospital (Rothstein 1972). Standards at Johns Hopkins became the model of medical education in other leading institutions around the country. The raising of standards made it difficult for proprietary schools to survive, and, in time, proprietary schools were closed.

The Association of American Medical Colleges (AAMC) was founded in 1876 by 22 medical schools (Coggeshall 1965).

Later, the AAMC set minimum standards for medical education, including a 4-year curriculum, but it was unable to enforce its recommendations. In 1904, the AMA created the Council on Medical Education, which inspected the existing medical schools and found that less than half provided acceptable levels of training. The AMA did not publish its findings but obtained the help of the Carnegie Foundation for the Advancement of Teaching to provide a rating of medical schools (Goodman and Musgrave 1992). The Foundation appointed Abraham Flexner to investigate medical schools located in both the United States and Canada. The Flexner Report, published in 1910, had a profound effect on medical education reform. The report was widely accepted by both the profession and the public. Schools that did not meet the proposed standards were forced to close. State laws were established, requiring graduation from a medical school accredited by the AMA as the basis for a license to practice medicine (Haglund and Dowling 1993).

Once advanced graduate education became an integral part of medical training, it further legitimized the profession's authority and galvanized its sovereignty. Stevens (1971) noted that American medicine moved toward professional maturity between 1890 and 1914, mainly as a direct result of educational reform.

### Specialization in Medicine

Specialization has been a key hallmark of American medicine. As a comparison, in 1931, 17% of all physicians in the United States were specialists, whereas today, the proportion of specialists to generalists is approximately 58:42 (Bureau of Labor



Statistics 2011), and many generalists also have a subspecialty focus. The growth of allied health care professionals has also diversified, both in medical specialization—such as laboratory and radiological technologists, nurse anesthetists, and physical therapists—as well as in new or expanded specialist fields—such as occupational therapists, psychologists, dietitians, and medical social workers (Stevens 1971).

Lack of a rational coordination of medical care in the United States has been one consequence of the preoccupation with specialization. The characteristics of the medical profession in various countries often shape and define the key attributes of their health care delivery systems. The role of the primary care physician (PCP), the relationship between generalists and specialists, the ratio of practicing generalists to specialists, the structure and nature of medical staff appointments in hospitals, and the approach to group practice of medicine have all been molded by the evolving structure and ethos of the medical profession. In Britain, for example, the medical profession has divided itself into general practitioners (GPs) practicing in the community and consultants holding specialist positions in hospitals. This kind of stratification did not develop in American medicine. PCPs in America were not assigned the role that GPs had in Britain, where patients could consult a specialist only by referral from a GP. Unlike Britain, where GPs hold a key intermediary position in relation to the rest of the health care delivery system, the United States has lacked such a gatekeeping role. Only since the early 1990s, under health maintenance organizations (HMOs), has the *gatekeeping* model requiring initial contact with a generalist and the generalist's referral to a specialist gained prominence. The

distinctive shaping of medical practice in the United States explains why the structure of medicine did not develop around a nucleus of primary care.

### From the Asylum to Community Mental Health

At the turn of the 20th century, the scientific study and treatment of mental illnesses, called neuropathology, had just begun. Later, in 1946, federal funding was made available under the National Mental Health Act for psychiatric education and research. This Act led to the creation, in 1949, of the National Institute of Mental Health (NIMH). Early treatment of mental disorders was championed, and the concept of community mental health was born. By this time, new drugs for treating psychosis and depression had become available. Reformers of the mental health system argued that long-term institutional care had been neglectful, ineffective, and even harmful (US Surgeon General 1999). Passage of the Community Mental Health Centers Act of 1963 lent support to the joint policies of “community care” and “deinstitutionalization.” From 1970 to 2000, state-run psychiatric hospital beds dropped from 207 to 21 beds per 100,000 persons (Manderscheid et al. 2004). The deinstitutionalization movement further intensified after the 1999 US Supreme Court decision in *Olmstead v. L.C.* that directed US states to provide community-based services to people with mental illness.

### The Development of Public Health

Historically, public health practices in the United States have concentrated on sanitary regulation, the study of epidemics, and vital statistics. The growth of urban centers

for the purpose of commerce and industry, unsanitary living conditions in densely populated areas, inadequate methods of sewage and garbage disposal, limited access to clean water, and long work hours in unsafe and exploitative industries led to periodic epidemics of cholera, smallpox, typhoid, tuberculosis, yellow fever, and other diseases. Such outbreaks led to arduous efforts to protect the public interest. For example, in 1793, the national capital had to be moved out of Philadelphia due to a devastating outbreak of yellow fever. This epidemic prompted the city to develop its first board of health that same year. In 1850, Lemuel Shattuck outlined the blueprint for the development of a public health system in Massachusetts. Shattuck also called for the establishment of state and local health departments. A threatening outbreak of cholera in 1873 mobilized the New York City Health Department to alleviate the worst sanitary conditions within the city. Previously, cholera epidemics in 1832 and 1848–1849 had swept through American cities and towns within a few weeks, killing thousands (Duffy 1971). Until about 1900, infectious diseases posed the greatest health threat to society. The development of public health played a major role in curtailing the spread of infection among populations. Simultaneously, widespread public health measures and better medical care reduced mortality and increased life expectancy.

By 1900, most states had health departments that were responsible for a variety of public health efforts, such as sanitary inspections, communicable disease control, operation of state laboratories, vital statistics, health education, and regulation of food and water (Turnock 1997; Williams 1995). Public health functions were later extended to fill gaps in the medical care system. Such

functions, however, were limited mainly to child immunizations, care of mothers and infants, health screening in public schools, and family planning. Federal grants were also made available to state and local governments for programs in substance abuse, mental health, and community prevention services (Turnock 1997).

Public health has remained separate from the private practice of medicine because of the skepticism of private physicians that the government could take control of the private practice of medicine. Physicians realized that the boards of health could be used to control the supply of physicians and to regulate the practice of medicine (Rothstein 1972). Fear of government intervention, loss of autonomy, and erosion of personal incomes created a wall of separation between public health and private medical practice. Under this dichotomous relationship, medicine has concentrated on the physical health of the individual, whereas public health has focused on the health of whole populations and communities. The extent of collaboration between the two has been largely confined to the requirement by public health departments that private practitioners report cases of contagious diseases, such as sexually transmitted diseases, human immunodeficiency virus (HIV) infection, and acquired immune deficiency syndrome (AIDS), and any outbreaks of cases such as West Nile virus and other types of infections.

### Health Services for Veterans

Shortly after World War I, the government started to provide hospital services to veterans with service-related disabilities and for nonservice-related disabilities if the veteran declared an inability to pay for private care.

At first, the federal government contracted for services with voluntary hospitals, but, over time, the Department of Veterans Affairs (formerly called Veterans Administration) built its own hospitals, outpatient clinics, and nursing homes. (Additional details are provided in Chapter 6.)

### Birth of Workers' Compensation

The first broad-coverage health insurance in the United States emerged in the form of workers' compensation programs initiated in 1914 (Whitted 1993). Workers' compensation was originally concerned with cash payments to workers for wages lost due to job-related injuries and disease. Compensation for medical expenses and death benefits to the survivors were added later (discussed in Chapter 6). Between 1910 and 1915, workers' compensation laws made rapid progress in the United States (Stevens 1971). Looking at the trend, some reformers believed that, since Americans had been persuaded to adopt compulsory insurance against industrial accidents, they could also be persuaded to adopt compulsory insurance against sickness. Workers' compensation served as a trial balloon for the idea of government-sponsored, universal health insurance in the United States. However, the growth of private health insurance, along with other key factors discussed later, has prevented any proposals for a national health care program from taking hold.

