CHAPTER THREE

The Liberal Years

THE POSTWAR decades of economic expansion saw a dramatic growth in the scale of American medicine. From modest prewar beginnings the United States built up an immense medical research establishment. It enlarged and equipped the most scientifically advanced hospitals in the world and created an entirely new network of community mental health centers. Between 1950 and 1970, the medical work force increased from 1.2 to 3.9 million people. National health care expenditures grew from $12.7 billion to $71.6 billion (up from 4.5 to 7.3 percent of the GNP), and medical care became one of the nation's largest industries.1 But the growth in scale, made possible by prosperity and the rise of private health plans, was only the most visible expression of American devotion to medicine in the pursuit of health.

Americans now gave science unprecedented recognition as a national asset. During World War II the research effort that produced radar, the atom bomb, and penicillin persuaded even the skeptical that support of science was vital to national security. At the war's end, an advisory board on medical research reported, "Penicillin and the sulfonamides, the insecticide DDT, better vaccines, and improved hygienic measures have all but conquered yellow fever, dysentery, typhus, tetanus, pneumonia, meningitis. Malaria has been controlled. Disability from venereal disease has been radically reduced by new methods of treatment. Dramatic progress in surgery has been aided by the increased availability of blood and plasma for transfusions." Com-
pared to World War I, the death rate from disease in the Army had fallen from 14.1 to .6 per 1,000 soldiers. 2

Postwar recognition of a national interest in science and medicine also stemmed from America’s new role of international leadership. The United States emerged from the Second World War as the major economic and military power in the world. European economies were devastated while American industrial production and national income more than doubled during the war. In 1947 the United States produced more than half the world’s manufactured goods, 62 percent of its oil, and 80 percent of its automobiles. It was also producing a larger share of the world’s science than ever before (with the help, to be sure, of European scientists who had fled from the Nazis). Spokesmen for American science pointed out that it would be neither wise nor possible for the United States to depend any longer on European, much less German, scientific achievement. And in the cold war, science assumed a symbolic as well as a practical function in maintaining America’s position as “leader of the free world.”

At home the advance of science and medicine, like economic growth, offered the prospect of improved well-being without requiring any profound reorganization of society. Liberal opinion held that America had transcended the need for drastic political reform by incorporating progressive change into its free institutions. Medical science epitomized the postwar vision of progress without conflict. All could agree about the value of medical progress, and all could benefit from it (that is, if they could afford the cost, as the advocates of national health insurance would add). On the page that Time magazine devoted each week to medicine, Americans could read about the latest “wonder drugs” and other miracles of modern medicine. Here was evidence that life was getting better. Here was proof that this was already, as Henry R. Luce called it, “the American century.” The routine of innovation was one of the fruits of what Luce’s editors at Fortune wryly referred to as capitalism’s “permanent revolution.”

Prosperity gave Americans the opportunity to worry about their health, and it also changed the health problems they worried about. From the beginning of the twentieth century, the chief sources of mortality had been shifting from infectious to chronic disease. The Depression and the war, however, had diverted attention to more urgent needs than chronic illness. Now facing the medical problems of peace, scientists and the public became more concerned about cancer, heart disease, and those conditions, such as obesity and neurosis, on which only an affluent society can afford to dwell. And at a time when the antibiotics were providing effective therapeutic means for treating infec-
tious diseases, chronic illness reengaged medicine intimately in questions of social behavior and moral choice.

Liberal-minded people approved of a broad extension of medical authority into the regulation of social life. The consensus of the enlightened favored substituting therapeutic for punitive responses in the social management of delinquency, alcoholism, narcotics use, and sexual deviation. Psychiatry, previously concerned primarily with the care of the insane, had been institutionally marginal in America before World War II. Now it moved into the “mainstream” of American medicine and American society and enormously expanded its claims and its clientele. Whereas formerly its province was mental illness, now it became mental health. In the postwar years, the advocacy of professional intervention to advance mental health took on an evangelistic fervor. Here politics and professionalism were at work together. With the collapse of the left as an ideological force, social reformers increasingly appropriated the language of clinical medicine. Psychiatrists were at the vanguard of this movement to redefine social problems in medical terms. Therapeutic intervention so often failed, they argued, because it was too late; what was needed was “mass preventive psychiatry” in which medical judgment participated in all manner of activities from child rearing to international peace keeping.4

The conflict between liberals and the AMA over national health insurance should not obscure the deeper alliance between liberalism and medicine in the postwar decades. Both liberal and medical opinion supported a broad mandate for professional authority. Liberals and physicians did not differ in their enthusiasm for medicine, only about the form in which enthusiasm ought to be expressed. The movement toward incorporating medicine into the state had to find channels of expression acceptable to the organized profession. The use of psychiatry in social welfare and the courts did not offend any interest of private practitioners. Public support for medical research, hospital construction, and other forms of resource development also posed fewer problems for the AMA than did health insurance. These programs typically increased the capital resources of the system (scientific knowledge, physical infrastructure) without limiting physicians’ income from it. Acceptable measures were forms of complementary rather than competitive investment.

In medicine, as in the broader society, the vision of growth without conflict broke down in the 1960s. The postwar expansion did not remedy the acknowledged deficiencies in the distribution of medical services. Aiding medical research and facilities construction, without providing for primary care, set off an unbalanced expansion that became
increasingly costly and irrational. The first phase of postwar policy, favoring growth without redistribution, gave way by the mid-1960s to policies that tried to improve distribution yet without any fundamental reorganization of the system. Still later, in the 1970s, public policy, after pursuing growth and redistribution without reorganization, accepted the need for reorganization to stop growth.

The succession of objectives in medical policy—expansion, equity, cost containment—paralleled the more general succession of concerns in postwar social policy. The predominant issue in the late 1940s in housing, transportation, and other fields was the problem of inadequate supply. Home mortgage guarantees and the highway trust fund were of a piece with federal aid to hospital construction. Social policy sought to underwrite the expansion of infrastructure that made possible the new middle-class life in the suburbs. By the mid-1960s the federal government became increasingly concerned with the stubborn problems of those who were left behind, and policy shifted in many areas to explicitly redistributive objectives. And in the 1970s, with persistent stagflation, social policy became increasingly sensitive to cost. In this and the following chapter, my objective is to show how this evolution specifically affected medical care and the medical profession: how postwar public policy initially respected and then threatened to undermine the sovereignty of American medicine.

AID AND AUTONOMY, 1945-1960

Public Investment in Science

The Second World War, more than the New Deal, marked the beginning of the great expansion of the federal government’s support of medicine. This was notably the case in both medical research and mental health.

American scientists before the war generally opposed any large-scale federal financing or coordination of research.* Between 1900 and 1940, the primary sources of financing for medical research were private. Pri-

*This was the position, for example, of the National Academy of Sciences. Created during the Civil War, the academy soon after became largely an honorific rather than an advisory body, as it was originally intended to be. The National Research Council, set up during World War I as the academy’s operating arm, also quickly fell into disuse. Until World War II, the pattern of the federal government was to create central scientific organizations in war and ignore them in peace.*
vate foundations and universities were the principal sponsors and hosts of basic research. The most richly endowed research center, the Rockefeller Institute for Medical Research, was established in New York in 1902 and by 1928 had received from John D. Rockefeller $65 million in endowment funds. In that same period, wealthy donors set up several other independent institutes, but most medical research was conducted by scientists in universities, supported by endowment income, special research funds, and foundation grants.6

The other major private sponsors of research were pharmaceutical companies, which grew rapidly after the 1920s. Unlike the nonprofit patrons, they were interested primarily in applied research and hired scientists to work in their own laboratories. An estimate in 1945 put the research expenditures of the drug companies at $40 million, compared to $25 million for the foundations, universities, and research institutes.7

There were, in addition, several smaller sources of private financing: voluntary health agencies, such as the National Tuberculosis Association, which initiated a research program in 1921; professional societies, such as the AMA, which offered small research grants beginning in 1903; the Metropolitan Life Insurance Company, which supported public health research; and a few private group practices, such as the Mayo Clinic, that set up research foundations.

By comparison with all private sources, the financial contribution of the federal government was relatively small. In the early 1900s, the budget of the Rockefeller Institute alone was many times larger than federal expenditures for medical research. The one area of research for which Congress generously appropriated money was agriculture. As critics liked to point out, congressmen were prepared to spend more money to figure out how to save hogs than how to save people. Had human beings sold for as high a price as pork, the situation might have been different. In its heyday, from the 1890s to the 1930s, the Department of Agriculture was the leading agency of the federal government with scientific interests and the locus of much health-related scientific work. It was altogether natural for Congress to assign Agriculture responsibility to enforce the 1906 food and drug law; under this authority, its Bureau of Chemistry conducted toxicological and pharmacological studies. Concern about pesticides containing lead and arsenic produced early research on environmental toxins. Indirectly, agricultural research yielded some notable medical advances. Work in veterinary medicine improved understanding of the transmission of disease, and research in soil chemistry led to the discovery by René Dubos of the early antibiotic gramicidin, to Selman Waksman's work on streptomycin, and to the discovery of the other antibiotics that followed penicillin.8
Direct federal sponsorship of medical research originated in the role of the old Marine Hospital Service in the control of epidemics. In 1887 a young doctor, Joseph J. Kinyoun, set up a bacteriological laboratory in the Marine Hospital at Staten Island, New York. Four years later this Hygienic Laboratory was moved to Washington. It received authority to test and improve biological products in 1902 when Congress passed the Biologics Control Act to regulate vaccines and sera sold in interstate commerce. That same year, the Hygienic Laboratory added divisions in chemistry, pharmacology, and zoology, though its annual budget was still less than $50,000. In 1912 the service—by then called the U.S. Public Health Service—was authorized to study chronic as well as infectious diseases. Though working with limited funds, its medical officers made several important contributions, including a vaccine against Rocky Mountain spotted fever. In the 1920s, one of its physicians, Joseph Goldberger, showed that pellagra was not an infectious but a deficiency disease that could be prevented by proper diet. In 1930, reorganized under the Randsell Act, the Hygienic Laboratory became the National Institute of Health (NIH), and in 1938 it moved to a large, privately donated estate in Bethesda, Maryland, which is still its home today.9

Until the 1930s, nearly all the medical research financed by the federal government was conducted in government laboratories. In 1937, however, Congress departed from this practice when it passed the first of a series of measures to promote cancer research and cancer control. The legislation set up a National Cancer Institute under NIH, but for the first time, Congress also authorized the Public Health Service to make grants to outside researchers. In addition, it created a program of training fellowships. These proved to be important institutional precedents, though the funds involved were still quite limited. As late as 1938, the research budget of the Public Health Service was only $2.8 million, compared to $26.3 million for the Department of Agriculture.10

The war gave medical research priority. In July 1941 President Roosevelt created an Office of Scientific Research and Development (OSRD) with two parallel committees on national defense and medical research. The Committee on Medical Research (CMR) undertook a comprehensive research program to deal with the medical problems of the war. The work, costing $15 million, involved 450 contracts with universities and another 150 with research institutes, hospitals, and other organizations. Altogether, some 5,500 scientists and technicians were employed in the enterprise. Since the Japanese had seized the sources of quinine in the Pacific, the United States required a substitute in the treatment of malaria. Researchers were able to develop and standardize a synthet-
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ic, atabrine, that proved even more effective than quinine. In a major breakthrough, scientists isolated the therapeutically useful derivatives of blood, such as gamma globulin. Interest in penicillin was initially stimulated by its possible use against staphylococic infections. Though the therapeutic value of penicillin had been demonstrated in the 1930s, it could be produced only in minute quantities at great cost. The CMR contracted with the Bradley Polytechnic Institute in Peoria, Illinois, to improve the strains and media for producing penicillin. Soon it was being turned out in 15,000-gallon tanks, and by the war’s end was available for civilian as well as military use.11

The development of penicillin was paradigmatic of wartime medical research. Most of the work took advantage of the tremendous backlog of scientific ideas awaiting application. It was carried out primarily in independent laboratories. Scientific decisions were left to panels of independent scientists, and there was little government control of scientific work after grants were awarded. This was the pattern even in OSRD’s military research, and it was widely considered not merely a success, but a lesson for the future that was pregnant with political meaning.

Early in the twentieth century, American science and graduate education were deeply influenced by German models. Now Germany provided a model in reverse. The Nazis had purged the universities and laboratories and centralized control of research, and by politically tampering with science slowed its progress. The allied victories in scientific work seemed to testify for a political system that gave science as well as its citizens more autonomy. This experience strengthened the case of American scientists, universities, and the medical profession that the research sponsored by government ought to be performed under minimal control primarily in independent institutions, rather than in government laboratories as was generally the practice in Europe. Here was yet another point of structural choice, when American institutions moved toward greater private control and functional autonomy than has been the European pattern.

Even before the war was over, President Roosevelt in a public letter asked Vannevar Bush, head of OSRD, to recommend plans for postwar government aid to science, including what could be done to aid “the war of science against disease.” Bush’s report, Science: The Endless Frontier, insisted on the vital need to aid science and to preserve its autonomy. Basic research, Bush wrote, is “scientific capital”; “more and better scientific research is one essential to the achievement of our goal of full employment.” Consequently, he favored federal money for scholarships and research. But science had to be kept free: free from
the influence of pressure groups, free from the necessity of producing immediate practical results. The mechanism he proposed for achieving these objectives was an independent National Research Foundation whose trustees would be appointed by the President from nominees submitted by the National Academy of Sciences. Though this idea had wide support, the exact arrangements were a sticking point. Some liberals in the Senate wanted more assurance that the public would receive a return on its investment; they favored greater public control and public ownership of discoveries made under federal grants. Some scientists were afraid of just such demands and worried that even Bush’s proposal was leading them down the slippery slope into socialism. It took several years to resolve these issues, and the National Science Foundation (NSF) was not established until May 1950.

By that time, another agency, the Public Health Service, had gained the leading role in medical research. The service had gradually accumulated a wide, if desultory, array of functions that reflected the diverse repertoire of bit parts the federal government was called upon to play in medicine. Transferred from the Treasury Department to the Federal Security Agency in 1939, the Public Health Service operated medical services for merchant seamen, inmates of federal prisons, Coast Guardsmen, lepers at a hospital in Louisiana, and narcotics addicts at two hospitals in Texas and Kentucky. It conducted medical examinations of immigrants, federal employees, and longshoremen. It administered the public health grants to the states created by the Social Security Act of 1935 as well as special programs of state grants for the control of venereal disease and tuberculosis. It was responsible for administrating the Biologics Control Act and the cancer program as well as its own intramural research in NIH. In 1944, in the process of consolidating the statutes governing the PHS, Congress authorized it to make grants for outside investigations in fields of medicine other than cancer research. At the time, little money was available for the purpose, but at the war’s end, the CMR’s projects still in progress were transferred to NIH. With this transfer, the NIH research budget grew from $180,000 in 1945 to $4 million in 1947.

In the late forties, a new force began to be felt that greatly spurred the expansion of NIH. This was the emergence of a private, lay lobby for medical research. Its chief architects, Mary Lasker and Florence Mahoney, brought money and influence to a cause of ready-made appeal. Mrs. Mahoney’s husband owned the Cox newspaper chain, and Mrs. Lasker and her husband, who had made a fortune in advertising, had recently taken a major role in reorganizing the American Society for the Control of Cancer. The Lasker group had led the organization,
which they renamed the American Cancer Society, to introduce modern advertising techniques and to devote the proceeds to cancer research. Mass fund raising for medical research had already been turned into a high art by the National Foundation for Infantile Paralysis, created in 1937. The huge success of its March of Dimes and other voluntary fund-raising efforts for medical research in the late 1940s testified to the new status of research as a popular cause. Public opinion polls confirmed the breadth of this sentiment, and politicians were not insensitive to the possibilities. Opponents of national health insurance could display their deep concern for health by voting generous appropriations for medical research. The Lasker lobby cultivated key figures in Congress, and the new Surgeon General appointed in 1946, Leonard Scheele, began to work closely with both groups in what became one of Washington’s classic “triangles” of influence.14

This “noble conspiracy,” also known as “Mary and her little lambs,” believed that the doctors and research scientists were too accustomed to thinking small. Mary Lasker encouraged them to ask for more money from Congress than ever before, and lo and behold, Congress voted it. Like the voluntary health organizations, NIH discovered that the way to open wide the public’s purse was to call attention to one disease at a time. This was called the “categorical” approach. In 1948, when Congress created a National Heart Institute, NIH became the National Institutes of Health. Five other categorical institutes followed. In 1950, the year the National Science Foundation was established, Congress authorized the Surgeon General to set up such research institutes as he saw fit. Medicine would not be incorporated into a single national program of scientific research, as Bush had advised. Just as the cancer, polio, and other voluntary groups went directly to the public rather than take part in United Way fund raising, so medical researchers went directly to Congress rather than via a unified science foundation to take advantage of the distinctive good will medicine enjoyed.