### Rise of Private Health Insurance

Private health insurance was commonly referred to as *voluntary health insurance*, in contrast to proposals for a government-sponsored compulsory health insurance system. The initial role of private health

insurance was income protection during sickness and temporary disability. Some private insurance coverage limited to bodily injuries was also available since approximately 1850. By 1900, health insurance policies became available, but their primary purpose was to protect against loss of income during sickness (Whitted 1993). Later, coverage was added for surgical fees, but emphasis remained on replacing lost income due to sickness or injury. Thus, the coverage was, in reality, disability insurance rather than health insurance (Mayer and Mayer 1984).

As detailed in subsequent sections, technological, social, and economic factors created a general need for health insurance. However, certain economic conditions that prompted private initiatives, self-interests of a well-organized medical profession, and the momentum of a successful health insurance enterprise, gave private health insurance a firm footing in the United States. Coverage for hospital and physician services began separately and was later combined under the auspices of Blue Cross and Blue Shield. Later, economic conditions during the World War II period laid the foundations for health insurance to become an employment-based benefit.

### Technological, Social, and Economic Factors

The health insurance movement of the early 20th century was the product of three converging developments: the technological, the social, and the economic. From a technological perspective, medicine offered new and better treatments. Because of its well-established healing values, medical care had become individually and socially desirable, which created a growing demand for medical services. From an economic perspective,

people could predict neither their future needs for medical care nor the costs, both of which had been gradually increasing. In short, scientific and technological advances made health care more desirable but less affordable. These developments pointed to the need for some kind of insurance that could spread the financial risks over a large number of people.

### Early Blanket Insurance Policies

In 1911, insurance companies began to offer blanket policies for large industrial populations, usually covering life insurance, accidents and sickness, and nursing services. A few industrial and railroad companies set up their own medical plans, covering specified medical benefits, as did several unions and fraternal orders; however, the total amount of voluntary health insurance was minute (Stevens 1971). Between 1916 and 1918, 16 state legislatures, including New York and California, attempted to enact legislation compelling employers to provide health insurance, but these efforts were unsuccessful (Davis 1996).

### Economic Necessity and the Baylor Plan

The Great Depression, which started at the end of 1929, forced hospitals to turn from philanthropic donations to patient fees for support. Patients now faced not only loss of income from illness but also increased debt from medical care costs when they became sick. People needed protection from the economic consequences of sickness and hospitalization. Hospitals also needed protection from economic instability (Mayer and Mayer 1984). During the Depression, occupancy rates in hospitals fell, income from endowments and contributions dropped sharply,

and the charity load almost quadrupled (Richardson 1945).

In 1929, the blueprint for modern health insurance was established when J.F. Kimball began a hospital insurance plan for public school teachers at the Baylor University Hospital in Dallas, Texas. Kimball was able to enroll more than 1,200 teachers, who paid 50 cents a month for a maximum of 21 days of hospital care. Within a few years, it became the model for Blue Cross plans around the country (Raffel 1980). At first, other independent hospitals copied Baylor and started offering single-hospital plans. It was not long before communitywide plans, offered jointly by more than one hospital, became more popular because they provided consumers a choice of hospitals. The hospitals agreed to provide services in exchange for a fixed monthly payment by the plans. Hence, in essence, these were prepaid plans for hospital services. A *prepaid plan* is a contractual arrangement under which a provider must provide all needed services to a group of members (or enrollees) in exchange for a fixed monthly fee paid in advance.

### Successful Private Enterprise—The Blue Cross Plans

A hospital plan in Minnesota was the first to use the name Blue Cross in 1933 (Davis 1996). The American Hospital Association (AHA) lent support to the hospital plans and became the coordinating agency to unite these plans into the Blue Cross network (Koch 1993; Raffel 1980). The Blue Cross plans were nonprofit—that is, they had no shareholders who would receive profit distributions—and covered only hospital charges, as not to infringe on the domain of private physicians (Starr 1982).

Later, control of the plans was transferred to a completely independent body, the Blue Cross Commission, which later became the Blue Cross Association (Raffel 1980). In 1946, Blue Cross plans in 43 states served 20 million members. Between 1940 and 1950 alone, the proportion of the population covered by hospital insurance increased from 9 to 57% (Anderson 1990).

### Self Interests of Physicians—Birth of Blue Shield

Voluntary health insurance had received the AMA's endorsement, but the AMA had also made it clear that private health insurance plans should include only hospital care. It is, therefore, not surprising that the first Blue Shield plan designed to pay for physicians' bills was started by the California Medical Association, which established the California Physicians Service in 1939 (Raffel 1980). By endorsing hospital insurance and by actively developing medical service plans, the medical profession committed itself to private health insurance as the means to spread the financial risk of sickness and to ensure that its own interests would not be threatened.

From the medical profession's point of view, voluntary health insurance, in conjunction with private fee-for-service practice by physicians, was regarded as a desirable feature of the evolving health system (Stevens 1971). Throughout the Blue Shield movement, physicians dominated the boards of directors not only because they underwrote the plans but also because the plans were, in a very real sense, their response to the challenge of national health insurance. In addition, the plans met the AMA's stipulation of keeping medical matters in the hands of physicians (Raffel and Raffel 1994).

### Combined Hospital and Physician Coverage

Even though Blue Cross and Blue Shield developed independently and were financially and organizationally distinct, they often worked together to provide hospital and physician coverage (Law 1974). In 1974, the New York Superintendent of Insurance approved a merger of the Blue Cross and Blue Shield plans of Greater New York (Somers and Somers 1977). Since then, similar mergers have occurred in most states, and in nearly every state Blue Cross and Blue Shield plans are joint corporations or have close working relationships (Davis 1996).

The for-profit insurance companies were initially skeptical of the Blue Cross plans and adopted a wait-and-see attitude. Their apprehension was justified because no actuarial information was available to predict losses. But within a few years, lured by the success of the Blue Cross plans, commercial insurance companies also started offering health insurance.

### Employment-Based Health Insurance

Three main factors explain how health insurance in the United States became employment based: (1) To control high inflation in the economy during the World War II period, Congress imposed wage freezes. In response, many employers started offering health insurance to their workers in lieu of wage increases. (2) In 1948, the Supreme Court ruled that employee benefits, including health insurance, were a legitimate part of the union-management bargaining process. Health insurance then became a permanent part of employee benefits in the postwar era (Health Insurance Association of America 1991). (3) According to a 1954



revision to the Internal Revenue Code, employer contributions for the purchase of employee health insurance became exempt from taxable income for the employee. In other words, employees could get noncash income without having to pay taxes on this income.

Employment-based health insurance expanded rapidly. The economy was strong during the postwar years of the 1950s, and employers started offering more extensive benefits. This led to the birth of “major medical” expense coverage to protect against prolonged or catastrophic illness or injury (Mayer and Mayer 1984). Thus, private health insurance became the primary vehicle for the delivery of health care services in the United States.

### Failure of National Health Care Initiatives: A Historical Overview

Starting with Germany in 1883, compulsory sickness insurance had spread throughout Europe by 1912. Health insurance in European countries was viewed as a natural outgrowth of insurance against industrial accidents. Hence, it was considered logical that Americans would also be willing to espouse a national health care program to protect themselves from the high cost of sickness and accidents occurring outside employment.

The American Association of Labor Legislation (AALL) was founded in 1906. Although the AALL took no official position on labor unions, its membership did include prominent labor leaders (Starr 1982). Its relatively small membership, however, was mainly academic, including some leading economists and social scientists, whose all-important agenda was to bring about social reform through government action. The

AALL was primarily responsible for leading the successful drive for workers’ compensation. It then spearheaded the drive for a government-sponsored health insurance system for the general population (Anderson 1990) and supported the Progressive movement headed by former President Theodore Roosevelt, who was again running for the presidency in 1912 on a platform of social reform. Roosevelt, who might have been a national political sponsor for compulsory health insurance, was defeated by Woodrow Wilson, but the Progressive movement for national health insurance did not die.

The AALL continued its efforts toward a model for national health insurance by appealing to both social and economic concerns. The reformers argued that national health insurance would relieve poverty because sickness usually brought wage loss and high medical costs to individual families. Reformers also argued that national health insurance would contribute to economic efficiency by reducing illness, lengthening life, and diminishing the causes of industrial discontent (Starr 1982). Leadership of the AMA, at the time, showed outward support for a national plan, and the AALL and the AMA formed a united front to secure legislation. A standard health insurance bill was introduced in 15 states in 1917 (Stevens 1971).

As long as compulsory health insurance was only under study and discussion, potential opponents paid no heed to it; but, once bills were introduced into state legislatures, opponents expressed vehement disapproval. Eventually, support for the AMA’s social change proved only superficial.

Historically, repeated attempts to pass national health insurance legislation in the United States have failed for several reasons, which can be classified under four

broad categories: political inexpediency, institutional dissimilarities, ideological differences, and tax aversion.

### Political Inexpediency

Before embarking on their national health programs, countries in Western Europe, notably Germany and England, were experiencing labor unrest that threatened political stability. Social insurance was seen as a means to obtain workers' loyalty and ward off political instability. Political conditions in the United States were quite different. There was no threat to political stability. Unlike countries in Europe, the American government was highly decentralized and engaged in little direct regulation of the economy or social welfare. Although Congress had set up a system of compulsory hospital insurance for merchant seamen as far back as 1798, it was an exceptional measure.\* Matters related to health and welfare were typically left to state and local governments, and as a general rule, these levels of government left as much as possible to private and voluntary action.

The entry of America into World War I, in 1917, provided a final political blow to the health insurance movement as anti-German feelings were aroused. The US government denounced German social insurance, and opponents of health insurance called it a Prussian menace, inconsistent with American values (Starr 1982).

After attempts to pass compulsory health insurance laws failed at the state

levels in California and New York, by 1920, the AALL itself lost interest in an obviously lost cause. Also in 1920, the AMA's House of Delegates approved a resolution condemning compulsory health insurance that would be regulated by the government (Numbers 1985). This AMA resolution opposing national health insurance solidified the profession against government interference with the practice of medicine.

### Institutional Dissimilarities

The preexisting institutions in Europe and America were dissimilar. Germany and England had mutual benefit funds to provide sickness benefits. These benefits reflected an awareness of the value of insuring against the cost of sickness among a sector of the working population. Voluntary sickness funds were less developed in the United States than in Europe, reflecting less interest in health insurance and less familiarity with it. More important, American hospitals were mainly private, whereas in Europe they were largely government operated (Starr 1982).

Dominance of private institutions of health care delivery is not consistent with national financing and payment mechanisms. For instance, compulsory health insurance proposals of the AALL were regarded by individual members of the medical profession as a threat to their private practice because such proposals would shift the primary source of income of medical professionals from individual patients to the government (Anderson 1990). Any efforts that would potentially erode the fee-for-service payment system and let private practice of medicine be controlled by a powerful third party—particularly the government—were opposed.

\*Important seaports, such as Boston, were often confronted with many sick and injured seamen, who were away from their homes and families. Congress enacted a law requiring that 20 cents a month be withheld from the wages of each seaman on American ships to support merchant marine hospitals (Raffel and Raffel 1994).

Other institutional forces were also opposed to government-sponsored universal coverage. The insurance industry feared losing the income it derived from disability insurance, some insurance against medical services, and funeral benefits\* (Anderson 1990). The pharmaceutical industry feared the government as a monopoly buyer, and retail pharmacists feared that hospitals would establish their own pharmacies under a government-run national health care program (Anderson 1990). Employers also saw the proposals as contrary to their interests. Spokespersons for American business rejected the argument that national health insurance would add to productivity and efficiency. It may seem ironic, but the labor unions—the American Federation of Labor in particular—also denounced compulsory health insurance at the time. Union leaders were afraid they would transfer over to the government their own legitimate role of providing social benefits, thus weakening the unions' influence in the workplace. Organized labor was the largest and most powerful interest group at that time, and its lack of support is considered instrumental in the defeat of national health insurance (Anderson 1990).

### Ideological Differences

The American value system is based largely on the principles of market justice (as discussed in Chapter 2). Individualism and self-determination, distrust of government, and reliance on the private sector to address social concerns are typical American ideologies that have stood as a bulwark against

anything perceived as an onslaught on individual liberties. The cultural and ideological values represent the sentiments of the American middle class, whose support is necessary for any broad-based reform. Without such support, a national health care program was unable to withstand the attacks of its well-organized opponents (Anderson 1990). Conversely, during times of national distress, such as the Great Depression, pure necessity may have legitimized the advancement of social programs, such as the New Deal programs of the Franklin Roosevelt era (for example, Social Security legislation providing old-age pensions and unemployment compensation).

In the early 1940s, during Roosevelt's presidency, several bills on national health insurance were introduced in Congress, but all the proposed bills died. Perhaps the most notable bill was the Wagner-Murray-Dingell bill, drafted in 1943 and named after the bill's congressional sponsors. However, this time, World War II diverted the nation's attention to other issues, and without the president's active support the bill died quietly (Numbers 1985).

In 1946, Harry Truman became the first president to make an appeal for a national health care program (Anderson 1990). Unlike the Progressives, who had proposed a plan for the working class, Truman proposed a single health insurance plan that would include all classes of society. At the president's behest, the Wagner-Murray-Dingell bill was redrafted and reintroduced. The AMA was vehement in opposing the plan. Other health care interest groups, such as the AHA, also opposed it. By this time, private health insurance had expanded. Initial public reaction to the Wagner-Murray-Dingell bill was positive; however, when a government-controlled medical plan was

\* Patients admitted to a hospital were required to pay a burial deposit so the hospital would not have to incur a burial expense if they died (Raffel and Raffel 1994). Therefore, many people bought funeral policies from insurance companies.

compared to private insurance, polls showed that only 12% of the public favored extending Social Security to include health insurance (Numbers 1985).

During this era of the Cold War,\* any attempts to introduce national health insurance were met with the stigmatizing label of *socialized medicine*, a label that has since become synonymous with any large-scale government-sponsored expansion of health insurance or intrusion in the private practice of medicine. The Republicans took control of Congress in 1946, and any interest in enacting national health insurance was put to rest. However, to the surprise of many, Truman was reelected in 1948, promising national health insurance if the Democrats would be returned to power (Starr 1982). Fearing the inevitable, the AMA levied a \$25 fee on each of its members toward a war chest of \$3.5 million (Anderson 1990). It hired the public relations firm of Whitaker and Baxter and spent \$1.5 million, in 1949 alone, to launch one of the most expensive lobbying efforts in American history. The campaign directly linked national health insurance with Communism until the idea of socialized medicine was firmly implanted in the public's minds. Republicans proposed a few compromises in which neither the Democrats nor the AMA was interested. By 1952, the election of a Republican president, Dwight Eisenhower, effectively ended any further debate over national health insurance. Failure of government-sponsored universal health care coverage is often presented as a classic case of the tremendous influence of interest groups in American politics, especially in major health policy outcomes.

\*Rivalry and hostility after World War II between the United States and the then Soviet Union.

## Tax Aversion

An aversion to increased taxes to pay for social programs is another reason middle-class Americans, who are already insured, have opposed national initiatives to expand health insurance coverage. According to polls, Americans have been found to support the idea that the government ought to help people who are in financial need to pay for their medical care. However, most Americans have not favored an increase in their own taxes to pay for such care. This is perhaps why health reform failed in 1993.