In 1950 the NIH budget grew to $46.3 million, of which about one third went to extramural grants. A new Clinical Center opened on its Bethesda campus in 1953. Since the beginning of the war, funds for medical research had grown at a staggering rate. Between 1941 and 1951, the federal budget for medical research rose from no more than $3 million to $76 million. Total national expenditures for medical research increased from an estimated $18 million to $181 million.15

To a remarkable degree, control over research was ceded to the scientific community. The approval of grant applications as well as basic policy issues rested with panels of nongovernmental scientists. The individual scientist, too, enjoyed autonomy within the constraints of profes-
sional competition. The officials in charge of the NIH Division of Research Grants wrote in 1951, "The investigator works on problems of his own choosing and is not obliged to adhere to a preconceived plan. He is free to publish as he sees fit and to change his research without clearance if he finds new and more promising leads. He has almost complete budget freedom as long as he uses the funds for research purposes and expends them in accordance with local institutional rules." This grant of autonomy expressed, in a concrete way, the public trust in science and governmental acceptance of scientists' demand that they be left to follow their own rules.

Of the various divisions of NIH, none grew faster than the National Institute of Mental Health (NIMH), created in 1949 under legislation passed three years earlier. Like medical research, psychiatry had emerged from World War II with an enhanced public image. But whereas the achievements of medical research led to recognition, the recognition of psychiatry during the war was, quite likely, its greatest achievement.

The modern military, even more than other organizations, requires an elaborate system for selecting, classifying, ranking, and discharging people. In the twentieth century, as Morris Janowitz has pointed out, the means of control in the military have shifted from authoritarian and coercive techniques to more subtle, psychological manipulation. This evolution follows a pattern broadly evident in society, but the acute needs for control in the military have made it a proving ground for the psychological professions. The First World War saw the introduction of psychological testing for the assignment of military personnel and the creation of a Division of Neurology and Psychiatry to screen recruits and treat all mentally disturbed servicemen. World War I, however, did not leave a lasting mark on military psychiatry.

In the Second World War, more than 1 million men were rejected from military service because of mental and neurological disorders, and another 850,000 soldiers were hospitalized as psychoneurotic cases during the war. Psychiatrists and others later presented both these statistics as measures of the America's great unmet need for psychiatric services. In 1940 the Army had only 25 medical officers assigned to psychiatry, but during the war it had to assign 2,400 more. Their chief, Dr. William Menninger, held the rank of brigadier general, the highest ever for a psychiatrist. According to Menninger, when the war began psychiatry had relatively little latitude for effective intervention. Psychiatric patients were frequently regarded as malingerers; if the men were obviously ill, the psychiatrist was told to diagnose and discharge them. Dur-
ing the war, however, the psychiatric services were given more authority, and they claimed unexpected success in the treatment of psychiatric patients. In the profession's view, the military experience encapsulated the more general shift in the twentieth century from a purely "descriptive" psychiatry, which classified the mentally ill without helping them, to a "dynamic" psychiatry that was of positive benefit.\textsuperscript{18}

The arrival of European refugee psychiatrists also contributed to the growth of a more influential psychiatric profession. Although after Freud's visit to America in 1909 his ideas enjoyed a wider circulation in the United States than in much of Europe, private psychiatric practice continued to be rare. As late as 1930, nearly three quarters of the members of the American Psychiatric Association worked in state mental hospitals. Institutional psychiatry still had a predominantly organic orientation. The rural location of the state hospitals contributed to professional isolation. The 1930s and 1940s saw a shift in both professional views and professional practice, as more urban, psychoanalytically-oriented practitioners won a middle-class clientele and a wider popular and intellectual audience. In 1948 William Menninger could write, without undue exaggeration, that psychiatry "probably enjoys a wider popular interest at the present time than does any other field of medicine."\textsuperscript{19}

Public attention was also drawn to psychiatry at the end of the war when a national scandal erupted in the press over conditions in state mental hospitals. The newspaper scandal is a periodic feature of the history of mental institutions, and it takes at least two forms. In the scandal of repression, normal or not-so-dangerous people are shown to have been railroaded into institutions. The scandal of the 1940s, however, was of a second type, the scandal of neglect. During the war, conscientious objectors had been sent to work as aides in mental institutions. Appalled at what they saw, they formed an organization to publicize conditions there. The story was picked up by newspapers and magazines and even became the subject of a best-selling novel \textit{The Snakepit}. In one of the most widely read exposés, \textit{The Shame of the States}, based on visits to two dozen institutions, the historian and journalist Albert Deutsch reported scenes rivaling the horrors of Nazi concentration camps: half-starved mental patients herded into filthy, barn-like wards and stripped of every vestige of human decency. Like others at the time, Deutsch believed that mental hospitals needed closer relations with medicine as well as more resources. In a typical expression of the growing progressive faith in psychiatry, Deutsch wrote, "It is because modern psychiatry is a stranger to so many mental hospital wards that many more patients don't return to their communities as cured."\textsuperscript{20}
Aroused by the war experience and the state hospital scandal, Congress passed the National Mental Health Act in 1946. The Lasker lobby and psychiatrists in the Public Health Service originated the proposal and orchestrated congressional hearings and public support. (Since 1930 the Public Health Service had a small division of mental hygiene that ran the two federal narcotics hospitals and psychiatric services in federal prisons.) The new program was representative of the beliefs of the time. It provided funds for medical research and training programs, and it gave the states aid for mental health clinics and other special efforts. Research and training, however, became the priorities. Between 1948 and 1962, NIMH research grants rose from $374,000 to $42.6 million, training grants were up from $1.1 to $38.6 million, but state grants rose only from $1.7 to $6.6 million. Under the broad mandate of mental health, the agency’s research programs expanded to include such diverse problems as child development, juvenile delinquency, suicide prevention, alcoholism, and television violence. Its training programs sought to attract physicians by providing more generous stipends to residents in psychiatry than were available in other specialties. Moreover, the government required nothing in return, such as a commitment to work for some period in the state mental hospitals, whose shortages of psychiatrists had originally prompted the legislation. If young psychiatrists took advantage of the public purse and then practiced among the well-to-do, this choice had to be accepted. It was no business of public policy to influence it. This, too, reflected the premise that federal aid must not compromise professional autonomy.

One national experience in the 1950s seemed to confirm the value of waging concerted campaigns of medical research against specific diseases. I have already mentioned that the National Foundation for Infantile Paralysis was, by a wide margin, the single most popular medical cause in the postwar period. Polio was not the most prevalent disease at the time; its contribution to overall mortality rates was small. But it was deeply feared as the leading crippler of children. Its incidence had actually been growing throughout the twentieth century; in 1952 more children died of polio than of any other infectious disease. It was also more common among the middle and upper classes. Every year, promising that "research is winning the battle against polio," the March of Dimes would raise more money than any other health campaign. And in answer to the public’s hopes, medical research—supported in this case by voluntary donations—produced an effective vaccine. Probably no event in American history testifies more graphically to public acceptance of scientific methods than the voluntary participation of millions
of American families in the 1954 trials of the Salk vaccine. The methodological conscience of epidemiologists had demanded that these trials be double-blind: Neither doctors nor teachers, neither parents nor children, knew whether the children were receiving vaccine or placebo. And when on April 12, 1955, epidemiologists at the University of Michigan announced the results showing that the vaccine worked, pandemonium swept the country. “More than a scientific achievement, the vaccine was a folk victory,” observes Richard Carter in his biography of Jonas Salk. “People observed moments of silence, rang bells, honked horns, blew factory whistles, fired salutes, kept their traffic lights red in brief periods of tribute, took the rest of the day off, closed their schools or convoked fervid assemblies therein, drank toasts, hugged children, attended church, smiled at strangers, forgave enemies.”

The magic of science and money had worked. And if polio could be prevented, Americans had reason to think that cancer and heart disease and mental illness could be stopped, too. Who knew how long human life might be extended? Medical research might offer passage to immortality. Between 1955 and 1960, unswerving congressional support pushed up the NIH budget from $81 million to $400 million.

More money for research met no objections from the AMA. However, the story of aid to medical education was different, and it is worth recalling the contrast. In 1949 Congress was close to approving a five-year program of grants and scholarships for medical schools to increase the nation’s supply of physicians. A bill had passed the Senate and was reported out of House committee when it hit a small snag. Yet it seemed likely to pass the next year. The House of Delegates of the AMA approved the measure in December 1949. However, two months later, concerned about setting dangerous precedents, the AMA board reversed its position, and the bill died in Congress. Despite wide support from other groups, aid to medical education was blocked throughout the 1950s. Funding for medical research indirectly aided some expansion of medical enrollments but only barely enough to keep pace with population growth. The great increase in demand for medical care, with no corresponding increase in the supply of physicians, was to have repercussions for years.

The Tilt Toward the Hospital

As public officials formulated postwar science and medical policy in the mid-1940s, the postwar economy was never far from their minds. The first thought of those in the Roosevelt administration who initiated Vannevar Bush’s report was that innovations generated by scientific research could create new businesses and new jobs. Interest in aiding hos-
pital construction also arose in large part because of its potential for creating employment. Here was a public works program that conservatives would support as an alternative to national health insurance. The hospital industry itself was agitating for aid. Its needs for capital investment had been deferred during a decade and a half of depression and war. In addition, millions of returning veterans would need medical attention. So, almost without dissent, two hospital construction programs were adopted immediately after the war—one to expand the Veterans Administration hospitals, the other to aid the nation's community hospitals.

By World War II, the VA, with ninety-one institutions, was already operating the largest hospital system in the country. However, corruption, low pay for medical staff, and the isolated location of many rural facilities gave VA hospitals a dismal reputation. The new leaders of the agency after the war resolved to end its professional isolation as well as improve its physical plant. They decided to build new facilities in urban areas and, wherever possible, to establish close affiliations with medical schools. These affiliations involved the use of VA hospitals for clinical research and training in the health professions. Medical school committees received the right to vote on appointments to the VA medical staff. As a result, the revitalization of the VA, like the development of NIH, funneled new resources to the medical schools and expanded their role in running American hospitals.

The tilt toward technology in postwar health policy was nowhere more evident than in the decision to provide construction funds for community hospitals through the 1946 Hospital Survey and Construction Act (known as the Hill-Burton program, after its Senate sponsors, Lister Hill and Harold H. Burton). Proposals for national health insurance and the earlier report of the Committee on the Costs of Medical Care favored financing comprehensive medical services. But the measures adopted in the late forties put the power of public finance behind hospitals alone.

Planning for postwar hospital construction, as for postwar scientific research, began before the war was over. In 1942 the American Hospital Association decided to organize a national commission to develop—or, perhaps more accurately, to develop support for—a national program for hospitals. At that time, the AHA was still a relatively weak organization, with an annual budget of about $100,000. Three private foundations—Kellogg, Commonwealth, and the National Foundation for Infantile Paralysis, none of which had supported the CCMC—agreed to help underwrite the commission. (The Rockefeller Foundation de-
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clined to participate on the grounds that a more comprehensive approach was needed.) The Public Health Service provided extensive staff support as if the commission were an official undertaking, and the AHA rounded up the usual array of college presidents, corporate executives, and professional dignitaries to serve as the commission’s highly impartial membership.26

The Commission on Hospital Care, as might be expected, recommended a huge program of hospital construction: an additional 195,000 beds (an increase of 40 percent) at a capital investment of $1.8 billion. Annual operating costs would add $375 million a year to the nation’s health care bill, but the benefits, said the commission, would “fully justify” the expenditure.27 These benefits the commission evidently considered too obvious to establish. Still less did it weigh them against the potential benefits of alternative investments in health care or other fields.

The commission’s final report appeared after Hill-Burton was passed. But its pilot survey of hospital needs in Michigan guided surveys in other states, and by the time Congress acted, forty-four states had surveys in progress. This preparation made possible rapid implementation of the program.

The law carefully limited political, especially federal, discretion. In addition to $3 million for state surveys and plans, it originally authorized $75 million a year for five years to aid hospital construction. But federal administrators had no say as to how much any state or individual hospital would receive. In redrafting the bill, Senator Taft introduced a formula for allocating money among the states based on their population and per capita income. The states in turn distributed funds to applicants. While the law set procedural guidelines for state distribution of the money, it specifically barred any federal regulation of hospital policy. The states were to estimate regional hospital needs; when an applicant from an area received a grant, the area would go to the bottom of the list and wait another turn. These arrangements were meant to minimize “politics”; the entire process was presented as a scientific exercise.28

The expansionary bias of the program was evident in the fate of the ceiling it set on hospital growth. The law limited aid to states with no more than 4.5 hospital beds per 1,000 people (a figure suggested by industry experts that was far above the levels in any state). This ceiling gradually became a target. In later congressional hearings, the program’s directors would define the need for additional hospital beds by the gap between existing ratios and the 4.5 maximum. Other medical
services, such as primary care, did not benefit from any such legislative standard. Furthermore, the standard for hospitals was impervious to changes in medical practice, such as the growing belief in early ambulation instead of extended bed rest after surgery.

Between 1947 and 1971, the $3.7 billion disbursed under the program contributed to 30 percent of all hospital projects and provided an average of about 10 percent of the annual cost of construction. The program also generated an estimated $9.1 billion for hospital construction in local and state matching funds. Hill-Burton was modified in 1954 to permit grants to long-term care and ambulatory care facilities, but as of 1971, more than three quarters of the money had gone to hospitals.39

Advocates of Hill-Burton originally argued that the program would help provide access to hospital care for families and communities that otherwise could not afford the cost. The formula for allocating funds among the states favored those with low per capita income. In this regard, the law was redistributive. Over the next two decades, the supply of hospital beds in low-income states rose to the levels in high-income states; careful analyses suggest Hill-Burton was responsible for this change.30

Within states, however, the funds went disproportionately to middle-income communities.31 This pattern resulted in part from the law itself. Communities were initially required to raise two thirds of the construction cost on their own.32 Sponsors also had to show that hospitals supported by federal grants would be financially viable. “Which are the communities among those needing hospitals, that cannot meet these requirements?” asked Senator Wagner during the original congressional debate. “Obviously, the poorest communities—the very ones that need help the most; these are the ones that will have to be turned down.”33 Liberals did secure a concession in the legislation requiring that hospitals receiving assistance make available “a reasonable volume of hospital services to persons unable to pay.” But for the next twenty years, no regulations were issued specifying what a reasonable volume might be, and the provision went unenforced.34

Many hospitals in the South aided under the program refused to treat black people. The law itself prohibited discrimination by any assisted hospital, but said its conditions were met if separate but equal facilities were available in an area. The Supreme Court did not rule these provisions of Hill-Burton unconstitutional until 1963.

The original objectives of Hill-Burton included improved coordination of hospital development; this was the point of requiring state plans. Some saw the measure as a step in integrating regional health services. But the law required no continuing coordination among hospitals after
grants were made. In the long run, the Hill-Burton program probably retarded integration in the industry, since it provided money that enabled many smaller and uneconomical hospitals to keep operating.

All four of the major postwar programs—medical research, mental health, the VA, and community hospital construction—showed a common pattern in respecting the sovereignty of the medical profession and local medical institutions. While the functions of government were expanded, the sphere of political discretion was deliberately restricted. In NIH the mechanism for restricting political control was the required approval of grants by panels of experts drawn from outside government. NIH, as Don Price has observed, was the only agency of the federal government whose full-time officers could not allocate money without the approval of part-time committees representing the beneficiaries. The mental health program was initially established under NIH and shared its orientation to research and training and its reliance on peer evaluation. Political control in the VA was restricted by granting the power to appoint physicians to the “dean’s committees” of medical schools with which VA hospitals were affiliated. And in the Hill-Burton program a formula for grant allocation and statutory prohibition of federal intervention in hospital policy limited political discretion. In effect, by earmarking money for specific purposes and then outlawing federal interference, Congress and the professions joined in restricting any tendency toward administrative rationalization.

So, despite the growth of government aid to medicine, professional sovereignty was now buttressed by other kinds of claims against government control. In the Hill-Burton program, states’ rights and community autonomy were invoked as the basis for limiting federal intervention. These claims have a constitutional heritage behind them. On the other hand, medical research, like all scientific research, demands autonomy as a necessary condition of free inquiry. As Edward Shils has written, the autonomy of science has its own distinct origins, independent of the liberal tradition. The medical profession itself appealed for autonomy partly on the grounds of the privacy of the doctor-patient relationship. That was yet another basis for resisting government. These various elements were now combined to constitute a powerful case that public aid to medicine should not bring public control.
THE STRUCTURAL IMPACT OF POSTWAR POLICY

The New Structure of Opportunity

The new forms of national investment were meant to expand and strengthen medical research and hospitals. That they did. But they also changed the careers of thousands of physicians and in other, unexpected ways altered the postwar development of medical care.

The infusion of money into research and training programs created new opportunities in—and for—medical schools. During the 1940s, the average income of medical schools tripled from $500,000 to $1.5 million a year; by 1958–59 the average school’s income was up to $3.7 million and ten years later to $15 million. Medical schools became sprawling, complex organizations that now saw their missions as three-fold: research, education, and patient care (usually in that order). Full-time faculty increased 51 percent between 1940–41 and 1949–50, according to a study of thirty-two institutions. And during the next decade, full-time positions doubled nationally, increasing from 4,312 in 1950–51 to 11,319 by 1959–60. Though some growth in positions was due to the establishment of new schools, older institutions expanded far beyond the expectations of their own administrators. In 1957, when the average department of (internal) medicine had a staff of fifteen, a survey of chairmen around the country disclosed that by 1970 they hoped the number might rise to thirty-two. Robert G. Petersdorf, who was chairman at the University of Washington, notes that his department was five times that large by 1970 and that this growth was typical. And, not surprisingly, growth meant differentiation: The departments acquired new subspecialty divisions, which opened up new avenues for promotions.