While seeking the presidency in 1992, Governor Bill Clinton made health system reform a major campaign issue. Not since Harry Truman's initiatives in the 1940s had such a bold attempt been made by a presidential candidate. As long as the electorate had remained reasonably satisfied with health care—with the exception of uninsured Americans, who have not been politically strong—elected officials had feared the political clout of big interest groups and had refrained from raising tough reform issues. In the Pennsylvania US Senate election in November 1991, however, the victory of Democrat Harris Wofford over Republican Richard Thornburgh sent a clear signal that the time for a national health care program might be ripe. Wofford's call for national health insurance was widely supported by middle-class Pennsylvanians. Election results in other states were not quite as decisive on the health reform issue, but various public polls seemed to confirm that, after the economy (America was in a brief recession at the time), health care was the second most pressing concern on the minds of the American people. One national survey, conducted by Louis Harris and Associates, reported some disturbing findings about health care delivery. Substantial numbers of insured and

relatively affluent people said they had not received the services they needed. The poll also suggested that the public was looking to the federal government, not the states or private sector, to contain rising health care costs (Smith et al. 1992). In other opinion polls, Americans expressed concerns that they might not be adequately insured in the future (Skocpol 1995). Against this backdrop, both Bill Clinton and the running incumbent, President George (Herbert Walker) Bush, advanced health care reform proposals.

After taking office, President Clinton made health system reform one of his top priorities. Policy experts and public opinion leaders have since debated over what went wrong. Some of the fundamental causes for the failure of the Clinton plan were no doubt historical in nature, as discussed previously in this chapter. One seasoned political observer, James J. Mongan, however, remarked that reform debates in Congress have never been about the expansion of health care services but rather have been about the financing of the proposed services:

Thus, the most important cause of health care reform's demise was that avoiding tax increases and their thinly veiled cousin, employer mandates, took priority over expanding coverage. . . . There undoubtedly would have been pitched legislative battles over other issues—how to pay doctors and hospitals, the role of health insurers, the structure of (regional health) alliances—but these debates never happened in detail. The first and only battle . . . was how to pay for reform. . . . What explains this unwillingness to pay for expanded coverage, on the part of citizens and government alike? Any answer must take into account the economic, social, and political context of the past two decades. . . . The social context is that people tend to take for granted the

progress achieved through social insurance programs such as Medicare and Social Security, and they perceive little progress or achievement from welfare expenditures targeted on low-income people. Politically, politicians from the courthouse to the White House have played to an anti-tax sentiment and have convinced Americans and American businesses that they are staggering under an oppressive burden of taxation that saps most productive effort. Although there is little evidence from other countries to support this belief, it is widely held. This climate fosters a self-centeredness—a focus more on the individual's needs than on the community's needs. Some liberals might use a harsher, more grating word—selfishness—to describe this state of mind. But many conservatives would use the phrase *rugged individualism* to describe the same phenomenon. . . . Somewhere in here is where health reform died. . . . Until we as a nation make the right diagnosis and begin an honest dialogue about our national values, about the balance between self-interest and community interests, we will not see our nation join almost all others in guaranteeing health coverage to all of its citizens (Mongan 1995, 99–101).

When American polls indicated that a fundamental reform was needed, the people did not have in mind more government regulation or any significant redistribution of income through increased taxes. Most important, they did not wish to have a negative effect on their own access to care or the quality of care they were receiving (Altman and Reinhardt 1996).

### Creation of Medicaid and Medicare

Before 1965, private health insurance was the only widely available source of payment for health care, and it was available primarily to middle-class working people and their



families. The elderly, the unemployed, and the poor had to rely on their own resources, on limited public programs, or on charity from hospitals and individual physicians. Often, when charity care was provided, private payers were charged more to make up the difference, a practice referred to as *cost-shifting* or *cross-subsidization*. In 1965, Congress passed the amendments to the Social Security Act and created the Medicare and Medicaid programs. Thus, for the first time in US history, the government assumed direct responsibility to pay for some of the health care on behalf of two vulnerable population groups—the elderly and the poor (Potter and Longest 1994).

Through the debates over how to protect the public from rising costs of health care and the opposition to national health insurance, one thing had become clear: Government intervention was not desired insofar as it pertained to how most Americans received health care, with one exception. Less opposition would be encountered if reform initiatives were proposed for the underprivileged classes. In principle, the poor were considered a special class who could be served through a government-sponsored program. The elderly—those 65 years of age and over—were another group who started to receive increased attention in the 1950s. On their own, most of the poor and the elderly could not afford the increasing costs of health care. Also, because the health status of these population groups was significantly worse than that of the general population, they required a higher level of health care services. The elderly, particularly, had higher incidence and prevalence of disease compared to younger groups. It was also estimated that less than one-half of the elderly population were covered by private health insurance. By this

time, the growing elderly middle class was also becoming a politically active force.

Government assistance for the poor and the elderly was sought once it became clear that the market alone would not ensure access for these vulnerable population groups. A bill introduced in Congress by Aime Forand, in 1957, provided momentum for including necessary hospital and nursing home care as an extension of Social Security benefits (Stevens 1971). The AMA, however, undertook a massive campaign to portray a government insurance plan as a threat to the physician–patient relationship. The bill was stalled, but public hearings around the country, which were packed by the elderly, produced an intense grassroots support to push the issue onto the national agenda (Starr 1982). A compromised reform, the Medical Assistance Act (Public Law 86–778), also known as the Kerr-Mills Act, went into effect in 1960. Under the Act, federal grants were given to the states to extend health services provided by the state welfare programs to those low-income elderly who previously did not qualify (Anderson 1990). Since the program was based on a *means test* that confined eligibility to people below a predetermined income level, it was opposed by liberal congressional representatives as a source of humiliation to the elderly (Starr 1982). Within 3 years, the program was declared ineffective because many states did not even implement it (Stevens 1971). In 1964, health insurance for the aged and the poor became top priorities of President Johnson’s Great Society programs.

During the debate over Medicare, the AMA developed its own “Eldercare” proposal, which called for a federal–state program to subsidize private insurance policies for hospital and physician services. Representative John W. Byrnes introduced yet

another proposal, dubbed “Bettercare.” It proposed a federal program based on partial premium contributions by the elderly, with the remainder subsidized by the government. Other proposals included tax credits and tax deductions for health insurance premiums.

In the end, a three-layered program emerged. The first two layers constituted Part A and Part B of *Medicare*, or *Title XVIII* of the Social Security Amendment of 1965 to provide publicly financed health insurance to the elderly. Based on Forand’s initial bill, the administration’s proposal to finance hospital insurance providing hospital care and partial nursing home coverage for the elderly through Social Security became *Part A* of Medicare. The Byrnes proposal to cover physicians’ bills through government-subsidized insurance became *Part B* of Medicare. An extension of the Kerr-Mills program of federal matching funds to the states, based on each state’s financial needs, became *Medicaid*, or *Title XIX* of the Social Security Amendment of 1965. The Medicaid program was for the indigent, based on means tests established by each state, but it was expanded to include all age groups, not just the poor elderly (Stevens 1971).

Although adopted together, Medicare and Medicaid reflected sharply different traditions. Medicare was upheld by broad grassroots support and, being attached to Social Security, had no class distinction. Medicaid, however, was burdened by the stigma of public welfare. Medicare had uniform national standards for eligibility and benefits; Medicaid varied from state to state in terms of eligibility and benefits. Medicare allowed physicians to *balance bill*, that is, charge the patient the amount above the program’s set fees and recoup the difference. Medicaid prohibited balance billing

and, consequently, had limited participation from physicians (Starr 1982). Medicaid, in essence, has created a two-tier system of medical care delivery because some physicians refuse to accept Medicaid patients due to low fees set by the government.

Not long after Medicare and Medicaid were in operation, national spending for health services began to rise, as did public outlays of funds in relation to private spending for health services (Anderson 1990). For example, national health expenditures (NHE), which had increased by 50% from 1955 to 1960, and again from 1960 to 1965, jumped by 78% from 1965 to 1970, and by 71% from 1970 to 1975. Similarly, public expenditures for health care, which were stable at 25% of NHE for 1955, 1960, and 1965, increased to 36.5% of NHE in 1970, and to 42.1% of NHE in 1975 (based on data from Bureau of the Census 1976).

### Regulatory Role of Public Health Agencies

With the expansion of publicly financed Medicare and Medicaid programs, the regulatory powers of government have increasingly encroached upon the private sector. This is because the government provides financing for the two programs, but services are delivered by the private sector. After the federal government developed the standards for participation in the Medicare program, states developed regulations in conjunction with the Medicaid program. The regulations often overlapped, and the federal government delegated authority to the states to carry out the monitoring of regulatory compliance. As a result, the regulatory powers assigned to state public health agencies increased dramatically. Thus, most institutions of health care delivery are subject to annual scrutiny by public health agencies

under the authority delegated to them by the federal and state governments.

### Prototypes of Managed Care

Even though the early practice of medicine in the United States was mainly characterized by private solo practice, three subsequent developments in medical care delivery are noteworthy: contract practice, group practice, and prepaid group practice. All three required some sort of organizational integration, which was a departure from solo practice. These innovative arrangements can also be regarded as early precursors of managed care and integrated organizations (discussed in Chapter 9).

#### Contract Practice

In 1882, Northern Pacific Railroad Beneficial Association was one of the first employers to provide medical care expense coverage (Davis 1996). Between 1850 and 1900, other railroad, mining, and lumber enterprises developed extensive employee medical programs. Such companies conducted operations in isolated areas where physicians were unavailable. Inducements, such as a guaranteed salary, were commonly offered to attract physicians. Another common arrangement was to contract with independent physicians and hospitals at a flat fee per worker per month, referred to as *capitation*. The AMA recognized the necessity of contract practice in remote areas, but elsewhere contract practice was regarded as a form of exploitation because it was assumed that physicians would bid against each other and drive down the price. Offering services at reduced rates was regarded by the AMA as an unethical invasion of private practice. When group health insurance

became common in the 1940s through collective bargaining, the medical profession was freed from the threat of direct control by large corporations. Health insurance also enabled workers to go to physicians and hospitals of their choice (Starr 1982).

Corporate practice of medicine—that is, provision of medical care by for-profit corporations—was generally prohibited by law. It was labeled as commercialism in medicine. In 1917, however, Oregon passed the Hospital Association Act, which permitted for-profit corporations to provide medical services. Whereas health insurance companies, functioning as insurers and payers, acted as intermediaries between patients and physicians, the hospital associations in Oregon contracted directly with physicians and exercised some control over them. Utilization was managed by requiring second opinions for major surgery and by reviewing length of hospital stays. The corporations also restricted medical fees, refusing to pay prices deemed excessive. In short, they acted as a countervailing power in the medical market to limit physicians' professional autonomy. Even though physicians resented controls, they continued to do business with the hospital associations due to guaranteed payments (Starr 1982).

Early contract practice arrangements and the Oregon hospital associations can be viewed as prototypes of managed care. Since the 1980s and 1990s, MCOs have successfully replaced the traditional fee-for-service payment arrangements by capitation and discounted fees. Mechanisms to control excessive utilization are another key feature of managed care.

#### Group Practice

Group medicine represented another form of corporate organization for medical care.

Group practice changed the relationship among physicians by bringing them together with business managers and technical assistants in a more elaborate division of labor (Starr 1982). The Mayo Clinic, started in Rochester, Minnesota, in 1887, is regarded as a prototype of the consolidation of specialists into group practice. The concept of a multispecialty group presented a threat to the continuation of general practice. It also presented competition to specialists who remained in solo practice. Hence, the development of group practice met with widespread professional resistance (Stevens 1971). Although specialist group practice did not become a movement, sharing of expenses and incomes, along with other economic advantages, has caused group practices to continue to grow.

### Prepaid Group Plans

In time, the efficiencies of group practice led to the formation of prepaid group plans, in which an enrolled population received comprehensive services for a capitated fee. The HIP Health Plan of New York, started in 1947, stands as one of the most successful programs, providing comprehensive medical services through organized medical groups of family physicians and specialists (Raffel 1980). Similarly, Kaiser-Permanente, started in 1942, has grown on the West Coast. Other examples are the Group Health Cooperative of Puget Sound in Seattle, operating since 1947, which is a consumer-owned cooperative prepaid group practice (Williams 1993), and the Labor Health Institute in St. Louis, started in 1945, which is a union-sponsored group practice scheme (Stevens 1971).

The idea of prepaid group practice had limitations. It required the sponsorship of

large organizations. HIP, for example, was created by New York's Mayor Fiorello La Guardia for city employees. Industrialist Henry Kaiser initially set up his prepaid plan to provide comprehensive health care services to his own employees, but the health plan was later extended to other employers.

In 1971, President Nixon singled out prepaid group practice organizations as the model for a rational reorganization in the delivery of health services. They became the prototype of HMOs (Somers and Somers 1977). During the Nixon Administration, the use of HMOs in the private sector was encouraged by federal legislation, the Health Maintenance Organization Act (HMO Act) of 1973. The HMO Act required employers to offer an HMO alternative to conventional health insurance (Goodman and Musgrave 1992). MCOs still attempt to combine the efficiencies of contract and group arrangements with the objective of delivering comprehensive health care services at predetermined costs.

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## Medical Care in the Corporate Era

The latter part of the 20th century and start of the 21st century have been marked by the growth and consolidation of large business corporations and tremendous advances in global communications, transportation, and trade. These developments are starting to change the way health care is delivered in the United States and, indeed, around the world. The rise of multinational corporations, the information revolution, and globalization have been interdependent phenomena. The World Trade Organization's General Agreement on Trade in Services (GATS), which came into effect in 1995, aims to gradually remove all barriers to international trade in

services. In health care services, GATS may regulate health insurance, hospital services, telemedicine, and acquisition of medical treatment abroad. GATS negotiations, however, have met controversy, as various countries fear that it may shape their domestic health care systems (Belsky et al. 2004), although most analysts predict that GATS is likely to produce future market liberalization (Mutchnick et al. 2005).

### Corporatization of Health Care Delivery

Corporatization here refers to the ways in which health care delivery in the United States has become the domain of large organizations. These corporations may operate either on a for-profit or nonprofit basis, yet they are driven, for the most part, by the common goal of maximizing their revenues. At least one benefit of this corporatization has been the ability of these organizations to deliver sophisticated modern health care in comfortable and pleasant surroundings. But, one main expectation of delivering the same quality of health care at lesser cost remains largely unrealized.

On the supply side, until the mid-1980s, physicians and hospitals clearly dominated the medical marketplace. Since then, managed care has emerged as a dominant force by becoming the primary vehicle for insuring and delivering health care to the majority of Americans. The rise of managed care consolidated immense purchasing power on the demand side. To counteract this imbalance, providers began to consolidate, and larger, integrated health care organizations began forming (see Chapter 9). A second, influential factor behind health care integration was reimbursement cuts for inpatient acute care hospital services in the mid-1980s. To make up for lost revenues in the

inpatient sector, hospitals developed various types of outpatient services, such as primary care, outpatient surgery, and home health care, and expanded into other differentiated health care services, such as long-term care and specialized rehabilitation. Together, managed care and integrated delivery organizations have, in reality, corporatized the delivery of health care in the United States.

In a health care landscape that has been increasingly dominated by corporations, individual physicians have struggled to preserve their autonomy. As a matter of survival, many physicians consolidated into large clinics, formed strategic partnerships with hospitals, or started their own specialty hospitals. A growing number of physicians have become employees of large medical corporations. Proliferation of these new models of health care delivery has made it increasingly difficult for states to maintain outright bans on the employment of physicians (Farmer and Douglas 2001).

Both managed care and corporate delivery of medicine have made the health care system extremely complex from the consumer's standpoint. Managed care was supposed to be a market-based reform, but it has stripped the primary consumer, the patient, of practically all marketplace power. Dominance by any entity, whether organized medicine or integrated health organizations, subverts the sovereignty of the health care consumer. In this so-called market-driven integration, the consumer continues to wonder, "Where's the market?"

### Information Revolution

The delivery of health care is being transformed in unprecedented and irreversible ways by telecommunication. The use of telemedicine and telehealth is on the rise



(see Chapter 5). These technologies integrate telecommunication systems into the practice of protecting and promoting health, which may or may not incorporate actual physician–patient interactions.