This expansion radically changed academic medicine. In the 1920s and 1930s, promotions in medical schools were slow and uncertain. Vernon Lippard, a dean of Yale Medical School, notes that on each service, teaching hospitals then had two or three times as many interns as first-year residents, twice as many first as second-year residents, and so on until, after three to five years, one survivor emerged as chief resident. This man might then become an instructor and enter into another competition to become an assistant professor. Money for research was scarce and, as Lippard recalls, security was rarely achieved before age forty.

The U.S. Congress changed all that. NIH research grants helped to build new research centers, especially in the West, and training grants provided the stipends for an enlarged corps of investigators. The
growth of subspecialties broke down the old pyramidal pattern, since a larger number of residents could now rise to senior posts. As the demand for academic physicians rose, so did their income. And, like other academics in the postwar period, medical school professors also became more geographically mobile. One key consideration in attracting faculty became the provision of research space and clinical facilities. This increased the interest of medical schools in expanding their network of affiliated hospitals and acquiring land in local neighborhoods, tearing down residential buildings, and replacing them with institutes, clinics, and hospitals.

Inevitably, these developments had reverberations within and outside the medical schools.

The growth of full-time faculty in clinical as well as basic science departments meant the displacement of local physicians who had served as part-time instructors. Some private doctors also lost admitting privileges at hospitals that were affiliating with medical schools. To gain affiliation, the hospitals usually had to permit the medical schools either to initiate or approve staff appointments. The medical schools believed they required this authority to maintain the quality of graduate medical education. In their view, many older physicians, often general practitioners, were unacceptable as instructors. And when medical professors became chiefs of services in newly affiliated hospitals, the doctors who previously held those positions were also displaced.

Displacement brought resentment and recriminations. In a study in the early 1960s of relations between medical schools and private physicians in eight communities, Patricia Kendall found widespread anger and bitterness among the practitioners. “A lot of us,” one practitioner remarked, “feel that the medical school would dominate all of our hospitals if it could.” A medical school professor reported that “the practitioners have lost prestige and they feel it. Some of the doctors who were respected in the town are no longer in the same position of authority and respect that they were before we came here.” The local doctors (“LMDs,” as they are sometimes called) resented the loss of influence over medical school policy and of access to hospital beds. They did not like the emergence of a new group of doctors who received publicity for their research and were quoted in the newspapers and who, it seemed, were frequently brash and condescending. The medical professors, in turn, often thought the local practitioners were out of date. “The organized practitioners of medicine,” one professor told Kendall, “are so God-damned reactionary that I feel leery about educating them.”

“How reactionary?” she asked.
“In every way,” he responded, “politically, socially, economically, and educationally.”

These tensions were softened by the general prosperity that both groups enjoyed. Between 1945 and 1969, while the consumer price index rose at an annual rate of 2.8 percent, physicians’ fees rose 3.8 percent and their annual incomes at 5.9 percent a year. The average net profit from medical practice rose from just over $8,000 in 1945 to $32,000 in 1969. The postwar economic expansion meant that private doctors had all the business they could handle. Conflict was also partly relieved by the new geography of urban medical care. While the medical schools remained in the cities, many of the private doctors followed their patients to the suburbs.

Inside the medical schools, the growth of research funds changed the relation between the science and clinical departments. “One generation back,” a professor recalled, “surgeons here were very strong, both clinically and administratively, and could pretty much run the whole school.” Now the budget of the department of experimental medicine was five times the budget of the surgery department. “The preclinicians,” the professor continued, “have almost always had the idea that the clinicians are robber barons; now they feel that anyone really interested in clinical work bears watching, that he is an anachronism.”

The relations between science and clinical departments were also growing more distant because they were no longer functionally interlocked. For example, before the war, the science departments often performed diagnostic tests and other work for the clinical faculty. By the 1960s these ties had disappeared. “In the 1920s,” writes Lippard, “the basic sciences were taught by individuals who, although often not physicians, had an interest in clinical medicine and made an effort to relate their instruction to clinical problems. As they were relieved of clinically related responsibilities they turned their attention to more fundamental issues.” This shift was related to the movement of medical science toward the molecular level of analysis. As Lippard notes,

The anatomists lost interest in gross anatomy and became electron microscopists and cellular biologists; the biochemists turned from nutrition and intermediary metabolism to molecular structure and enzymology, and the physiologists from the function of mammalian organ systems to cells; the bacteriologists became microbiologists concerned with microbial physiology and genetics; and the pharmacologists turned from studying the effect of drugs on intact animals to chemistry and the effect of chemical agents at the cellular level.

This divorce of the basic sciences from the more immediate concerns of clinical medicine created new tensions and problems in medical edu-
The tremendous growth in knowledge—and in faculty—led to increased competition for time in the medical curriculum. Many professors thought their fields were not getting enough attention. Many students felt they were being forced to learn more than they could absorb and that much of the curriculum was marginally relevant to their future professional work. The grueling first-year work in anatomy—medicine’s “boot camp,” as one doctor calls it—had long epitomized this ordeal. Criticism now also came from those who wanted to give psychiatry more of a place in medical school and to provide a more comprehensive education in the social and psychological problems that physicians confront in medical practice. But established claims to an already crowded schedule were difficult to dislodge.

“It’s easier to move a cemetery than to change the curriculum,” one dean was reported to exclaim.45 In the nineteenth century, when medical schools were often accused of robbing corpses, the dean might have been presumed to be making the comparison from personal experience.

Change came easier in the last two years of undergraduate medical education, which students spent in clinical clerkships on hospital wards. The emphasis in clinical instruction changed as the mix of hospital patients shifted with the decline of infectious diseases. A major step in reorganizing the preclinical years occurred in 1952 when Western Reserve (now Case Western) adopted a new curriculum organized by body systems (cardiovascular, respiratory, renal, and so on) rather than by discipline. Many schools adopted this pattern or variations upon it. Some schools, notably Stanford, also permitted more electives. The postwar variations between progressive and conservative schools reintroduced a degree of heterogeneity in medical education that had been missing since it had assumed the rather rigid form often attributed (mistakenly) to Abraham Flexner.

Yet despite some variation in curriculum, one tendency was common virtually everywhere, and that was increasing specialization. In a study at Cornell in the 1950s, Patricia Kendall and Hanan C. Selvin found a dramatic change in students’ plans while in medical school. The proportion planning to be general practitioners dropped from 60 to 16 percent between the first and fourth years. Students planning to be specialists jumped from 35 to 74 percent, and those going into teaching and research increased from 5 to 10 percent. “I can see why specialization is the rage today,” one student wrote in his diary. “Medicine is so large now that a doctor doesn’t feel confident unless he knows at least one field extremely well, rather than a little about all subjects.” With this type of reaction in mind, Kendall and Selvin—and many others—
pointed to the growth of knowledge as the key factor leading medical students to become specialists.46

The difficulty with this view is that the distribution of opportunities does not always correspond to the inclinations of students. In other countries, the psychological distress of medical students facing the burden of modern science may be no less severe, but the positions available for specialty training and specialty practice are limited. In the legal profession in America, the burden of knowledge is staggering, but young lawyers need to be prepared to handle whatever cases they are assigned in the firms or bureaucracies that provide jobs. Early, formal specialization is discouraged. The rate of specialization in any field depends primarily on the opportunities and incentives generated by the market and the state. Throughout their education, students adjust their aspirations as they discover what awaits them outside. If it were the case that specialists earned less than general practitioners (or received a low return on their investment in advanced training), we might need a psychological explanation to understand what other rewards they would gain from entering a specialty. But this was not the case in postwar medicine. The economic rewards to specialization were considerable.

Three structural factors were especially important in producing the rising rate of specialization. First, the system for certifying medical specialists that had developed in the 1930s included no regulation of the size or distribution of the specialties. Second, beginning in the war, hospitals (and their associated physicians) had strong incentives to set up training programs for specialists—indeed, to create more openings for specialty training than there were American graduates to fill them. And, third, government subsidies, the high returns to specialty practice created by health insurance, and the lack of a corrective mechanism that would have reduced specialist incomes as their numbers increased gave physicians strong, continuing incentives to pursue the training opportunities hospitals created.

Since the 1930s, the organized medical specialties had acquired enough power to sensitize young doctors to the value of certification, but not enough power to become exclusive clubs. The development of certification began with the autonomous efforts of two early specialty groups. The ophthalmologists created the first examining board in 1916; the otolaryngologists the second in 1924. It is probably no accident that both fields keenly felt competition from non-M.D. specialists. The great expansion in examining boards occurred during the Depression of the 1930s and likewise partly represented a response to intensified competition. Like limits on entry into a profession, limits on entry into a specialty have the potential to create monopoly returns. In 1930, when the
obstetricians and gynecologists established the third examining board, they excluded doctors who did not limit their practice 100 percent to women. As Rosemary Stevens points out, "By these measures, no general practitioner, however large the proportion of his practice devoted to obstetrics or gynecology and however thorough his training in these fields, might be admitted to examination or considered for a diploma." By 1940 five of the specialty boards required 100 percent limitation of practice.47

As independent groups began to carve up medicine into specialty divisions, leaders of the profession moved to establish some order. In 1933 representatives of the AMA Council on Medical Education and Hospitals, the AMA specialty sections, the four examining boards then in existence, and other medical groups agreed to form a coordinating body. This became the Advisory Board for Medical Specialties (since 1970 called the American Board of Medical Specialties). Together with the AMA, this board set general standards for the examining boards and settled jurisdictional disputes. At least three years of training after internship were required for certification in any specialty. Certified specialists had to be members of the AMA (a requirement dropped in 1939). Twelve fields were listed as appropriate for certification, and by 1937 all twelve examining boards had been established. (Eight others were added in later years.) In 1940 the first edition of the Directory of Medical Specialists was published. For the first time, an elite within the profession received formal recognition.48

Yet numbers were not controlled. While the specialty boards initially hoped to limit hospital privileges to physicians they certified, this objective had to be abjured because of uncertainty about whether the courts would block such a move on antitrust grounds. (This concern arose after the Supreme Court's decision in the Group Health case.) The general practitioners in the AMA also continued to stand in the way of any limits on specialty practice or opportunities for specialty training. So the relations between GPs and specialists remained loosely defined. Patients could still go directly to a specialist without the mediation of the GP, and the GP could call himself a specialist without the approval of an examining board.

Yet repeated experience signaled the growing value of certification. During World War II, the AMA and the specialty boards aided the military in identifying properly certified specialists, who promptly received higher rank. This experience, as Stevens notes, gave doctors a "healthy respect for the value of board certificates."46 After the war, the VA also ruled that no doctor would be treated as a specialist without board certification. Aided by GI Bill education benefits, thousands of returning
physicians decided to seek certification. When the VA ruled that hospitals could receive payment for graduate training of physicians, it encouraged hospitals to set up programs to take advantage of the subsidies.

This was by no means the only advantage hospitals derived from graduate training programs. Interns and residents provided hospitals with relatively inexpensive professional labor. The hospitals with ample house staff could do more thorough workups of patients and perform a variety of functions for busy private practitioners. Without house staff, hospitals could not easily secure coverage at nights and on weekends. The demand for house staff initially increased when doctors were called into the armed forces but continued to grow afterward. The number of residency positions shot up from 5,000 to over 12,000 between 1940 and 1947 and reached 25,000 by 1955.50

Students in medical school, like young doctors in the Army, could plainly observe how general practitioners were treated. The universities generally did not want GPs to admit patients at affiliated hospitals. As the medical schools replaced part-time instructors from private practice with full-time professors from research backgrounds, they were also substituting new models of professional competence.

The higher income enjoyed by specialists, compared to general practitioners, continued throughout the postwar period and cannot be explained by the added costs of advanced training. And the hospital-oriented specialties, such as surgery, consistently maintained an edge in income over the specialties whose work was primarily office-based, such as internal medicine. They held this edge in spite of working fewer hours a week.51 Part of the explanation is probably that the hospital-oriented specialties had a higher proportion of cases covered by insurance. Specialty incomes vary directly with the percentage of work reimbursed by third parties.52 Since insurance developed faster for hospital than for office services, it encouraged doctors to move into hospital-oriented fields. Furthermore, the expansion of house staff and other hospital employees in the postwar period made hospital-oriented doctors more productive. They could see more patients in less time as hospital employees took over such functions as postoperative care. Hospital costs increased, but physicians did not cut their fees, even though they were spending less time to produce their services. And that, too, helped raise their incomes.53

Before the war, the great majority of doctors in active practice—76.5 percent in 1940—reported themselves as general practitioners or part-time specialists. The percentage of doctors reporting themselves as full-time specialists jumped from 24 percent in 1940 to 37 percent by 1949.
By 1955 the proportion rose to 44 percent; five years later to 55 percent; and in 1966 to 69 percent. Most dramatic was the growth in surgical specialties from only 10 percent of the profession in 1931, to 26 percent in 1960, and over 30 percent by 1969.54

The New Structure of Power

When opportunities in a profession change, so does the profession. Before the war, most doctors went directly into practice after an internship of one year and then practiced independently. In 1930 only one physician in sixteen worked in a hospital full-time. Much medical care—four of every ten encounters between doctors and patients—still took place in a patient's home. As of 1935, half of all births attended by doctors were home births.

By the 1950s, most doctors served at least three years in a hospital residency after internship, and one doctor in six worked full-time in a hospital. Ninety-six percent of all births were hospital births, and only one in ten contacts with doctors occurred in patients' homes.55

The tremendous increase in physicians in teaching, research, government, and other institutional positions took place while the ratio of doctors to population was little changed. Between 1940 and 1957, institutionally employed physicians jumped from 12.8 to 26.5 percent of the profession. Doctors in private practice declined not only as a proportion of physicians, but also in relation to population, down from 108 to 91 per 100,000 people.56

The concentration of medical work in hospitals and doctors' offices, the growth in demand for personal health services, and the declining availability of private practitioners made it possible for doctors to increase their volume of practice dramatically. The average private physician in 1930 saw about fifty patients a week; by 1950 he saw more than one hundred.57

Some observers have suggested that hospitals replaced private practitioners as the most powerful force in the postwar medical system. This does not express their relation accurately. They were not involved in a zero-sum situation. Rather, the power of the medical system as a whole increased. Both doctors and hospitals shared in this expansion. While hospitals expanded, their very expansion increased their need to satisfy the doctors who could keep their beds filled. More beds provided doctors with more alternatives for hospitalizing their patients. In a 1968 study of a medical center (unidentified, but clearly Yale-New Haven), August Hollingshead and Raymond Duff record that the administration at one point proposed taxing the affiliated private doctors
to support the house staff. Since the house staff performed services for which the practitioners often charged fees, this idea might not seem unreasonable. Of course, the ensuing uproar among the private physicians caused the proposal to be withdrawn. The hospital could not afford to antagonize them.  

The profit that doctors and hospitals derived from house staff was one of the driving forces of the postwar medical system. As demand for house staff grew, competition among hospitals intensified. Between 1940 and 1950 the proportion of approved house staff positions that hospitals were unable to fill rose from 10 to 30 percent. The house staff shortage, of course, resulted directly from the decision to expand hospitals without expanding medical school enrollments. By 1957 hospitals were looking for more than 12,000 interns annually, but American medical schools were graduating fewer than 7,000 students a year.

The competition for available graduates led to improved stipends for house staff and a rationalized system of intern placement. But more significantly, it also led hospitals to look abroad to fill their openings. Congress and state legislatures cooperated by making it easier for foreign-trained doctors to enter and work in the United States. During the 1950s foreign medical graduates increased from 10 to 26 percent of all house staff. Initially, these doctors came primarily from Europe, but in the 1960s a major influx began from Asia, mainly Korea, India, and the Philippines. Though ostensibly in America for graduate training in hospitals, the majority chose to remain permanently. Like other immigrants, they often took jobs that Americans did not want (for example, in mental institutions). In effect, the peculiar slant of American health policy (expanding hospitals, but keeping down medical enrollments) was producing a new lower tier in the medical profession drawn from the Third World.

Intensified competition for American graduates also had the unanticipated consequence of enlarging the role of medical schools in the hospital system. Academic physicians had long favored consolidating graduate medical education under medical schools, but the private doctors who benefited from house staff in community hospitals were too influential in the AMA to permit that to happen. As of 1959, unaffiliated hospitals represented 73 percent of hospitals with approved residency programs; though on the average smaller than affiliated programs, the unaffiliated offered 42 percent of all residency positions. But they were at a serious disadvantage in attracting American interns and residents. To strengthen their position, more community hospitals sought medical school ties.