Telemedicine dates back to the 1920s, when shore-based medical specialists were radio linked to address medical emergencies at sea (Winters 1921). Telemedicine came to the forefront in the 1990s, with the technological advances in the distant transmission of image data and the recognition that there was inequitable access to medical care in rural America. Federal dollars were poured into rural telemedicine projects.

Telehealth consultations can occur in real time. Videoconferencing is now replacing telephone consultation as the preferred vehicle for behavioral telehealth or telepsychiatry. *E-health* has also become an unstoppable force that is driven by consumer demand for health care information and services offered over the Internet by professionals and non-professionals alike (Maheu et al. 2001). The Internet has created a new revolution that is increasingly characterized by patient empowerment. Access to expert information is no longer strictly confined to the physician's domain, which in some ways has led to a dilution of the dependent role of the patient.

## Globalization

*Globalization* refers to various forms of cross-border economic activities. It is driven by global exchange of information, production of goods and services more economically in developing countries, and increased interdependence of mature and emerging world economies. It confers many advantages but also has its downsides.

From the standpoint of cross-border trade in health services, Mutchnick and

colleagues (2005) identified four different modes of economic interrelationships: (1) Use of advanced telecommunication infrastructures in telemedicine transfers information cross-border for instant answers and services. For example, teleradiology (the electronic transmission of radiological images over a distance) now enables physicians in the United States to transmit radiological images to Australia, where they are interpreted and reported back the next day (McDonnell 2006). Innovative telemedicine consulting services in pathology and radiology are being delivered to other parts of the world by cutting-edge US medical institutions, such as Johns Hopkins. (2) Consumers travel abroad to receive medical care. Specialty hospitals, such as the Apollo chain in India and Bumrungrad International Hospital in Thailand, offer state-of-the-art medical facilities to foreigners at a fraction of the cost for the same procedures done in the United States or Europe. Physicians and hospitals outside the United States have clear competitive advantages: reasonable malpractice costs, minimum regulation, and lower costs of labor. As a result of these efficiencies, Indian specialty hospitals can do quality liver transplants for one-tenth of the cost in US hospitals (Mutchnick et al. 2005). Some health insurance companies have also started to explore cheaper options for their covered members to receive certain costly services overseas. Conversely, dignitaries and other wealthy foreigners come to multispecialty centers in the United States, such as the Mayo Clinic, to receive highly specialized services. (3) Foreign direct investment in health services enterprises benefits foreign citizens. For example, Chindex International, a US corporation, provides medical equipment, supplies, and clinical care in China. Chindex opened the Beijing

United Family Hospital and Clinics in 1997 (Mutchnick et al. 2005). (4) Health professionals move to other countries that present high demand for their services and better economic opportunities than their native countries. For example, nurses from other countries are moving to the United States to relieve the existing personnel shortage. Migration of physicians from developing countries helps alleviate at least some of the shortage in underserved locations in the developed world.

To the above list, we can add two more: (1) Corporations based in the United States have increasingly expanded their operations overseas. As a result, an increasing number of Americans are now working overseas as expatriates. Health insurance companies based in the United States are, in turn, having to develop benefit plans for these expatriates. According to a survey of 87 insurance companies, health care is also becoming one of the most sought after employee benefits worldwide, even in countries that have national health insurance programs. Also, the cost of medical care overseas is rising at a faster rate than the rate of inflation in the general economy (Cavanaugh 2008). Hence, the cost-effective delivery of health care is becoming a major challenge worldwide. (2) Medical care delivery by US providers is in demand overseas. American providers, such as Johns Hopkins, Cleveland Clinic, Mayo Clinic, Duke University, and several others, are now delivering medical services in various developing countries.

Globalization has also produced some negative effects. The developing world pays a price when emigration leaves these countries with shortages of trained professionals. The burden of disease in these countries is often greater than it is in the developed world, and emigration only exacerbates the

ability of these countries to provide adequate health care to their own populations (Norcini and Mazmanian 2005). Tobacco use is on the decline in many developed countries, yet economic development in emerging markets provides new targets for multinational tobacco companies. In addition, as developing countries become more prosperous, they acquire Western tastes and lifestyles. In some instances, negative health consequences follow. For example, increased use of motorized vehicles results in a lack of physical exercise, which, along with changes in diet, greatly increases the prevalence of chronic diseases, such as heart disease and diabetes, in the developing world. Conversely, better information about health promotion and disease prevention, as well as access to gyms and swimming pools, in developing countries is making a positive impact on the health and well-being of their middle-class citizens. Globalization has also posed some new threats. For instance, the threat of infectious diseases has increased, as diseases appearing in one country can spread rapidly to other countries. HIV/AIDS, hepatitis B, and hepatitis C infections have spread worldwide. New viral infections, such as avian flu and SARS, have at times threatened to create worldwide pandemics.

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### Has the Era of Socialized Medicine Arrived?

Perhaps it has arrived, but only time can tell. Despite the obstacles to national health insurance, discussed previously in this chapter, on March 21, 2010, the House Democrats in Congress successfully passed, by a 219 to 212 vote, the Patient Protection and

Affordable Care Act, which was signed into law 2 days later by President Obama. Not a single Republican voted in favor of the legislation.

Among many campaign promises to bring change to America, Barack Obama stated his goal of drastically reducing the number of Americans who had no health insurance coverage. Details of any “plan” to accomplish this, however, were left unstated. President Obama was sworn into office in January 2009. A Democratic president also had Democrat majority in both houses of Congress for the first time since 1993, the year in which President Clinton had proposed a massive overhaul of the US health care system. Unlike the defeat of Clinton’s reform proposals, which were criticized by some congressional leaders in his own party, Obama was able to maneuver the passage of his health care agenda by uniting his party behind a common cause. Support for the bill required backroom deals with waffling members of the Democratic Party and with interest groups representing the hospital and pharmaceutical industries. Surprisingly, the AMA sheepishly pledged its support for the legislation, which was a complete reversal of its historic stance toward national health insurance. According to one commentator, the AMA has tried to protect itself. The AMA is no longer the powerful organization it once was; it now represents only 17% of the physicians in the United States. It is plausible that the AMA has tried to protect its monopoly over the medical coding system that health care providers must use to get paid, which generates an annual income of over \$70 million for the organization (Scherz 2010). The American public was also kept in the dark about the details buried in the 2,700 pages filled by the final legislation.

Over one-half of the states and some private parties filed lawsuits challenging the constitutionality of the new law. In December 2010, a federal judge in Virginia ruled that at least certain provisions of the law were unconstitutional because they force individuals to purchase health insurance. In January 2011, a federal judge in Florida ruled in a lawsuit, joined by 26 states, that the entire law was unconstitutional. Many legal scholars think the matter will be finally settled by the Supreme Court.

Polls showed that nearly two-thirds of Americans opposed the legislation as too ambitious and too costly (Page 2010). A more current Gallup poll showed that 46% of Americans were in favor of repealing the law; 40% opposed repealing it (Jones 2011).