As a result, the postwar decades saw a steady extension of the power
of medical schools into the hospital systems of metropolitan areas. In New York City seven such networks radiated out from the city's medical schools, covering half the hospital beds in the city. Chicago had six such networks; Philadelphia five. These medical school empires, as their critics called them, now held a powerful position in medical affairs: They could grant or withhold teaching positions, hospital privileges, and the assorted capital equipment and labor that hospitals provide. As of the early 1970s, the proportion of general hospital beds in affiliated hospitals in the major metropolitan areas ranged from 32 percent in Detroit to 79 percent in Philadelphia. Nationally, the proportion of approved residencies in unaffiliated hospitals fell to less than 10 percent of all positions.64

At the hub of these empires was typically a cluster of institutions linked directly to the medical school in a university medical center. Columbia-Presbyterian in New York City is generally acknowledged to have been the first medical center of this kind. In 1910 Columbia University and Presbyterian Hospital reached an understanding on the principles of an affiliation; this was basically the kind of model already established at Johns Hopkins. But by the time the Medical Center actually opened in 1928 at a new site in upper Manhattan, it had grown to include ten separate institutions, including various hospitals, clinics, and schools that had previously been independent. As the center continued to grow, it integrated record keeping and other services. In the late 1940s it began adding a series of research institutes.65 This became the general pattern. A medical center typically would have not only a medical and dental school but also schools in pharmacy, public health, nursing, and other paramedical occupations; research institutes for heart disease, mental illness, cancer, rehabilitation, and other fields; several general teaching hospitals, perhaps a women's hospital, a children's hospital, a psychiatric hospital, various clinics, doctors' office buildings, and so on. Universities became the umbrella organizations for America's regional medical centers, which instead of being organized around the immediate needs of patients, were oriented primarily toward research and training. Did this show a magnificent concern for the health of future generations? Alas, there may have been other motives. In any event, what was remarkable about this arrangement is how little remarked it was.

The rise of the medical centers introduced a significant bureaucratic element into professional experience. But accounts such as Duff and Hollingshead's indicate that power in medical centers resides not so much in the administration as in the "chairmen-chiefs." These are the professors who simultaneously serve as chairmen of the major medical
school departments and chiefs of medicine, surgery, psychiatry, obstetrics-gynecology, and pediatrics in the teaching hospitals. They control the key policy-making boards in both institutions. Their judgments shape the careers of the house staff. They are the ones to whom interns and residents must turn for support when conflicts arise, and on whom they must depend for recommendations. "It is inconceivable," an administrator commented, "that the university would try to carry out a policy contrary to the wishes of the department chairmen of the Medical School and damned difficult for the hospital to carry out a policy contrary to the wishes of the chiefs." This is almost a textbook definition of power.

As powerful as these medical school empires were, they did not embrace the entire system of medical care in America. Though they were increasing their share of the nation’s hospital system, the hospitals affiliated with medical schools still represented only 25 percent of the community hospital beds in the country in 1972. While the medical schools were dominant in the metropolis, theirs was only one of several spheres of medicine.

By the 1960s the medical profession had developed three more or less distinct sectors. First of all, there were the doctors who worked in medical schools and hospitals, including the house staff and full-time faculty, whose priorities were research and training. This was a far more significant group than it had been before the war. The chief feature of their relations with patients was that they rarely had any long-term relations with them at all. Physicians in training or engaged in research do not require their patients’ good will for future business. Their professional rewards depend on the opinion of colleagues. Those who make their careers in research operate in a “grants economy” whose key decision makers are professionals at other institutions. All these factors contribute to professional autonomy and, not coincidentally, to the powerlessness of patients and to their objectification as “clinical material.”

The second group were the private, primarily office-based practitioners who in large numbers had moved to the suburbs. Though they had lost control of some medical institutions, they still had a privileged and dominant role in community hospitals. As a group, they were doing far better economically than ever before, since consumer demand and hospital resources had grown rapidly, while their own numbers had not. Theirs was a sellers’ market. Still, they depended more on the good will of patients than did institutionally based physicians, and they also required the good will of their colleagues in private practice for referrals, staff privileges at local hospitals, and malpractice defense. These kinds of interdependence fostered professional solidarity, and indeed, these
doctors were the organizational base of the AMA. However, many were beginning to identify more strongly with their specialty than with the profession as a whole, as was evident in the more rapid growth of membership in specialty societies and the relative increase in subscriptions to specialty journals over general medical publications.

And, finally, there were the doctors working in rural or inner-city areas or state institutions. Smallest in number, lowest in prestige, these were often older general practitioners or, increasingly, younger foreign medical graduates. They were the most professionally isolated of physicians, though some worked almost in the shadows of the great medical centers.

The contrast among physicians was only a reflection of contrasts in the medical care system. Gleaming palaces of modern science, replete with the most advanced specialty services, now stood next to neighborhoods that had been medically abandoned, that had no doctors for everyday needs, and where the most elementary public health and preventive care was frequently unavailable. In the 1960s many began to observe that abundance and scarcity in medicine were side by side. After World War II, medicine had been a metaphor for progress, but to many it was now becoming a symbol of the continuing inequities and irrationalities of American life.

REDISTRIBUTION WITHOUT REORGANIZATION, 1961–1969

The Liberal Opportunity

The triumph of the liberal agenda in the mid-1960s brought a new generation of programs and policies in health care. Like the generation of ’46 (NIH, Hill-Burton), the new programs reflected the distinctive environment of their time. The postwar celebration of American achievement—that extended self-congratulation of a society which believed it had solved life’s most serious problems, except what to do with one’s spare time—had begun to die down at the end of the fifties. Recurring recessions, rising unemployment, and slow economic growth in the Eisenhower years led to talk that America had “lost its way.” When John F. Kennedy campaigned for president, he spoke of “getting the country moving again.” In its spirit and ambitions, the Kennedy administration continually challenged the settled complacency and resistance to change in Congress and the “permanent government.” Yet for all
its impatience, the Kennedy administration by no means had a radical program. As the journalist Godfrey Hodgson writes, Americans in the early 1960s wanted change, but they did not want to be changed. This was very much the case with regard to medical care. Americans wanted medicine to bring them change (new advances, more services), but they were not yet prepared for the sake of health to make changes in their way of life or their institutions.

As the 1960s began, the themes of criticism and reform were conventional but expressed with greater vehemence. The movement for a contributory hospital insurance program for the aged, already called Medicare, was gathering force. Concern about a “doctor shortage” began to grow. A 1959 government report declared that if the current ratio of doctors to population were just to be maintained, the output of American medical schools would have to be increased from 7,400 to 11,000 graduates a year by 1975. But to satisfy higher demand for services per capita and growing requirements for doctors in research and teaching, the report concluded an even larger expansion of medical schools was needed. Nurses were also said to be in short supply. The need for more “health manpower” became widely accepted, and in 1963 Congress adopted the first of a series of measures to aid and expand education in the health professions.

The emerging view among liberals in health policy was that federal policy overemphasized hospital construction, while ambulatory care was neglected. In January 1959 Milton Roemer and Max Shain completed an influential study which argued that the supply of hospital beds was “probably the most fundamental” of all factors determining their use under health insurance. The “simplest fact of hospital operation,” they wrote, “is the magnetism of an empty bed when payment for its use is assured.” As hospital beds were built, physicians admitted patients they would otherwise have treated at home. “A half century ago,” they noted, “only the most desperately ill were hospitalized; cases of pneumonia, tonsillectomies, deliveries, heart attacks, fractures were treated at home or in the doctor’s office. Today not only are these cases hospitalized, but so are cases of multiple-tooth extractions, psychoneurosis, epilepsy, diabetes for insulin stabilization, or any obscure condition for diagnosis. All this is made possible by an increase in the relative supply of beds, and reciprocally it creates pressures for continual expansion of the bed supply.” They pointed to evidence that much being done in hospitals could be done as well elsewhere if adequate provision had been made for less expensive outpatient and nursing care.

Criticism of the single-minded emphasis on hospital construction took the same course as contemporary criticism of the bricks-and-
morton approach of urban renewal. Indeed, the same words recurred in writing about urban affairs and medical policy: “community,” “coordination,” “comprehensive services.” In both cases, critics attacked established policy for its fragmented approach and lack of understanding of broader “community needs.”

The field of medicine where the “rediscovery of community” found an immediately welcome reception was mental health services. A movement away from mental hospitals had already begun in the mid-1950s. The national census of mental hospitals declined from a peak of 634,000 in 1954 to 579,000 by 1963.70 The predominant, though contested, explanation for the drop is that the discovery and introduction of the major tranquilizers (e.g., Thorazine) was the decisive event. Patients who were previously hospitalized could now be safely treated, or at least more safely ignored, on an outpatient basis. Another interpretation points to the adoption by Congress in 1956 of amendments to Social Security that provided greater aid to states to support the aged in nursing homes. Mental hospitals had been filled with unwanted older people suffering only from a harmless senility. By transferring such patients from mental hospitals to nursing homes, the states could transfer part of the cost of upkeep to the federal government.71 Probably both drugs and nursing homes had some effect on the decline of mental hospitalization. The shift also began to receive strong encouragement from advocates of “community psychiatry,” who argued that the state hospitals reinforced disability and isolation, while local services and halfway houses could help return the mentally ill to normal roles in society.

The Kennedy administration took up the cause of “community care” and turned it into a major new federal program. In 1960 a national commission set up by Congress five years earlier to reexamine mental health services called for a major new commitment of federal funds; among its proposals was more money for community clinics, but it favored more hospital aid, too.72 The Kennedy administration chose to emphasize community services alone, along with more money for research and training, in what the president in February 1963 called a “bold new approach” to the problems of the disturbed and retarded. With new “community based” mental health services, he told Congress, “reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability.”73 Congress agreed that year to the proposal for construction funds for the new community programs, and two years later it added money for initial staffing grants.

In a variety of ways, this program presaged the later initiatives of the 1960s. It created a new kind of organization, the community mental
health center, which was meant to overcome the rigidities of the traditional social service agencies. In contrast to Hill-Burton, it linked the federal government and local communities and reduced the role of the states. However, there was no permanent federal funding; the program was meant to be a demonstration project. Ultimately, other sources were supposed to sustain the effort, if evaluations showed it to be effective. In this respect, the government took up the practice of the big foundations in distributing “seed” money and demanded new services from the social sciences to determine whether anything sprouted that was worth cultivating. And, finally, there was a linguistic shift: The use of the term “centers” rather than “clinics” suggested they would go beyond traditional medical functions. Just as the substitution of the term “clinic” for “dispensary” at the turn of the century indicated a widening of institutional mandate for ambulatory services, so, too, did substituting “center” for “clinic.”

The two major contributions of President Kennedy to domestic policy—and indirectly to medical care—both came after his death. One was the tax cut he initiated in the face of a budget deficit. Enacted in 1964, it propelled the economy into its fifth successive year of expansion and brought in higher revenues at lower rates, as his advisers predicted. After the sluggish Eisenhower years the Democrats’ economic record was dazzling. The economy expanded by one fourth between 1961 and 1965; the annual rate of growth, after adjusting for prices, was 5.3 percent. 74 Thanks also to the Republicans’ nomination of Barry Goldwater, Democrats harvested the votes in 1964, picking up thirty-two seats in the House to gain a margin not seen since the New Deal. For liberals, it was a rare moment of political opportunity.

The fruits of economic policy made possible, among other things, the second of Kennedy’s initiatives. In the year before he died, evidently convinced that a rising tide would not lift all boats, the president had asked his advisers to begin developing an antipoverty program. A crusade against poverty appealed to Kennedy as a way to rally Americans in a positive cause. The civil rights movement was also increasingly emphatic about economic issues; the 1963 March on Washington demanded jobs as well as freedom. The summer of 1963 saw the start of the ghetto riots. Almost immediately after Kennedy’s assassination, Lyndon Johnson took up the cause of economic opportunity, and on January 8, 1964, he stood before both houses of Congress to announce “unconditional war on poverty in America.”

Although contemporary liberal analyses continually stressed the importance of bad health as a link in the “cycle of poverty,” medical care was at the outset not a central part of the antipoverty program. In his
Great Society speech, Johnson’s only specific references to medicine were to Medicare and more money for training health professionals. These were not aimed specifically at the poor. The initial priorities of the antipoverty program turned out to be community action and education. But, once under way, the antipoverty effort and other Great Society programs became deeply involved in medical care.

What forces shaped government intervention in the 1960s? In his study of the community action program, Daniel Moynihan argues that liberal academic reformers were chiefly influential as its originators. This was also the case in regard to the neighborhood health centers that emerged shortly out of the community action effort. But these intellectual influences were relatively marginal in medical care, and they grew progressively weaker as programs were winnowed out. The system created in part by postwar public policy now imposed demands for support and continuity that obstructed efforts to move policy in a new direction.

Redistributive Reform and Its Impact

A few general forces were at work in initiating the profusion of medical programs that emerged in the 1960s. Ideologically, nearly all the programs were framed, in one way or another, as responses to the public concern for greater access to medical services. But different interests called for different strategies in meeting (and even conceiving) that objective.

The structural impact of postwar policy, as I have described it, had been to create an immense new system of medical schools, teaching hospitals, and other allied institutions that now, to some extent, counterbalanced the private practitioners. This system demanded to be fed. Its representatives saw an inescapable role for themselves in solving the problems of society. Self-interest and noble aspirations both dictated that they begin a new chapter in the history of social reform. The community hospitals, though tied to private physicians, had their own independent interests, represented by the AHA and Blue Cross. They, too, demanded support under any new program.

A second and distinct influence came from the older and broader constituencies outside medical care that continued to favor a compulsory and contributory health insurance system. The labor movement was the most significant of these groups. Liberal political leaders favored its cause. Their agenda still consisted primarily of the unfinished business of the New Deal. While they wanted an insurance system, they had no objection to the programs sought by medical institutions to build additional capacity. In fact, one seemed to require the other. Their
chief conflict came with those who still wanted to restrict government aid to the poor on public assistance.

And, finally, there were the critics who took the view that something more radical needed to be done. The term "community medicine," ambiguous though it is, may stand for their viewpoint. They wanted "comprehensive" services that trespassed the conventional limits of medicine. They saw their primary mission among the poor, and they favored greater community participation in health services. Before the late sixties, this viewpoint had no constituency to speak of outside the small band of progressives in public health and academic medicine.

Medicare was initially the overriding political issue. In 1958 a congressman from Rhode Island, Aime Forand, introduced a new and extremely modest proposal covering only hospital costs for the aged on Social Security. Unsurprisingly, virtually the same political constellation appeared that had existed ten years earlier. As before, the AMA undertook a massive campaign to portray a government insurance plan as a threat to the doctor-patient relationship. But by concentrating on the problems of the aged, liberals began changing the terms of debate.

The turn toward the aged aroused support from a growing constituency that felt the problem of hospital costs with unusual keenness. In the course of a year, one in six of those over sixty-five entered a hospital and stayed, on the average, twice as long as someone under sixty-five. Hospital care doubled in price during the 1950s. The aged could be presumed both needy and deserving, and the contributory nature of Social Security gave the entire program legitimacy. In 1959 a new Senate subcommittee on aging held hearings around the country. "The old folks lined up by the dozen everyplace we went," one staff member later recalled. "And they didn't talk much about housing or recreational centers or part-time work. They talked about medical care." Within two years, congressmen were reporting more mail on the subject than on any other pending legislation. A news magazine reported that pressure for the bill was "assuming the proportions of a crusade." Opinion polls had shown support before, but in the entire history of the campaign for national health insurance, this was the first time that a grassroots support forced the issue onto the national agenda.76

In 1960 Congress responded to the pressure for Medicare by passing a substitute measure introduced by two of the most powerful members of Congress, Senator Robert Kerr of Oklahoma and Representative Wilbur Mills, chairman of the House Ways and Means Committee. The Kerr-Mills program extended federal support for welfare medicine programs in the states. The benefits were subject to few limits, and the fed-
eral government would provide between 50 and 80 percent of the funds (higher percentages going to poorer states). But the beneficiaries would be limited to the aged poor, and so Kerr-Mills did not settle the issue. Liberals opposed any "means-tested" program on principle as a source of humiliation to the aged and as an inadequate response to their financial and medical needs. They also charged that the states would not move vigorously to take advantage of Kerr-Mills. Three years later, reports confirmed that prediction. Many states had not acted at all, and five large industrial states, with one third of the nation's population, were receiving 90 percent of the funds.77

Despite President Kennedy's support, Medicare was short of votes in Congress until the Democratic sweep in 1964. It then received the highest priority among Great Society programs. However, strategists for the bill, still smarting from past defeats by the AMA, were against expanding its provisions to include physicians' services or to cover any broader group than the aged. At a time of expansive reform, they continued to back a measure framed in the more conservative 1950s. Ironically, the AMA, which now introduced its own "Eldercare" plan for expanding voluntary insurance, stressed that its program would provide the aged broader benefits, including physicians' services. The senior Republican on the Ways and Means Committee also introduced a proposal for a voluntary insurance plan, subsidized out of government revenues, that would cover major medical risks and include doctors' services and drugs. The share paid by the aged would be scaled to their Social Security benefits.