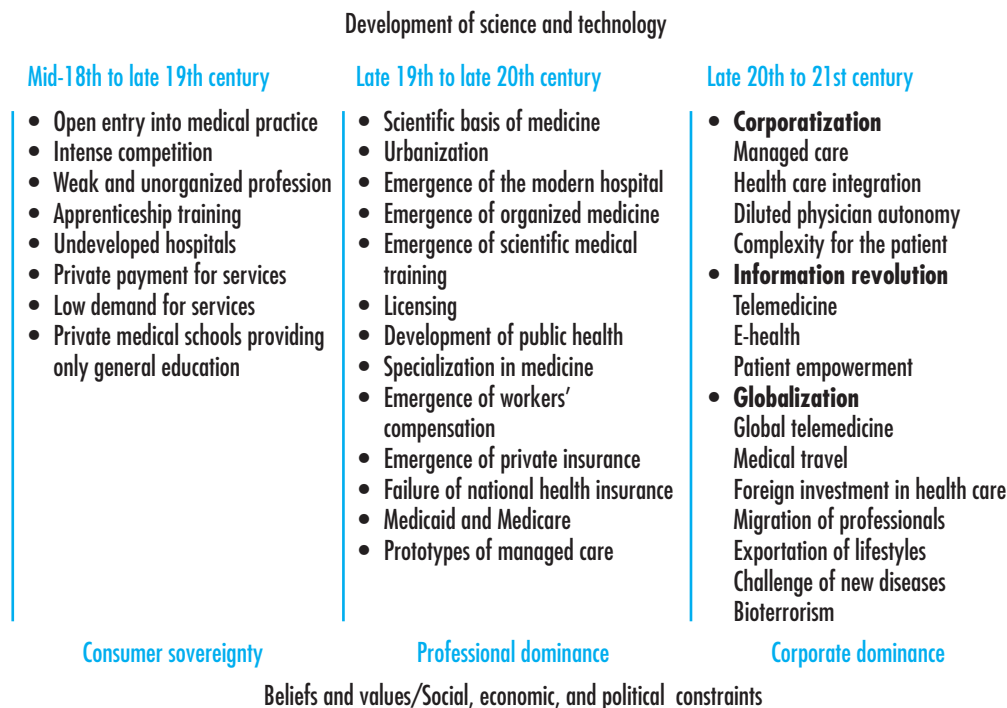
In the 2010 midterm elections, Republicans gained control of the House, whereas the Democrats held their majority in the Senate. The balance of power shifted. The Republicans, taking advantage of their majority in the House, voted to repeal the health care law, but the Senate rejected this measure by a vote of 51 to 47 in favor of not repealing the law. Miller (2010) describes the stalemate in health reform as a “cease-fire in a political hundred years’ war.” The cease-fire may not last for too long.

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## Summary

Figure 3–1 provides a snapshot of the historical developments in US health care delivery. The evolution of health care services has been strongly influenced by the advancement of scientific research and technological development. Early scientific discoveries were pioneered in Europe, but they were not readily adopted in the United States.

Figure 3–1 Evolution of the US Health Care Delivery System.



Therefore, medicine had a largely domestic, rather than professional, character in preindustrial America. The absence of standards of practice and licensing requirements allowed the trained and untrained alike to deliver medical care. Hospitals were more akin to places of refuge than centers of medical practice. The demand for professional services was relatively low because services had to be purchased privately, without the help of government or health insurance. Medical education was seriously deficient in providing technical training based on scientific knowledge. The medical profession faced intense competition; it was weak, unorganized, and insecure.

Scientific and technological advances led to the development of sophisticated institutions, where better-trained physicians

could practice medicine. The transformation of America from a mainly rural, sparsely populated country to one with growing centers of urban population created increased reliance on the specialized skills that only trained professionals could offer. Simultaneously, medical professionals banded together into a politically strong organization, the AMA. The AMA succeeded in controlling the practice of medicine, mainly through its influence on medical education, licensing of physicians, and political lobbying.

In Europe, national health insurance has been an outgrowth of generous social programs. In the United States, by contrast, the predominance of private institutions, ideologies founded on the principles of market justice, and an aversion to tax increases have been instrumental in maintaining a

health care delivery system that is mainly privately financed and operated. The AMA and other interest groups have also wielded enormous influence in opposing efforts to initiate comprehensive reforms based on national health insurance. Access to health services in the United States is achieved, primarily, through private health insurance; however, two major social programs, Medicaid and Medicare, were expediently enacted to provide affordable health services to vulnerable populations.

The corporate era in health care dawned in the latter part of the 20th century. The rise of multinational corporations, the information revolution, and globalization have marked this current era. Managed care represents

corporatization of health care delivery on the demand side. On the supply side, providers have been integrated into various types of consolidated arrangements. The information revolution is characterized by the growth of telemedicine and E-health. Globalization has made the mature and the emerging world economies more interdependent, which has both advantages and disadvantages.

In 2010, thanks to control of Congress and the presidency by the Democratic Party, a sweeping health care reform legislation was passed. However, amid legal challenges, loss of control of the House of Representatives by the Democratic Party, and public opposition, the fate of this new law remains uncertain.

### Terminology

*almshouse*

*balance bill*

*capitation*

*cost-shifting*

*cross-subsidization*

*cultural authority*

*E-health*

*fee for service*

*gatekeeping*

*globalization*

*means test*

*Medicaid*

*Medicare*

*organized medicine*

*Part A*

*Part B*

### Test Your Understanding

*pesthouse*

*prepaid plan*

*socialized medicine*

*Title XVIII*

*Title XIX*

*voluntary health insurance*

### Review Questions

1. Why did the professionalization of medicine start later in the United States than in some Western European nations?
2. Why did medicine have a domestic, rather than professional, character in the preindustrial era? How did urbanization change that?
3. Which factors explain why the demand for the services of a professional physician was inadequate in the preindustrial era? How did scientific medicine and technology change that?
4. How did the emergence of general hospitals strengthen the professional sovereignty of physicians?



5. Discuss the relationship of dependency within the context of the medical profession's cultural and legitimized authority. What role did medical education reform play in galvanizing professional authority?
6. How did the organized medical profession manage to remain free of control by business firms, insurance companies, and hospitals until the latter part of the 20th century?
7. In general, discuss how technological, social, and economic factors created the need for health insurance.
8. Which conditions during the World War II period lent support to private health insurance in the United States?
9. Discuss, with particular reference to the roles of (a) organized medicine, (b) the middle class, and (c) American beliefs and values, why reform efforts to bring in national health insurance have historically been unsuccessful in the United States.
10. Which particular factors that earlier may have been somewhat weak in bringing about national health insurance later led to the passage of Medicare and Medicaid?
11. On what basis were the elderly and the poor regarded as vulnerable groups for whom special government-sponsored programs needed to be created?
12. Discuss the government's role in the delivery and financing of health care, with specific reference to the dichotomy between public health and private medicine.
13. Explain how contract practice and prepaid group practice were the prototypes of today's managed care plans.
14. Discuss the main ways in which current delivery of health care has become corporatized.
15. How has the information revolution affected the practice of medicine?
16. In the context of globalization in health services, what main economic activities are discussed in this chapter?

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## REFERENCES

- Altman, S.H., and U.E. Reinhardt, eds. 1996. *Strategic choices for a changing health care system*. Chicago: Health Administration Press.
- Anderson, O.W. 1990. *Health services as a growth enterprise in the United States since 1875*. Ann Arbor, MI: Health Administration Press.
- Belsky, L. et al. 2004. The general agreement on trade in services: Implications for health policymakers. *Health Affairs* 23, no. 3: 137–145.
- Bordley, J., and A.M. Harvey. 1976. *Two centuries of American medicine 1776–1976*. Philadelphia, PA: W.B. Saunders Company.
- Bureau of the Census. 1976. *Statistical abstract of the United States, 1976*. Washington, DC: US Department of Commerce.
- Bureau of Labor Statistics. 2011. *Occupational outlook handbook, 2010–11*. Available at: <http://www.bls.gov/oco/home.htm>. Accessed January 2011.