These proposals called attention to the limited benefits and regressive financing of the administration's Medicare plan. An AMA-financed survey found that 72 percent of those questioned thought Medicare ought to cover doctors' bills as well. Concerned about likely public disappointment, Representative Mills decided to expand the legislation. In an ingenious move, he proposed combining the administration's and the Republican measures and then adding a third program to aid services for the poor. The result was what one observer described as a three-layered cake. The first layer was the Democratic plan for a compulsory hospital insurance program under Social Security. This became Part A of Medicare. The second layer was the revised Republican program of government-subsidized voluntary insurance to cover physicians' bills. This became Part B of Medicare. And the third layer, called Medicaid, expanded assistance to the states for medical care for the poor. President Johnson signed the programs into law July 30, 1965. Some physicians initially swore they would organize a boycott, but
cooler heads prevailed in the AMA and, after it went into effect a year later, the profession not only accepted Medicare but discovered it was a bonanza. The story was different with Medicaid.

Though adopted together, Medicare and Medicaid reflected sharply different traditions. Medicare was buoyed by popular approval and acknowledged dignity of Social Security; Medicaid was burdened by the stigma of public assistance. While Medicare had uniform national standards for eligibility and benefits, Medicaid left the states to decide how extensive their programs would be. Medicare allowed physicians to charge above what the program would pay; Medicaid did not and participation among physicians was far more limited. The objective of Medicaid was to allow the poor to buy into the “mainstream” of medicine, but neither the federal government nor the states were willing to spend the money that would have been required.78

The same Congress that enacted Medicare adopted a host of other measures to expand health services. One of these, the Regional Medical Programs, is particularly revealing of the tilt toward the hospitals and medical schools that persisted in government policy even as it became more redistributive in its objectives. In 1964 a Presidential Commission on Heart Disease, Cancer, and Stroke (the DeBakey Commission), which had been appointed at the behest of the Lasker lobby, recommended a massive commitment of federal funds to establish “a national network of regional centers, local diagnostic and treatment stations, and medical complexes designed to unite the worlds of scientific research, medical education, and medical care.”79 The report paid no attention to any environmental, nutritional, or other public health and preventive concerns. Like the report of the Hospital Commission of the 1940s, the DeBakey Commission report was a classic of the kind of myopia that the medical establishment of the mid-twentieth century confused with visionary ideals. No one, as Elizabeth Drew later pointed out, ever asked whether other diseases, such as those affecting children, or diseases that could actually be cured, might be more worthy of federal effort. The commission’s conclusions in favor of a medical assault on heart disease, cancer, and stroke were foreordained by the commission’s name and its composition (the Lasker lobby, as one of its representatives said, had a “quorum”). The aim was to make medical services more available, but there was little thought as to whether such an investment might actually make any difference in health.80

The neighborhood health centers reflected yet another approach to improving access to health care. Though the original Office of Economic Opportunity (OEO) legislation included no specific provisions for medical care, local community action programs became involved...
in various health care projects. The program’s directors decided, however, that instead of supporting more fragmented services, they would support the development of new institutions to provide comprehensive ambulatory care. Accordingly, they took up the initiative of two professors of community medicine at Tufts University, H. Jack Geiger and Count D. Gibson, Jr., to establish a model comprehensive health center in a housing project in Boston. The proposal was expanded to include a second center in rural Mississippi. By the summer of 1966, eight health centers were approved for funding as demonstration projects under OEO’s authority for research and development. In 1967 Senator Edward M. Kennedy sponsored an amendment to authorize special funds for comprehensive health services, and over the next four years OEO helped to start about one hundred neighborhood health centers and other comprehensive service projects. HEW supported another fifty centers under the authority to support demonstration projects granted it in the Comprehensive Planning Legislation passed in 1966. In addition, older programs, such as Hill-Burton and community mental health centers, were modified to focus efforts on low-income communities.

The aim of the health centers program was to create a “one-stop” facility in low-income communities that could provide virtually all necessary ambulatory health service. The centers would try to employ as many local residents as possible and encourage community participation in running the organizations. Part of the objective was to develop indigenous competence and leadership. This concern reflected the general aim of the War on Poverty to “help the poor help themselves”—a fundamentally conservative idea that had radical implications in the context of modern professionalism. Initially, the centers did not observe the conventional boundaries of medicine. A good example comes from the early project started at Mound Bayou, Mississippi, where malnutrition proved to be one of the most serious health problems. As Jack Geiger describes it, when the health center began stocking and prescribing food for the malnourished, some officials objected that its pharmacy was only supposed to carry drugs for the treatment of disease. To which the staff responded, “The last time we looked in the book, the specific therapy for malnutrition was food.” The center also became involved in starting farm cooperatives, public transportation, and other local projects.81

Like the mental health centers, the neighborhood health centers were started on the premise that as demonstration projects they had only temporary federal funding. Once again, a national program planted a new type of organization at the local level, outside existing bureaucracies. But these aspects of the program were also the source
of its vulnerability. In the long run, the centers were supposed to derive their funds from other sources, such as third-party reimbursement. Medicaid, however, did not cover the broad range of services the centers provided. (As of 1975 Medicare and Medicaid generated only 10 to 20 percent of operating income for most centers.) Furthermore, in 1967 Congress restricted the centers to providing free services to low-income families; two years later, this restriction was interpreted as limiting paying patients at the centers to 20 percent of their total registrants. These provisions were adopted at the behest of private practitioners who did not want the health centers competing with them for good business (the old story of "dispensary abuse" again). But as Karen Davis and Cathy Schoen point out, "These restrictions guaranteed the almost total dependence of the neighborhood health center program on public funds."82

About half the medical schools in the country participated in developing or staffing health centers. Hospitals and health departments also took part as sponsors. But they frequently became embroiled in conflicts with community representatives, and as federal funds for developing centers became more scarce in the early 1970s, the interest of the medical establishment in the program cooled considerably.

In plans developed by HEW in 1967, the administration looked mainly to health centers rather than Medicaid as the main vehicle for providing medical care to poverty areas. Plans called for one thousand centers serving 25 million people by 1973. This program, of course, was never carried out. Little money was available for community medicine in the sense the health centers were demonstrating. While the Medicaid budget ballooned, the growth of the centers was stunted. Yet neighborhood health centers were not any less successful. In fact, studies suggest they had positive effects on the health of their communities and significantly reduced use of hospitals (savings that they did not capture).83 But policy makers did not deliberately choose to push Medicaid over neighborhood health centers on the basis of any evaluation of relative cost effectiveness. Medicaid simply had the advantage of institutional compatibility. It covered what would otherwise have been bad debts for hospitals and raised no challenge to private interests in the medical sector. Although neighborhood health centers managed to survive (and even grow in the later seventies), they never became more than a marginal alternative.84

The programs of the 1960s represented a second stage in the extension of medical services in American society in the twentieth century. The first stage was the extension of services to the working class and the South in the period after the Second World War. The growth of
health insurance as a fringe benefit of employment and the rise of real incomes in the 1940s and 1950s made it possible for working-class families to enjoy greater access to medical services than they had before the war. Similarly, the Hill-Burton program brought about the development of hospitals in the South and other areas of the country where previously arrested economic development had made medical resources relatively scarce. The studies of the Committee on the Costs of Medical Care, carried out between 1928 and 1931, showed that middle-income families then used health services at a rate that was closer to the low use by the poor than the high use by the rich. But by the 1950s the receipt of health services among people of moderate incomes was approaching the level of higher-income households. Now it was the poor, rather than the rich, who stood out as different from the rest of society. This shift may be described as a change from mass exclusion to minority exclusion from medical care. And it followed the general pattern in postwar America that John Kenneth Galbraith, Michael Harrington, and others have described as the shift from "mass poverty" to "minority poverty." The social programs of the 1960s were aimed at alleviating minority poverty; the health programs were aimed specifically at reducing the exclusion from medical care of the poor and the aged, who were marginal to the core sectors of the economy where health insurance was available as a fringe benefit.

There is little question that these efforts had an impact. The decade after 1965 witnessed a sharp increase in the use of medical services by the poor. In 1964 the nonpoor saw physicians about 20 percent more frequently than the poor; by 1975 the poor visited physicians 18 percent more often than the nonpoor. In 1964 whites saw physicians 42 percent more often than blacks; by 1973 whites still saw physicians more often, but only by 13 percent. In 1963 those with incomes under $2,000 a year had only half as many surgical procedures per 100 people as those with incomes of $7,500 or more, but by 1970 the rate for the low-income group was 40 percent higher. Most of this increase was probably due to Medicare and Medicaid. Data from 1969, for example, show that for every level of health status, public assistance recipients eligible for Medicaid used medical services much more often than other poor people not eligible for Medicaid.

However, another reason for increased use of medical care by the poor—virtually unnoticed in research in this area—was that the composition of the poverty population was changing. Between 1959 and 1969, according to the standard government data, the poverty population dropped from 22.4 to 12.8 percent of the American people. But as the poverty population diminished, it included an increasing proportion
who were poor because the head of household could not work. The reduction of poverty among working families seems to have left a higher proportion of chronically ill and disabled people among the poor relative to the rest of society. The rising use of health services by low-income people may partly reflect this change in composition of the poverty population.

Various studies taking into account differences in health do show increased use of medical care relative to "need." These studies disagree as to whether the poor gained equal access to medical care in the 1970s when the redistributive programs reached their peak. But the balance of evidence suggests that significant differences remained even then in use relative to need and in the quality of services received by the poor.

The continuing differences in the access of the poor to medical care reflected the limitations of the programs established in the 1960s. Even before the cutbacks of the Reagan administration, Medicare covered less than half of the health expenditures of the elderly, Medicaid covered only one third of the poor, and neighborhood health centers reached only an additional 5 percent. Because of differences in eligibility requirements for Medicaid, the proportion of the poor able to receive benefits varied sharply among the states. Medicaid omitted from coverage most two-parent families and childless couples, widows, and other single persons under sixty-five years of age, families with fathers working at low-paying jobs, and medically needy families in the twenty-two states that did not provide such coverage.

So by 1970 the structure of inequality had changed once again. Those without any financial protection in sickness, public or private, were households with part-time or recently unemployed workers and the working poor who earned too little to afford private insurance and too much to qualify for public assistance. Along with the many poor people excluded from Medicaid because they failed to fit into eligibility categories, these were the medically excluded even in the heyday of redistributive effort—those who wandered in what might be called the "Medicaid-private insurance corridor," the purgatory of categorical social welfare systems.

*The Politics of Accommodation*

Buried in the detail of the Medicare statutes and administrative regulations were a number of far-reaching decisions about the organization and financing of health care in America. I will mention only two of them
because of their bearing on the present argument and later developments in health care.

In setting up Medicare, Congress and the administration were acutely concerned to gain the cooperation of the doctors and hospitals. Consequently, they established buffers between the providers of health care and the federal bureaucracy. Under Part A of Medicare, the law allowed groups of hospitals, extended care facilities, and home health agencies the option of nominating "fiscal intermediaries," instead of dealing directly with the Social Security Administration. These intermediaries were to provide reimbursements, consulting, and auditing services. The federal government was to pay the bills. As expected, the overwhelming majority of hospitals and other institutions nominated Blue Cross. Under Part B, the secretary of HEW was to choose private insurance agents called "carriers" to serve the same function in a geographical area. The majority of these carriers turned out to be Blue Shield plans. As a result, the administration of Medicare was lodged in the private insurance systems originally established to suit provider interests. And the federal government surrendered direct control of the program and its costs.

The second key decision involved the rules of payment for hospitals under Medicare. The legislation adopted the practice followed by Blue Cross of paying hospitals according to their costs rather than, for example, a schedule of negotiated rates. And in carrying out this provision, the administration agreed to rules for calculating costs that were extremely favorable to the hospital industry. The hospitals wanted Medicare to pay depreciation on hospital assets. Depreciation for a nonprofit institution is a peculiar idea; when a community donates capital to an institution, it does not necessarily agree to replace it. Yet the administration agreed not just to pay depreciation, but to pay it on an accelerated basis and to include Hill-Burton assets. Moreover, by providing capital through reimbursement, it would provide the most capital to the hospitals with the newest and most expensive facilities. And, unlike Hill-Burton, which originally required a planning procedure for setting priorities, the capital would flow without any governmental review of the relative needs of different areas. In a study of Medicare, Judith Feder notes that administration officials understood all these drawbacks of liberal reimbursement, but ignored them in making policy.

Why? Partly because senior SSA [Social Security Administration] and HEW officials accepted the consensus in the health field that hospital "improvement" was a good thing. . . . But even they would have been less generous if the hospi-
tals had not pressed them. What made these officials . . . [give in] was their commitment to a "proper takeoff" for Medicare. Some observers have said that Medicare officials feared a hospital boycott if they did not give in. The officials themselves explain their position differently. Their feeling, according to a senior SSA official, was that the hospitals would have to go along . . . . "But there's a real difference in launching a program with the help of the hospitals as opposed to against them. To an administrator, that difference makes all the difference in the world." 92

This was the politics of accommodation, and it affected every aspect of government policy.

The decision to provide capital reimbursement under Medicare involved millions of dollars annually in federal expenditures over and above the money still being spent through the Hill-Burton program. So, despite the widespread sense that federal policy ought to shift its emphasis to ambulatory care, the government was still putting big money behind hospital expansion. Medicare enormously strengthened the financial position of the hospital industry, enabling hospitals to accumulate and borrow capital on their own more easily. This greater financial independence undermined the simultaneous efforts to improve voluntary planning and coordination of medical facilities.

The emergence of health planning in the 1960s was part of the general attempt to provide "comprehensive" and "coordinated" services. In the United States, where planning has never been widely approved as a role for government, health planning was a limited exception. It had begun with voluntary hospital planning. The earliest efforts, such as the Hospital Planning Council of Greater New York, established in 1938, grew out of attempts to coordinate hospital philanthropy. These efforts to rationalize the hospital industry, often led by large employers, took place primarily in such cities as Rochester, Pittsburgh, and Detroit, where industrial leadership was highly concentrated. Between 1938 and 1962 only eight such local hospital planning agencies were established in the country. In 1962, however, the movement received a major boost when Hill-Burton funds became available for such activities on a fifty-fifty matching basis. By 1965 there were fifty areawide agencies. Then, in 1966, Congress adopted legislation for Comprehensive Health Planning, which authorized partial federal funding for planning agencies. But the whole effort was vitiated from the start by the refusal to give the agencies any control over the allocation of health care capital or the reimbursement system that determined the flow of revenues. 93

The meager record of planning agencies was consistent with the deeper tendencies at work in federal policy. While government expanded its redistributive efforts, it continually sought to reassure pri-
The Liberal Years

Private interests that it would make no effort to control them. Like Hill-Burton, Medicare included a specific provision that no part of the law meant to authorize any changes in the organization of medical services. And, indeed, initially there were none.84

To provide medical care or other services, the state can act via the market or its own agencies. If it chooses to rely on the market, it has the option of buying or subsidizing privately produced services through direct appropriations or tax incentives. Alternatively, it can “produce” and distribute medical services directly. The American pattern has been to rely on the market. And, curiously, the programs of the 1960s not only followed that pattern but strengthened it. As government financing expanded, the tendency was for the government production of medical care to diminish. Outside of the armed services and various other special categories, the few spheres of government production had been veterans’ and welfare medicine. When Medicare and Medicaid made the indigent eligible for subsidized care in private institutions, they undermined the rationale for municipal, veterans’, and other government hospital services.

Some might argue that this preference for privately produced services reflects a typically capitalist bias, but other capitalist societies lean more in the opposite direction in medical care. Britain and Sweden have replaced systems of national health insurance with national health services, thereby moving off the market into direct production and assuming greater control over the health system. The extent of variation in medical services among capitalist countries suggests that there is no simple correspondence between capitalism and medical care, at least not in organizational and financial structure.85

The medical profession does not have the same basis of power as large corporations. Private capital is not simply one of several interest groups in society; the economy and hence the government’s own tax revenues depend on “business confidence.” Hence business confidence generally acts as a constraint on policy without businessmen ever having to lobby on behalf of their interests as a class. If government threatens to undermine business confidence, it jeopardizes its own stability by bringing about a reduction in investment and a general economic crisis, with rising unemployment and lower tax revenues. The medical profession clearly does not have this degree of “structural power.”96 Government can lose the confidence of doctors without grave economic repercussions. If threatened, doctors can try to withdraw their “human capital”—that is, to strike or even to emigrate. But these threats are much harder to carry out than a shift of business investment. Opposition from doctors is a potentially serious problem, but it is far from insuperable.
As the case of Medicare illustrates, the power of doctors and hospitals to withhold cooperation from a government program helped them to secure long-run advantages. The AMA may have lost its long campaign against government insurance at a rare moment of liberal political success. But the superior political organization of the AMA and the hospitals enabled them to shape what might be called the "interior" of reform. The AMA's dread predictions that Medicare would be a disaster made it especially important for the administration to demonstrate quickly to the public that services would be available when they wanted them. An administration more concerned with the budgetary consequences of concessions than with smooth take-off would not have yielded as much. The government and liberal reformers would pay a price for this choice later on. So would the doctors and the rest of the health care industry, for the concessions they won in public money would hurt them later in public confidence.

It was almost as if an internal dynamic were playing itself out in the postwar decades. In virtually the classic Marxian fashion, the expansion of the forces of production in health services—government subsidies, private insurance, technology, consumer demand—was breaking down the old social relations of production and preparing the way for more decisive change. As the institutional side of medicine expanded, the medical profession itself became more divided, especially between academic medicine and private practice. The cohesiveness of the profession, so vital to its past successes, was beginning, like so many other things in the 1960s, to come apart. New interests emerged inside medicine that began to overshadow the private practitioners. And as public dissatisfaction increased with rising costs, these new forces threatened to reduce the sovereignty that private doctors had long exercised over medical care.
CHAPTER FOUR

End of a Mandate

MEDICINE, like many other American institutions, suffered a stunning loss of confidence in the 1970s. Previously, two premises had guided government health policy: first, that Americans needed more medical care—more than the market alone would provide; and second, that medical professionals and private voluntary institutions were best equipped to decide how to organize those services. Until the 1970s the first of these premises had not yet undermined the second. Increased federal aid initially did not much enlarge the scope of public regulation. Practitioners, hospitals, researchers, and medical schools enjoyed a broad grant of authority to run their own affairs.

In the 1970s this mandate ran out. The economic and moral problems of medicine displaced scientific progress at the center of public attention. Enormous increases in cost seemed ever more certain; corresponding improvements in health ever more doubtful. The prevailing assumptions about the need to expand medical care were reversed: The need now was to curb its apparently insatiable appetite for resources. In a short time, American medicine seemed to pass from stubborn shortages to irrepressible excess, without ever having passed through happy sufficiency. Rising costs brought medical care under more critical scrutiny, and the federal government, as a major buyer of health services, intervened in unprecedented ways.

Slow economic growth and persistent inflation in the seventies undoubtedly lay behind the shift from a redistributive to a regulatory politics in health care, but the new constraints were not purely economic
in origin. Even the response to rising costs cannot be entirely understood apart from a diminished faith in the efficacy of medicine and increased concern about its relation to other moral values. Many worried—and the courts often agreed—that doctors and hospitals might abuse their power, if patients' rights were not more clearly protected. The women's movement also challenged the authority and power of the profession. For the first time in a century, American physicians faced a serious challenge simultaneously to their political influence, their economic power, and their cultural authority.

And yet the 1970s did not yield a victory for medicine's progressive critics. One dose of inflation and disillusionment with medicine produced a movement for reform, but a second dose produced impasse and despair, and a third dose a movement against many of the changes adopted earlier. Like American politics more generally, the politics of health care passed through three phases in the 1970s:

1. A period of agitation and reform in the first half of the decade, when broader entitlements to social welfare and stricter regulation of industry gained ground in public opinion and law

2. A prolonged stalemate, beginning around 1975, when the preoccupation increasingly became coping with inflation, doubts arose about the value of medical care, and initiatives such as national health insurance were set aside

3. A growing reaction against liberalism and government, culminating in the election of President Reagan in 1980 and the reversal of many earlier redistributive and regulatory programs

Despite these shifts, the underlying tension remained throughout the 1970s—and continues today—between a medical care system geared toward expansion and a society and state requiring some means of control over medical expenditures. By 1980 health care expenditures reached $230 billion, up from $69 billion in 1970, a jump from 7.2 to 9.4 percent of GNP. Growth of this kind cannot be indefinitely sustained regardless of the administration in Washington; other sectors of the economy cannot and will not support it. Yet controlling expansion means redrawing the "contract" between the medical profession and society, subjecting medical care to the discipline of politics or markets or reorganizing its basic institutional structure. This is what began to happen in the 1970s.
LOSING LEGITIMACY, 1970–1974

Discovery of a Crisis

The 1970s opened with ominous declarations of a “crisis” in health care. The wide use of the term “crisis” did not simply register an objective reality—it changed it. Crises make hard decisions seem unavoidable; they change the political agenda and create political opportunities. For years liberals had been trying to persuade Americans to recognize a health care crisis in order to open the way for reforms beyond Medicare. On assuming office, the Nixon administration confronted rapidly escalating costs in Medicare and Medicaid, and it, too, adopted the rhetoric of crisis. “We face a massive crisis in this area,” President Nixon told a press conference in July 1969. “Unless action is taken within the next two or three years . . . we will have a breakdown in our medical system.”2 In January 1970 Business Week ran a cover story on the “$60 billion crisis” that compared medical care in America unfavorably to national health programs in Western Europe.3 That same month, the editors of Fortune, in a special issue on medical care, declared that American medicine stood “on the brink of chaos.” Their indictment was as stinging as any in the liberal press:

Much of U.S. medical care, particularly the everyday business of preventing and treating routine illnesses, is inferior in quality, wastefully dispensed, and inequitably financed. Medical manpower and facilities are so maldistributed that large segments of the population, especially the urban poor and those in rural areas, get virtually no care at all—even though their illnesses are most numerous and, in a medical sense, often easy to cure.

Whether poor or not, most Americans are badly served by the obsolete, overstrained medical system that has grown up around them helter-skelter. . . . the time has come for radical change.4

A survey of heads of families in 1970 found that three quarters agreed with the statement, “There is a crisis in health care in the United States.”5

First and last, this was understood to be a crisis of money. In the phrase of the day, the costs of medical care were “skyrocketing.” If allowed to continue, “runaway” inflation would “price medical care out of the reach of most Americans.” No discussion of the health care crisis was complete without stories of the many families that were ruined financially by staggering medical bills. But in the early seventies, the list of medicine’s inadequacies always went beyond its expense. As Karl
Yordy, an analyst at the Institute of Medicine said in 1973, "The cost question turned the spotlight on the other deficiencies of the system." Even with all the additional public expenditures, the poor were still not receiving adequate medical care. Middle-class families were upset that they couldn’t find a doctor evenings or weekends. As general practitioners became a rapidly dwindling species, many people were frustrated that they no longer seemed to have any access to medical care even in areas where doctors and hospitals were numerically abundant. And, for all the costs, the health of Americans did not seem to be as good as that of the people of most other industrialized countries. The articles announcing the health crisis typically pointed out that Americans—even excluding blacks—had higher infant mortality rates and lower life expectancy than most Europeans.

Most of these facts were hardly new, but the attention paid to them was unprecedented. For the moment, the liberal critics of medical care commanded the political debate. Their conceptions of the problem and their remedies now became common wisdom. American medicine, the consensus held, was overly specialized, overbuilt and overbedded, and insufficiently attentive to the needs of the poor in inner-city and rural areas. The system needed fewer hospitals, more “primary” care, incentives to get doctors into underserved communities, and better management and organization. And most of all, Americans required national health insurance—not a giveaway to the providers like Medicare, but a “rational,” “coordinated” program that would include “tough cost controls.”

After a hiatus of twenty years, national health insurance again began to receive attention in November 1968, when Walter Reuther, president of the United Auto Workers, issued a new call for its passage in a speech to the American Public Health Association. Reuther played the leading role in organizing a new Committee for National Health Insurance, and in January 1969 Senator Edward M. Kennedy, a member of the group, announced he would introduce legislation. Then in a remarkably short time, the idea received wide acceptance and the number of alternative plans proliferated. By 1970 the traditional opposition to national health insurance was so frail that the AMA, the hospitals, and the insurance industry were each sponsoring their own proposals.

Conservatives and liberals still had their disagreements about the scope of health insurance and the roles of the public and private sectors. But even some conservatives now acknowledged that reforms had only begun with Medicare and Medicaid, that federal programs were a hodgepodge, and that an overall program of national health insurance might be desirable. Since expanded entitlements to health care were
likely, changes in the organization of health services would be a fiscal necessity.

In the early seventies, unlike later in the decade, the sense of crisis in health care was accompanied by considerable optimism about the possibilities for successful reform. The record of the Kaiser Health Foundation suggested it was possible to provide high quality prepaid health care at 20 to 40 percent lower cost than fee-for-service medicine. Advocates of the "health team" approach hoped that nurse practitioners, physicians' assistants, and other "physician extenders" could improve access and efficiency. High rates of surgery and hospitalization suggested that more careful peer review might significantly reduce expenses by discouraging unnecessary procedures. Extensive duplication of facilities and equipment suggested that effective health planning could yield notable benefits and savings.

For the first time since the Committee on the Costs of Medical Care, the economic and political leadership of American society seemed ready to bring about changes in the organization of medical care over the opposition of the providers. The doctors, hospitals, and insurance companies were now completely on the defensive, trying to hold back a tide of disaffection. So in a political sense, the medical system was very much in crisis, not because it was really about to break down, as the president and the business press suggested, but because it had lost their confidence. Medicine had overdrawn its credit. It had also aroused a variety of new social movements to much bolder opposition. Two processes were at work in producing this extraordinary loss of favor. I will call them the contradictions of accommodation and the generalization of rights.

The Contradictions of Accommodation

The concessions that the doctors and hospitals had secured in Medicare and other public programs denied the government any leverage to control costs. But once those costs began to escalate, government acquired an independent interest in reorganizing the system and the political influence of the providers began to erode. Employers paying rising insurance rates also increasingly began to distinguish their interests from those of the health care industry. The politics and institutions of accommodation, in other words, were their own undoing. Their contradictions were driving government and business to pronounce health care in crisis and to seek reform.

The cost problem took on a new meaning by 1970. Although medical costs were rising before 1965, they had been regarded mainly as a prob-
lem for individuals and families. Congress generally favored increasing total health expenditures in the belief that medical care was a prudent and popular social investment. After 1970, however, public officials began to regard the aggregate costs of health care as too high and to doubt that the investment was worth the return in health.

Two objective realities had changed. Medical costs had begun to rise much more sharply, and government’s share of costs had increased. The rate of growth in the cost of medical services rose from 3.2 percent a year in the seven years before Medicare to 7.9 percent annually during the five years afterward. (Meanwhile, the inflation rate for all other services in the consumer price index increased from 2.0 to 5.8 percent annually.) National health expenditures, up from $142 to $198 per capita between 1960 and 1965, had risen to $336 per capita by 1970. Hospital costs had become especially troublesome. From 1950 to 1965 per capita expenditures on community hospitals rose 8 percent annually; after 1965 the rate of growth jumped to 14 percent a year.  

The impact on government was even more severe. Its share of national health expenditures jumped from 26 to 37 percent between 1965 and 1970. In that same period, the annual rate of increase in state and federal health expenditures was 20.8 percent. The $10.8 billion government had spent in 1965 became $27.8 billion by 1970.

Many now doubted the need for these high expenditures. Health services research indicated that Americans had too much surgery and that perhaps one fifth of the patients in hospitals did not need to be there. News stories told of doctors and nursing home owners making small fortunes off government programs through inflated reimbursements or outright fraud.

Many attributed rising health care costs to Medicare and Medicaid, or to advances in science; but a more fundamental explanation lay in the basic incentives in the health care system, especially its financing arrangements, which Medicare and Medicaid had only reinforced. To be sure, advances in science and technology created new demands for investment. The advances during and after World War II had been in relatively inexpensive drugs; after 1960 they increasingly involved complex equipment and procedures. Hospital employees also had long been paid substandard wages; now they wanted to catch up to comparable workers. Doctors wanted more assistants to enable them to perform new tests and procedures. In hospitals—where most of the growth in costs came—the clamor for more resources was constant, relentless, and plausible. But the cause of rising costs was not so much the intensity of the clamor as the financial arrangements that allowed hospitals to yield to it. As Martin S. Feldstein put it, “increases in the components
of cost” were “primarily the result and not the cause of higher prices.” The tolerance of the market for higher prices allowed costs to increase. Higher incomes and higher expectations were partly responsible for that increased tolerance, but the key was the structure of financing.9

As third parties, both private insurers and government programs effectively insulate patients and providers from the true cost of treatment decisions and so reduce the incentive to weigh costs carefully against benefits. From 1960 to 1975 the share of health care expenditures paid by third parties increased from 45 to 67 percent.10 Like most private plans, Medicare and Medicaid reimburse providers on a fee-for-service basis. Since under fee-for-service, doctors and hospitals make more money the more services they provide, they have an incentive to maximize the volume of services. Third-party, fee-for-service payment was the central mechanism of medical inflation.

In addition, the reimbursement practices for hospitals and doctors were peculiarly designed to encourage higher costs. As I have already mentioned, Medicare and Medicaid, like Blue Cross, chose to reimburse hospitals on the basis of their costs. Under such a system, any institution that reduced its costs would reduce its income, possibly for years to come, since the record of past costs affects future reimbursement levels. On the other hand, the greater its costs, the higher its reimbursements. Thus hospitals were encouraged to solve financing problems, not by minimizing costs but by maximizing reimbursements. What was individually a solution for hospitals was, in aggregate, a problem for society.

Instead of establishing a fixed fee schedule, Medicare paid doctors according to their “customary” fees, assuming them to be the “prevailing” fees in the area or, failing precedent, to be “reasonable.” Fees began to soar when some young doctors, who had no record of charges, billed at unprecedented levels and were paid. When their older colleagues saw what was possible, they, too, raised their fees, and soon what was customary was higher than ever before. Blue Shield adopted a similar system (“usual, customary, and reasonable” reimbursement), and the result was rampant inflation in medical fees.11

This system continues today. Reimbursements reflect the prevailing charges in a community and thus favor doctors who practice in high-priced areas. Since reimbursement rates also depend on a physician’s record of past charges, the system gives doctors an incentive to keep pushing their prices up to improve their profile. Medicare also permits doctors to charge patients over and above what the government will pay.

But probably most important, the prevailing relative fees paid physicians provide higher compensation for services performed in a hospital
than for identical services performed in an office. Doctors earn more, for example, for a follow-up hospital visit than for an office visit, even though the hospital visit costs the doctor far less to produce. In the mid-1970s, according to data assembled by Mark Blumberg, doctors earned 50 to 60 percent more per hour for hospital labor time. Third parties also pay more per minute of physician time for certain procedures and auxiliary services. Originally, these procedures were often complicated and time-consuming, but as Blumberg points out in his historical analysis of doctors' fees, prices have typically remained high even when the procedures have been simplified. As a result, some services, like cataract surgery, are financial "winners" because they pay much more than they cost to produce, while other services, like talking to a patient, are "losers" because they pay less than they cost. These relative prices also result in higher incomes for those specialties that do more procedures and practice more in hospitals. A cardiac surgeon, writing in *The New England Journal of Medicine*, has estimated that members of his own specialty doing coronary bypass operations in 1979–80 were earning an average of $350,000 a year on that operation alone. And since they were doing many other operations, notes Dr. Benson Roe, "it is conservative to estimate that their average gross income exceeds $500,000." Originally, the surgeon took part in the entire procedure, from the diagnostic studies through all stages of the operation to post-operative care. Now the surgeon has been relieved of many of these responsibilities by assistants and technicians, whose services are all billed separately. "Under these circumstances," writes Dr. Roe, "one might expect the surgeon's fee to have dropped considerably, but it has not. On the contrary, fees for cardiac surgery have escalated at a rate that far exceeds the inflation factor."

Distorted prices distort decisions about services, careers, and investments. In the system as a whole, the biases they create regularly produce overuse of hospital care, tests, and surgery and encourage more doctors to enter specialties like surgery than the society needs.

The dynamics of the system in everyday life are simple to follow. Patients want the best medical services available. Providers know that the more services they give and the more complex the services are, the more they earn and the more they are likely to please their clients. Besides, physicians are trained to practice medicine at the highest level of technical quality without regard to cost. Hospitals want to retain their patients, physicians, and community support by offering the maximum range of services and the most modern technology, often regardless of whether they are duplicating services offered by other institutions nearby. Though insurance companies would prefer to avoid the
uncertainty that rising prices create, they have generally been able to
pass along the costs to their subscribers, and their profits increase with
the total volume of expenditures. No one in the system stands to lose
from its expansion. Only the population over whom the insurance costs
and taxes are spread has to pay, and it is too poorly organized to offer
resistance.

The obvious defect is the absence of any effective restraint. Yet this
is no accidental oversight. It is, as we have seen, the outcome of a long
history of accommodation to private physicians, as well as to hospitals
and insurance companies, which in their own internal organization had
adjusted to the practitioners’ interests. This institutional phalanx suc-
cceeded in blocking any form of control or any alternative form of orga-
nization that would have threatened their domination of the market.

Public dissatisfaction about access to medical care had much the same
origins as excessive costs. Political accommodation of dominant private
institutions in medical care allowed them to pursue their own internal
priorities. No limits were placed on the number or variety of medical
specialties, while specialists received higher insurance reimbursements
than general practitioners. Almost every conceivable encouragement
was given to hospitals to grow. Most insurance covered hospital care;
doctors’ services, if given in hospitals, were more likely to be covered
and paid at a higher rate.