- Burns, J. 2004. Are nonprofit hospitals really charitable? Taking the question to the state and local level. *Journal of Corporate Law* 29, no. 3: 665–683.
- Cavanaugh, B.B. 2008. Building the worldwide health network. *Best's Review* 108, no. 12: 32–37.
- Clark, C. 1998. A bloody evolution: Human error in medicine is as old as the practice itself. *The Washington Post*, 20 October, Z10.
- Coggeshall, L.T. 1965. *Planning for medical progress through education*. Evanston, IL: Association of American Medical Colleges.
- Davis, P. 1996. The fate of Blue Shield and the new blues. *South Dakota Journal of Medicine* 49, no. 9: 323–330.
- Duffy, J. 1971. Social impact of disease in the late 19th century. *Bulletin of the New York Academy of Medicine* 47: 797–811.
- Falk, G. 1999. *Hippocrates assailed: The American health delivery system*. Lanham, MD: University Press of America, Inc.
- Farmer, G.O., and J.H. Douglas. 2001. Physician “unionization”—A primer and prescription. *Florida Bar Journal* 75, no. 7: 37–42.
- Gabe, J. et al. 1994. *Challenging medicine*. New York: Routledge.
- Goodman, J.C., and G.L. Musgrave. 1992. *Patient power: Solving America's health care crisis*. Washington, DC: CATO Institute.
- Haber, S. 1974. The professions and higher education in America: A historical view. In: *Higher education and labor markets*. M.S. Gordon, ed. New York: McGraw-Hill Book Co.
- Haglund, C.L., and W.L. Dowling. 1993. The hospital. In: *Introduction to health services*. 4th ed. S.J. Williams and P.R. Torrens, eds. New York: Delmar Publishers. pp. 135–176.
- Hamowy, R. 1979. The early development of medical licensing laws in the United States, 1875–1900. *Journal of Libertarian Studies* 3, no. 1: 73–119.
- Health Insurance Association of America. 1991. *Source book of health insurance data*. Washington, DC: Health Insurance Association of America.
- Henry J. Kaiser Family Foundation. 2011. *Summary of coverage provisions in the Patient Protection and Affordable Care Act*. Available at: <http://kff.org/healthreform/upload/8023-R.pdf>. Accessed April 2011.
- Jones, J.M. 2011. In U.S., 46% favor, 40% oppose repealing healthcare law. Available at: <http://www.gallup.com/poll/145496/Favor-Oppose-Repealing-Healthcare-Law.aspx>. Accessed April 2011.
- Kaptchuk, T.J., and D.M. Eisenberg. 2001. Varieties of healing 1: Medical pluralism in the United States. *Annals of Internal Medicine* 135, no. 3: 189–195.
- Kardos, B.C., and A.T. Allen. 1993. Healthy neighbors: Exploring the health care systems of the United States and Canada. *Journal of Post Anesthesia Nursing* 8, no. 1: 48–51.
- Kaufman, M. 1980. American medical education. In: *The education of American physicians: Historical essays*. R.L. Numbers, ed. Los Angeles: University of California Press.
- Koch, A.L. 1993. Financing health services. In: *Introduction to health services*. 4th ed. S.J. Williams and P.R. Torrens, eds. New York: Delmar Publishers. pp. 299–331.
- Law, S.A. 1974. *Blue Cross: What went wrong?* New Haven, CT: Yale University Press.

- Maheu, M.M. et al. 2001. *E-health, telehealth, and telemedicine: A guide to start-up and success*. San Francisco: Jossey-Bass.
- Manderscheid, R.W. et al. 2004. Highlights of organized mental health services in 2000 and major national and state trends. In: *Mental health, United States, 2002*. R.W. Manderscheid and M.J. Henderson, eds. Washington, DC: US Government Printing Office.
- Martensen, R.L. 1996. Hospital hotels and the care of the “worthy rich.” *Journal of the American Medical Association* 275, no. 4: 325.
- Mayer, T.R., and G.G. Mayer. 1984. *The health insurance alternative: A complete guide to health maintenance organizations*. New York: Putnam Publishing Group.
- McDonnell, J. 2006. Is the medical world flattening? *Ophthalmology Times* 31, no. 19: 4.
- Miller, T.P. 2010. Health reform: Only a cease-fire in a political hundred years’ war. *Health Affairs* 29, no. 6: 1101–1105.
- Mongan, J.J. 1995. Anatomy and physiology of health reform’s failure. *Health Affairs* 14, no. 1: 99–101.
- Mutchnick, I.S. et al. 2005. Trading health services across borders: GATS, markets, and caveats. *Health Affairs – Web Exclusive* 24, suppl. 1: W5-42–W5-51.
- Norcini, J.J., and P.E. Mazmanian. 2005. Physician migration, education, and health care. *Journal of Continuing Education in the Health Professions* 25, no. 1: 4–7.
- Numbers, R.L. 1985. The third party: Health insurance in America. In: *Sickness and health in America: Readings in the history of medicine and public health*. J.W. Leavitt and R.L. Numbers, eds. Madison, WI: The University of Wisconsin Press.
- Numbers, R.L., and J.H. Warner. 1985. The maturation of American medical science. In: *Sickness and health in America: Readings in the history of medicine and public health*. J.W. Leavitt and R.L. Numbers, eds. Madison, WI: The University of Wisconsin Press.
- Page, S. 2010. Health care law too costly, most say (USA Today). Available at: [http://www.usatoday.com/news/washington/2010-03-29-health-poll\\_N.htm](http://www.usatoday.com/news/washington/2010-03-29-health-poll_N.htm). Accessed January 2011.
- Potter, M.A., and B.B. Longest. 1994. The divergence of federal and state policies on the charitable tax exemption of nonprofit hospitals. *Journal of Health Politics, Policy and Law* 19, no. 2: 393–419.
- Raffel, M.W. 1980. *The U.S. health system: Origins and functions*. New York: John Wiley & Sons.
- Raffel, M.W., and N.K. Raffel. 1994. *The U.S. health system: Origins and functions*. 4th ed. Albany, NY: Delmar Publishers.
- Richardson, J.T. 1945. *The origin and development of group hospitalization in the United States, 1890–1940*. University of Missouri Studies XX, no. 3.
- Rosen, G. 1983. *The structure of American medical practice 1875–1941*. Philadelphia, PA: University of Pennsylvania Press.
- Rosenberg, C.E. 1979. The therapeutic revolution: Medicine, meaning, and social change in nineteenth-century America. In: *The therapeutic revolution*. M.J. Vogel, ed. Philadelphia, PA: The University of Pennsylvania Press.
- Rosner, L. 2001. The Philadelphia medical marketplace. In: *Major problems in the history of American medicine and public health*. J.H. Warner and J.A. Tighe, eds. Boston: Houghton Mifflin Company.

- Rothstein, W.G. 1972. *American physicians in the nineteenth century: From sect to science*. Baltimore, MD: Johns Hopkins University Press.
- Scherz, H. 2010. Why the AMA wants to muzzle your doctor (*The Wall Street Journal*). Available at: <http://online.wsj.com/article/SB10001424052748703961104575226323909364054.html>. Accessed April 2011.
- Shryock, R.H. 1966. *Medicine in America: Historical essays*. Baltimore, MD: The Johns Hopkins Press.
- Skocpol, T. 1995. The rise and resounding demise of the Clinton plan. *Health Affairs* 14, no. 1: 66–85.
- Smith, M.D. et al. 1992. Taking the public's pulse on health system reform. *Health Affairs* 11, no. 2: 125–133.
- Somers, A.R., and H.M. Somers. 1977. *Health and health care: Policies in perspective*. Germantown, MD: Aspen Systems.
- Starr, P. 1982. *The social transformation of American medicine*. Cambridge, MA: Basic Books.
- Stevens, R. 1971. *American medicine and the public interest*. New Haven, CT: Yale University Press.
- Turnock, B.J. 1997. *Public health: What it is and how it works*. Gaithersburg, MD: Aspen Publishers, Inc. pp. 3–38.
- US Surgeon General. 1999. *Mental health: A report of the Surgeon General. Overview of mental health services*. Available at: <http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2.html>. Accessed February 2011.
- Whitted, G. 1993. Private health insurance and employee benefits. In: *Introduction to health services*. 4th ed. S.J. Williams and P.R. Torrens, eds. New York: Delmar Publishers. pp. 332–360.
- Williams, S.J. 1993. Ambulatory health care services. In: *Introduction to health services*. 4th ed. S.J. Williams and P.R. Torrens, eds. New York: Delmar Publishers.
- Williams, S.J. 1995. *Essentials of health services*. Albany, NY: Delmar Publishers. pp. 108–134.
- Winters, S.R. 1921. Diagnosis by wireless. *Scientific American* 124: 465.
- Wright, J.W. 1997. *The New York Times almanac*. New York: Penguin Putnam, Inc.