So just as the financing system promoted overexpansion in some
areas, it produced an undersupply of services in others. The incentives
that favored hospital care promoted the neglect of ambulatory and pre-
ventive health services; the incentives that favored specialization also
caused primary care to be neglected. Paying doctors according to the
fees prevailing in their areas encouraged doctors to settle in wealthy
suburbs rather than in the rural or inner-city areas.

Paradoxically, public financing weakened the medical institutions in
the public sector. Medicaid drained state and local government budgets
for health care, allowed the eligible poor to go to voluntary hospitals,
and left municipal and other public institutions with limited resources
to care for the millions of people who remained uninsured.

The same reimbursement practices that encouraged community hos-
pitals in wealthy areas to expand caused financial difficulties for hospi-
tals in poor neighborhoods. The effect of cost-based reimbursement on
the solvency of hospitals depends on the relative proportions of charity
and privately insured patients. Medicare and Medicaid, both cost-based
payers, do not consider charity care to other patients as a cost of service
to their beneficiaries. (Blue Cross plans vary.) Hence hospitals have to
recover the costs of charity from some other source, such as those pa-
tients who pay charges (usually people covered by commercial insurance who then receive indemnity benefits). Hospitals with few charity patients and many privately insured ones have little difficulty raising charges on the latter to make up their losses. But hospitals with many charity patients, few privately insured, and the remainder paid at cost can easily find themselves in deep trouble. These are typically hospitals that serve the poor.

The differences between cost-based payers and charge-based payers led to unexpected political effects. The commercial insurance companies worried that if the government tried to solve its fiscal problems simply by tightening up cost-based reimbursement, the hospitals might shift the costs to patients who pay charges, which would force up commercial insurers' rates and make them less competitive with Blue Cross. Hence the commercial insurance industry began to favor more comprehensive responses, such as community health planning or state regulation of hospital charges.¹⁴

Thus three powerful forces were now arraying themselves against the health care providers in a drive for greater state intervention—the insurance industry, the employers, and the government itself. In the seventies, these interests found themselves in a temporary alliance with long-time liberal critics of the health system and a variety of new social movements demanding reform.

The Generalization of Rights

Every society shapes the demands made against it. In the United States, the two-party system, the absence of a socialist tradition, and the distinctive role of the judiciary in interpreting the Constitution encourage the dissatisfied to organize in social movements outside the political parties and to present their demands as claims under the Bill of Rights. These tendencies were never more in evidence than during the 1970s.

The civil rights' struggle lost its momentum as a protest movement in the seventies, but it set the example for dozens of other movements of similar purpose. Instead of marching through the streets, they marched mainly through the courts. And instead of a single movement centered on blacks, the new movements advocated the rights of women, children, prisoners, students, tenants, gays, Chicanos, native Americans, and welfare clients. The catalogue of rights and of groups entitled to them was immensely expanded in both variety and detail. Medical care figured prominently in this generalization of rights, particularly as a concern of the women's movement and in the new movements specifically for patients' rights and for the rights of the handi-
capped, the mentally ill, the retarded, and the subjects of medical research.

Health care as a matter of right, not privilege: No other single idea so captures the spirit of the time. The law did not, in fact, recognize any general right to health care, and philosophers and lawyers questioned what a right to health care or to health itself might require. But despite such objections, the claim was for a time so widely acknowledged as almost to be uncontroversial. The entitlement programs had created a specific set of rights to medical care, but only for those who could establish eligibility. Some hospitals, having accepted federal funds under the Hill-Burton program, had obligated themselves to provide charity care—an obligation that attorneys for the poor sought to enforce in the courts in the early 1970s. Other legal claims were raised on behalf of patients committed to mental institutions. In a notable case in 1971, *Wyatt v. Stickney*, a federal court in Alabama ruled that patients in one of the state's mental hospitals had a right to psychiatric treatment as long as the state kept them confined.15

The new health rights movements were also concerned with rights in health care, such as the right to informed consent, the right to refuse treatment, the right to see one's own medical records, the right to participate in therapeutic decisions, and the right to due process in any proceeding for involuntary commitment to a mental institution. Claims of a right to health care demand equality between rich and poor, whereas rights in health care demand greater equality between professional and client. For every right, there are always correlative obligations. Recognition of a right to health care would obligate the state to guarantee provision of services. Recognized rights in health care, such as informed consent, obligate doctors and hospitals to share more information and authority with their patients. Thus the new health rights movement went beyond traditional demands for more medical care and challenged the distribution of power and expertise. These efforts, like the attempts to enlarge entitlements to services, met some success in the courts. Indeed, few other developments so well illustrate the decline of professional sovereignty in the 1970s as the increased tendency of the courts to view the doctor-patient relationship as a partnership in decision making rather than a doctors' monopoly. On the issue of informed consent, the courts took the view that doctors had an affirmative duty to present all material facts, including risks of treatment, to the patient. (A patient can sue a physician for malpractice if the doctor fails to disclose such risks and the patient suffers an injury.) Public authorities, beginning in the 1960s, also adopted new safeguards to assure the right of informed consent to the subjects of medical research.16
In 1972 the trustees of the American Hospital Association, following the lead of some local hospitals and health centers, adopted a Patient’s Bill of Rights, which included rights to informed consent and to considerate and respectful care. Though well received by the press, the declaration prompted one critic, Dr. Willard Gaylin, to remark that it was an example of “the thief lecturing his victim on self-protection,” since it only returned to patients some legal rights that hospitals had previously stolen from them.17

One of the AHA’s more controversial provisions said patients had the right to refuse treatment “to the extent permitted by law.” The controversy that ensued concerned the proper limits of medical intervention—whether, for example, doctors and hospitals were bound to honor the request of a dying patient no longer to be kept alive. Some worried that medicine might lose its commitment to sustain life if the commitment were qualified in any way; others argued that hospitals were keeping alive patients who no longer wanted to live. The controversy was symptomatic of a deeper problem. A French physician calls it “therapeutic relentless.”18 In its commitment to the preservation of life, medical care ironically has come to symbolize a prototypically modern form of torture, combining benevolence, indifference, and technical wizardry. Rather than engendering trust, technological medicine often raises anxieties about the ability of individuals to make choices for themselves.

Advocates of patients’ rights made their case as much from these concerns as from concerns about the poor. In so doing, they raised radical questions about the prerogatives of the doctor’s role. Implicit was a belief that the interests of doctors and patients frequently diverged, and hence that patients needed protection, especially in relation to medical research and the use of experimental techniques, such as psychosurgery. Some doctors did not appreciate this signal of distrust. “What I resent, and resent very deeply,” said one surgeon in 1977, explaining why he objected to review boards supervising the selection of patients for psychosurgery, “is the idea that has been prevalent for the past seven years that patients have to be protected from physicians. This is a terrible, terrible thought to me. The best guardian that you can have of your welfare when you are ill with anything is your physician.”19

This was precisely what many Americans had ceased to believe. Since the Progressive era, as David Rothman has written, reformers had assumed that professionals, including physicians, would act in the interests of the dependent; consequently, they were willing to give them wide discretion in institutions such as prisons and hospitals. By the 1970s, reformers had become intensely skeptical of professionals and
the benevolent institutions they supervised. From this distrust emerged a variety of legal safeguards aimed at limiting professional autonomy and power. A related movement also developed to “deinstitutionalize” the dependent and “demedicalize” critical life events, such as childbirth and dying. The interest in hospices and home births derived, at least in part, from a desire to escape professional dominance as well as the desensitizing environment of the hospital. In the view of its critics, the hospital had become a zone of medical domination, and the only escape was to remove the “patient” to a setting where medical authority would be secondary.

Perhaps nowhere was the distrust of professional domination more apparent than in the women’s movement. Feminists claimed that as patients, as nurses, and in other roles in health care, they were denied the right to participate in medical decisions by paternalistic doctors who refused to share information or take their intelligence seriously. They objected that much of what passed for scientific knowledge was sexist prejudice and that male physicians had deliberately excluded women from competence by keeping them out of medical schools and suppressing alternative practitioners such as midwives.

The most direct consequence of the feminist movement for medicine was a sharp increase in the number of women entering the profession. As late as 1970, only about 9 percent of medical students were women; by the end of the decade, the proportion had passed 25 percent. But just as striking as the change in numbers was the change in consciousness. The older generation of women physicians had felt obliged to prove they could make it on the terms set by the dominant male physicians. The younger generation of women physicians demanded that male physicians change their attitudes and behavior and modify institutional practices to accommodate their needs as women. Here the new consciousness of rights invaded the house of medicine and insisted on changes in the rules of professional behavior and practice.

The more radical elements of the women’s movement argued that women had to take medicine “into their own hands.” In 1969 members of the Chicago Women’s Liberation Union organized an underground referral service for abortions. Several women then learned how to perform the procedure themselves, and by 1973, when the Supreme Court issued its decision legalizing abortion, they were doing abortions at the rate of fifty a week for far less than private abortionists charged. In the early seventies women’s groups also began learning gynecological self-care and encouraging a revival of lay midwifery. Feminists argued that medical care needed to be demystified and women’s lives demedicalized. They maintained that childbirth was not a disease and normal de-
liveries did not require hospitalization and the supervision of an obstetrician. The conflict over home birth proved to be one of the most bitter between the medical profession and the women's movement. While no state forbade home birth, the American College of Obstetricians and Gynecologists actively discouraged it as unconscionably risky. Doctors who participated in home births by offering backup in emergencies were threatened with loss of hospital privileges and even their medical licenses. Midwives in California were prosecuted for practicing medicine without a license.

The developments in feminism were related to a broader revival of a therapeutic counterculture with political overtones. Folk, non-Western and entirely novel therapies gained not only a clientele but also surprising respectability, in part because they belonged to a broader cultural and political movement. Much of the new counterculture went under the rubric "holistic medicine" and presented itself as a humane alternative to an overly technical, disease-oriented, impersonal medical system. Just as nineteenth-century heroic medicine had given rise to therapeutic dissent, so did twentieth-century technological medicine. And just as nineteenth-century critics called for a democratization of medical knowledge ("every man his own doctor"), so did the new advocates of self-care.

Therapeutic dissent also had political associations on the right. The movement to legalize the alleged cancer-cure laetrile had links to conservative organizations opposed to federal intervention in private affairs. They, too, saw the content of medical practice as imbued with political meaning.

The left-wing advocates of health rights saw a common thread linking national health insurance, community participation on the boards of health centers and hospitals, and individual patients' rights to take part in their own treatment and to treat themselves. The issue was basically professional dominance, and their aim was to increase the power of consumers. This new consciousness about medicine shaped new intellectual developments. In medical ethics, medical sociology, and medical history, the dominant sympathies began to change. Much of the traditional work in these fields was written from the physicians' viewpoint, if not by doctors themselves. Increasingly, over the past decade, philosophers, lawyers, sociologists, historians, and feminists, newly interested in health care, have portrayed the medical profession as a dominating, monopolizing, self-interested force. Once a hero, the doctor has now become a villain, and the resentment of this new work by the profession and older scholars in these fields has been intense.
This intellectual shift reflects a deepening ambivalence about medicine in the entire society. While Americans express confidence in their own personal physicians, they are more hostile to doctors as a class. The desire to enter medicine as a career is undiminished, but there is great antagonism toward those who do. This ambivalence is evident in the patients' rights and women's movements, which simultaneously claimed rights of access to and rights of protection against medical authority.

The generalization of rights and the intensification of ambivalence toward medical authority contributed to the pressure for government intervention. Advocates for the mentally ill, the handicapped, and other patients sponsored new laws and pursued litigation that led to greater regulatory control. During the seventies, the mobilization of these groups also blocked any resolution of the cost problem simply by wholesale cutbacks in public expenditures. Growing acceptance of a right of equal access to medical care meant that cost control had to be built into the medical system. If health care was a right, structural reform was a necessity.

*The Conservative Assimilation of Reform*

In the early 1970s, American medicine seemed to be caught in a political vise between the concern of government and business about high costs and the demands of protest movements and liberals for equality and participation in medical care. Both sorts of critics agreed health care was in crisis, and both ascribed responsibility to the medical profession. "The doctors created the system. They run it. And they are the most formidable obstacle to its improvement," said one writer in *Fortune* in 1970. This was a sentiment the advocates of health rights vigorously seconded.

Reform, both types of critics agreed, would require an extension of the boundaries of the political. An undersecretary of the Department of Health, Education and Welfare (HEW) in the Nixon administration, John G. Veneman, put the point succinctly at a news conference June 3, 1971: "In the past, decisions on health care delivery were largely professional ones. Now the decisions will be largely political." This, too, was a belief the advocates of health rights shared.

From different directions, the efficiency-oriented and the rights-oriented critics had arrived at many of the same reform proposals. Liberals had long supported prepaid group practice, expanded use of a health team including nurse practitioners and physicians' assistants, auditing of professional performance, and health planning as ways to im-
prove medical care. In the early seventies, conservatives began to appropriate many of these ideas as ways to cut costs. Liberals also thought there would be savings from reform but hoped to use the savings to make health insurance universal and comprehensive. Yet even without consensus about the ends of reform, there was agreement about many of the means.

In its early years, 1969 to 1971, the Nixon administration fought a rear-guard action against the social programs of the Great Society, but the political climate was still predominantly liberal. Democrats controlled Congress by a wide margin, and the administration was typically in the position of responding to liberal initiatives. Nixon was not a doctrinaire conservative. Despite the impression created by deep cuts in Great Society programs, his administration actually presided over a shift in the federal budget from defense to social expenditures, a huge expansion of Social Security, a wave of environmental and health and safety legislation, and acceptance of population planning and other ideas that had long been considered too controversial for liberal administrations to carry out. The president's proposal of a guaranteed minimum income was particularly out of line with conventional Republican philosophy, as was his adoption of wage-price controls and his opening to China. Nixon accepted the gospel of macroeconomic management according to Keynes. Under constant siege from Vietnam through Watergate, struggling to gain the offensive, the president assimilated and recast liberal ideas. This is exactly what happened in medical care.

Indeed, health care policy in the 1970s is a paradigmatic case of the conservative assimilation of reform—and its subsequent repudiation by conservatives themselves.

In 1970 the liberal initiative in medical care was the Health Security plan introduced by Senator Edward Kennedy and Representative Martha W. Griffiths of Michigan. Health Security called for a comprehensive program of free medical care, replacing all public and private health plans in a single, federally operated health insurance system. Though it did not involve any nationalization of facilities nor require physicians to work on salary, it would have set a national budget, allocated funds to regions, provided incentives for prepaid group practice, and obliged private hospitals and physicians to operate within budget constraints. There were to be no copayments by consumers.

In response to Kennedy's political challenge and the threat of rising costs, the Nixon administration in late 1969 began preparing a strategy of its own. In a memo to presidential assistant John Ehrlichman in December 1969, Lewis H. Butler, an HEW assistant secretary, wrote that "ultimately some kind of national health insurance should be enacted,
but the immediate problem is to train more doctors and subprofessional people, and get away from hospital-dominated care into more efficient systems." On February 5, 1970, Butler, Veneman, and a few other HEW officials met with Paul M. Ellwood, Jr., a Minneapolis physician who directed the American Rehabilitation Foundation. Ellwood had been trying for several years to get a hearing for his view that reform of the health system had to address its "structural incentives." In rehabilitation, as in other fields, fee-for-service payment penalized medical institutions that returned patients to health. The financing system, Ellwood argued, ought to reward health maintenance; prepayment for comprehensive care could achieve that end. So as an alternative to both fee-for-service and centralized governmental financing, Ellwood favored the development of comprehensive health care corporations, like the Kaiser plan. At the meeting in Washington, he first suggested calling them "health maintenance organizations" (later simply HMOs). The federal government could begin prepaying for services under Medicare and Medicaid and use its resources to stimulate development of prepaid plans. Butler was immediately sympathetic but did not want the type of organization to be narrowly prescribed by the federal government. The appeal of the "health maintenance strategy," as it soon was called, was that rather than requiring a new government bureaucracy and large public expenditures, it called for stimulating private initiative. A proposal prepared by Ellwood's associates the next month identified the choice in health policy as between a "health maintenance industry that is largely self-regulating" and "continued or increased federal intervention through regulation, investment and planning." In those terms, HMOs made a lot of sense to Republicans.

The initial reception of the health maintenance strategy in the federal bureaucracy was less than enthusiastic, and among the president's aides it had to compete with a variety of other proposals. But the White House gave its approval in March 1970, and HEW Secretary Robert Finch announced that the administration would seek legislative authority for an HMO option under Medicare and Medicaid. After succeeding Finch as secretary in June, Elliot Richardson became the program's most committed advocate. Later that year he decided to press ahead with a program to start HMOs even before Congress approved any new legislation. The administration would use funds already available under other programs.

By late 1970 political pressures were calling for a public response to what the president had already described as a "massive crisis" in health care. Senator Kennedy had made health care his major interest in domestic policy and was touring the country to hold public hearings on
The Struggle for Medical Care

the "health care crisis." Earlier, in September 1969, the National Governors’ Conference overwhelmingly endorsed a proposal for national health insurance by New York Governor Nelson Rockefeller. In 1970 the Senate Finance Committee approved 13 to 2 an amendment to Social Security introduced by its chairman, Russell Long, to establish a national insurance program for "catastrophic" health care costs. The measure was deleted on the Senate floor, but with Long’s sponsorship might well pass in the next Congress. Presidential advisers saw health care as a major issue in the next election. Searching for a strategy that could compete politically, the White House authorized Richardson to prepare a presidential health message for early the next year, which would offer an alternative national health insurance plan and call attention to HMOs as the centerpiece in the administration’s approach. At the last minute, presidential counselor Donald Rumsfeld submitted a counter-proposal to establish 800 neighborhood health centers, an idea that was rejected because it looked too much like a revival of the Great Society.

Instead, on February 18, 1971, President Nixon announced “a new national health strategy.” HMOs were the major innovation proposed for medical care. The traditional system, Nixon said, “operates episodically” on an “illogical incentive” encouraging doctors and hospitals to benefit from illness rather than health. HMOs reversed that incentive. The president called on Congress to establish planning grants and loan guarantees for new HMOs. About half the $45 million requested for grants would be earmarked for medically underserved areas. In 1971, some thirty HMOs were in operation. The administration’s goal was to help create 1,700 HMOs by 1976, enrolling 40 million people. By the decade’s end, it hoped to see HMOs available to 90 percent of the population.

HMOs were also adopted as part of state health policy by Governors Ronald Reagan and Nelson Rockefeller; the business press and the business-sponsored Committee for Economic Development sung the virtues of HMO. A remarkable change had taken place. Prepaid group practice was originally associated with the cooperative movement and dismissed as a utopian, slightly subversive idea. The conservative, cost-minded critics of medical care had now adopted it as a more efficient form of management. They had substituted a rhetoric of rationalization and competition for the older rhetoric of cooperation and mutual protection. The socialized medicine of one era had become the corporate reform of the next.

Changes in the substance of the idea also came with changes in its sponsorship. The Nixon and Reagan administrations welcomed profit-making corporations as part of the health maintenance industry. This
was antithetical to the traditional advocates of prepaid group practice and made them wary of the administration's program. Furthermore, the term "health maintenance organization," introduced with premeditated ambiguity, referred not only to prepaid group practice, but also to comprehensive "medical care foundations." These were organizations, like the San Joaquin Medical Care Foundation, which receive pre-payments from subscribers and then reimburse independent physicians and hospitals on a fee basis.* The foundations were typically established by doctors when threatened by competition from prepaid group practice; liberals saw them as attempts by the profession to preserve its monopoly control. However, by putting doctors collectively at risk for medical costs, the foundations—or "independent practice associations" (IPAs), as they are called today—do provide an incentive to control the use of resources. The foundations developed systematic peer review procedures for cutting unnecessary services and regulating the quality of care. The control may be more limited than in prepaid group practice since it is exercised at a distance. But because the foundations permit doctors to remain in their own private offices, they are more acceptable to the profession and organized with lower initial expense.

As Nixon recast the liberal idea of prepaid group practice, so he recast national health insurance. The proposal he announced in February 1971 would have required employers to provide a minimum package of health insurance benefits under a National Health Insurance Standards Act. It would also have set up a federally run Family Health Insurance Program to provide a less generous package of benefits for low-income families. At the same time, the administration called for cutbacks in Medicare to pay part of the added cost. Opponents were outraged. The mandated employer plans, they said, would provide a "windfall" to the private insurance industry. The government would provide a second-class standard of coverage for the poor and actually reduce coverage for the poor in some states. And the entire plan would still leave uninsured 20 to 40 million people who fell outside its two programs.

The least controversial part of Nixon's 1971 national health "strategy" was a call to increase the supply of physicians and change the method of subsidizing medical schools. The administration was much influenced by a report of the Carnegie Commission on Higher Education, which urged that more support to medical schools be given in the form of "capitation grants" (so many dollars per student) with bonuses for increased enrollment. In 1971 Congress introduced the capitation grants in a revised Health Manpower Act.30

*On the San Joaquin program, see Book Two, Chapter 2.
The AMA was not happy about these developments, especially the endorsement of HMOs, which it publicly regretted and privately tried to reverse. But it was now trying to improve its "negative" image. In 1971 for the first time in a half century, AMA membership fell to 50 percent of the profession as young doctors refused to join. Radical physicians had organized a competing organization, the Medical Committee for Human Rights, which then claimed 7,000 members.31 Adopting a more liberal public stance, AMA leaders professed concern for the poor and called for a shift to family practice. The AMA's Medicredit national health plan provided tax credits for buying private insurance. Purely a subsidy, and a limited one at that, the plan had no cost controls whatsoever. "Organized medicine shouldn't concentrate only on the private interests of its members," said the AMA's president in 1970. "It should, and does, concern itself with such social issues as sex education, alcoholism, air pollution . . . ."32 The AMA's president the next year, Walter Bornemeier, called on the organization to support neighborhood health centers where doctors could be paid by fee-for-service, salary, or capitation as they chose: "[I]f we bring comprehensive medical care back into the population centers, the neighborhoods, and have medical care available 24 hours a day, seven days a week, the people will tell Congress that the present system does not need to be restructured."33

Yet these concessions to public opinion alienated die-hard conservatives who argued that the AMA had sold out its membership. As government intervention increased over the next several years, so did these right-wing protests within the organization.

Impelled by rising costs, state governments led the way toward stiffer regulation of the health care industry. New York in 1964 had been the first state to regulate capital expenditures of hospitals and nursing homes, but few followed its example until soaring Medicaid expenditures at the end of the decade obliged state legislatures to take action. By the end of 1972, twenty states required medical institutions, usually both hospitals and nursing homes, to get state approval for construction projects and other large capital investments. Though the states vested authority for these "certification of need" programs in state boards and commissions, they often gave local planning councils an advisory role in the review process. In many states, this was the first time that planning and regulation had been related to each other.34

The interest of state legislatures was plainly cost control. However, the main inspiration for certificate-of-need came from the American Hospital Association and its state affiliates. The hospitals, anxious to avoid other forms of control, stood to benefit from the limits on compe-
tition that this sort of regulation would create. Opposed were profit-
making hospitals and nursing homes and some state medical societies,
which objected to anyone but doctors regulating medical services.
However, state officials, labor, and business accepted the argument that
capital regulation would be an effective means of cost control. Accord-
ing to the current wisdom, which had become known as Roemer’s Law,
hospital beds would be used to the extent they were available, and so
regulating their availability was the most effective way to cut costs.

Besides regulating capital investment, a few states also enacted laws
to review and regulate hospital rates. These programs varied in cover-
age: Some covered only the rates charged Medicaid beneficiaries, while
other programs applied to all patients. New York began regulating hos-
pital rates in 1971. Other states passed legislation in the next two years,
but mandatory rate regulation did not get seriously underway until
1975-76. Once again, regulation was not introduced primarily by liber-
als; for example, the governors of New Jersey and Connecticut, two
states to adopt mandatory controls, were conservative Republicans.35

The most drastic price regulation, also a Republican measure, came
in August 1971, when President Nixon imposed a general wage-price
freeze. When modified that December, the program singled medical
care out for special treatment, limiting doctors’ fees to annual increases
of 2.5 percent and hospital charges to increases of 6 percent (about half
the inflation rate in medical care preceding the freeze). And when price
controls were lifted in January 1973, they were retained only for health
care and for the food, oil, and construction industries. The decision to
maintain controls on health care reflected concern about the structural
flaws in the industry that were felt likely to generate raging inflation
again. Once more, a specific interest of the state was involved: Health
expenditures had risen from 4.4 percent of the federal budget in 1965
to 11.3 percent in 1973.36

In 1972 the federal government also became involved in regulating
health care capital and medical practice. As part of amendments to So-
cial Security, Congress gave HEW power to deny full Medicare reim-
bursement to hospitals and nursing homes for a capital investment that
planning agencies did not approve.

In those same amendments, Congress created a new system for con-
trolling services financed by Medicare and Medicaid. The original Med-
icare law had required hospitals to set up committees of their medical
staffs to review whether services were actually necessary. But these
“utilization review” committees, as they were called, had no formal
criteria of evaluation, no power to deny payment, and no incentive to
be effective. In October 1969 the Nixon administration proposed giving
HEW authority to appoint “program review teams” of doctors, other
health professionals, and consumers to deny payment for unnecessary Medicare services. The AMA responded that the bill gave HEW too much power and that such review ought to be a responsibility of physicians alone. The next year the AMA suggested as an alternative that HEW contract with state medical societies to carry out peer review. This suggestion was taken up by Senator Wallace Bennett, a conservative Utah Republican, who offered a modified version of the AMA’s plan in August 1970.

Senator Bennett proposed that HEW contract with Professional Standard Review Organizations made up only of physicians, but that these PSROs not be state medical societies. Bennett’s models for PSROs were medical care “foundations,” which by 1970 were reviewing utilization under Medicaid programs in over twenty states. The foundations used computers to identify cases that deviated from statistical norms, such as hospital stays that were inordinately long. These cases were then investigated to determine whether the Medicaid program had been abused.37 Impressed by evidence that the programs could control costs, Bennett wanted them installed throughout the country. The AMA objected to several features of his proposal, especially its provisions for national norms of health care, government ownership of records, and mandatory advance approval by PSROs for elective surgery. Nonetheless, the Senate passed the bill, though the legislation died for lack of time that year to resolve differences with the House, which had passed the administration’s original proposal.

When peer review came up again in 1972, the AMA secured some important modifications. National norms were out; the federal government would not own the data; preadmission certification for elective surgery would no longer be mandatory; and a requirement was added that only physicians could participate in decisions. Although the original version of the bill included outpatient care, the final legislation limited the responsibilities of PSROs to institutional services.

Despite the AMA’s role in initiating the idea, many of its leaders were outraged. An AMA leader called it the most dangerous government intrusion into medical practice in American history. On the other hand, liberals opposed PSROs because of the complete exclusion of consumers from representation in the program. It was a case of “the fox guarding the henhouse,” said Ralph Nader’s Health Research Group, which pointed out that on licensing boards and hospital review committees, the profession had been less than zealous in regulating its own members.38

Yet another form of federal regulation was introduced by legislation finally passed in December 1973 to aid HMOs. The law required busi-
nesses with more than twenty-five employees to offer at least one qualifying HMO as an alternative to conventional insurance in their health benefit plan, if there were a qualifying HMO in the vicinity. The law also provided grants and loans to develop new HMOs. To qualify, an HMO had to offer, as basic services, not merely hospitalization, physicians' services, emergency care, and laboratory and diagnostic services, but also mental health care (up to twenty visits), home health services, family planning, and referral services for alcohol and drug abuse. (There was an additional list of supplemental services that had to be offered on an optional basis.) The act did not allow HMOs to offer lower-priced contracts with more limited benefits to meet the purchasing power of lower-income workers. At the same time, it offered no assistance to such groups to help them afford the high premiums. Another set of provisions required HMOs to charge all subscribers the same "community" rate and to allow open enrollment of individuals, regardless of health, for at least thirty days once a year. The same requirements were not imposed on the insurance companies with which the HMOs had to compete. The original theory of the health maintenance strategy was to encourage competition in order to avoid federal regulation. Instead, the 1973 law threatened to make HMOs the most heavily regulated part of the entire health care industry and less competitive with conventional health insurance than they had previously been.

The climax of this wave of regulatory legislation came in 1974 with the passage of a new health planning law. The law originated when some thirteen categorical grant programs were due to end June 30, 1973. These included the Hill-Burton hospital grants, the Regional Medical Program, and Comprehensive Health Planning. The administration wanted to allow the programs to expire. After initially extending them for a year, Congress accepted the need for consolidation and agreed to terminate many of the programs in a compromise that yielded a new planning law.

The consensus was that health planning had failed because the agencies had no power to enforce their decisions and were dominated by providers, on whom they depended for half their income. The administration's alternative was to give the states funds to establish certificate-of-need and rate-setting programs. Senator Kennedy, on the other hand, wanted to vest authority in independent, local, consumer-controlled boards that would be financed by and accountable to the federal government. These boards would be able not only to review new projects, but also to close down hospital and nursing home beds they decided were unnecessary. In the final legislation, the administration and congressional liberals had to compromise not only with each other,
but also with the lobbyists for the doctors and hospitals, who blocked proposals to include rate setting, authority for planners to decertify health facilities, and any regulation of equipment in physicians' offices.

The National Health Planning and Resource Development Act (93-641) established, as the foundation of a new planning system, some 200 Health Systems Agencies (HSAs), to be run by boards with consumer majorities representative of their areas. But the HSAs were not given any decision-making power; they were to draw up three-year Health System Plans, review proposals for new projects, and send recommendations to the states on certificates of need and to Washington on proposed uses of certain federal funds. All states were required to pass certificate-of-need legislation and to establish State Health Planning and Development Agencies (SHPDAs) and Statewide Health Coordinating Councils (SHCCs). The act also created ten regional Technical Assistance Centers and, at the federal level, a new Bureau of Health Planning and Development and a National Health Planning Advisory Council. Although the federal government would not directly operate the local HSAs, it would finance their activities, decide whether their contracts would be renewed, and establish guidelines for the health plans that the HSAs and the states would produce.

To advocates of a coordinated health system, this hierarchy of planning agencies looked like the framework for a future national health service. The law seemed to be a decisive rejection of the view that the market could correct itself and that the doctors and hospitals had the last word on how medical care ought to be organized. The AMA saw the law the same way. Russell Roth, an AMA president, complained that doctors and administrators had been “pointedly relegated to a minor role” and spoke of the “general resentment in the professional community” that it wasn’t entrusted with leadership of the effort. Of the consumers’ role, Roth observed, “Passengers who insist on flying the airplane are called hijackers!”

The PSRO and health planning laws specifically excluded physicians’ office practices from regulation, but they threatened to limit doctors’ discretion in institutions. Physicians would now have to be more concerned about deviations from conventional standards. With stronger planning authorities, they could no longer assume that their definitions of what hospital resources were necessary would prevail. The new forms of regulation also indirectly encouraged hospitals to regulate physicians. If PSROs denied payment for inappropriate care, the hospitals would lose reimbursement, even though a doctor authorized the treatment. As a committee of the AHA noted, “Hospitals thus are forced to
accept financial responsibility for the actions of physicians practicing in them. Hospital boards of trustees must increasingly exercise the authority conveyed to them by law to supervise their medical staffs.”

Similarly, the increased tendency of the courts to hold hospitals liable for the malpractice of their staff physicians also encouraged greater hospital regulation of medical practice. The once complete authority that doctors exercised over medical practice in hospitals was now qualified. At least in institutional practice, the costs and benefits of what doctors did when treating their patients would now be a concern of the government.

The new health care planning and regulation of the 1970s departed significantly from earlier programs. Earlier regulation—physician and hospital licensing and hospital accreditation—had sought only to guarantee minimum standards of quality. Like the 1962 amendments to federal drug regulation, the new health care regulation required that a medical service be demonstrably beneficial. Postwar planning was planning for expansion; now planning aimed at containment. Previously, regulation and planning had little connection with each other; now they were formally linked. Moreover, federal and state programs were interconnected, as the federal government tried to reinforce state controls by mandating and subsidizing regulation of health care capital.

The new planning and regulation resembled earlier efforts in the continued reliance of the federal government on independent, local quasi-governmental agencies. (Doctors were given a right of first refusal in constituting PSROs; while HSAs might be local government units, nine out of ten were private nonprofit corporations.) But this choice of organizational form was less important than the decision of Congress to finance the programs without local contributions. Furthermore, instead of ad hoc evaluation, both the planning and PSRO laws required the development of explicit guidelines and standards. These were movements towards greater social control of medical care.

The growing health care regulation of the 1970s fits into neither of the two most commonly held theories of regulation—that regulation typically originates in the efforts of producers to use the state to exclude competition, or that it is initiated by liberals unsympathetic to private enterprise. The distinctive factor in this instance is that a large share of medical costs had been socialized. Government, employers, and commercial insurers balked at both the rise in costs and the uncertainty that inflation created for them. To be sure, the hospitals influenced the movement toward certificate-of-need, and doctors were given complete control of PSROs. But the sum total of these regulatory efforts,
as the doctors and hospitals soon discovered, went far beyond what they wanted.

The entire debate over HMOs, PSROs, and health planning assumed that these agencies would be critical in controlling costs under national health insurance. During 1973 and 1974, the Nixon administration and Congress appeared to be making rapid progress toward a political compromise, and enactment of a program seemed imminent. After the 1972 election, the new secretary of HEW, Caspar Weinberger, had called for a review of Nixon’s earlier health insurance plan. To the surprise of those who had nicknamed him “Cap the Knife” for his budget cuts, Weinberger decided to back a much enlarged insurance plan, as a preferable alternative to the multitude of categorical grant programs HEW was running. The new plan would have covered the entire population and provided far more comprehensive benefits than the administration had offered in 1971. Once again, it would have used private insurance companies to provide coverage for the employed, and established a separate government-run program for the rest of the population. But this time there were to be no differences in the minimum benefits between the two programs. Patients would pay 25 percent of medical bills, up to a maximum of $1,500 a year. Despite the opposition of almost all of Nixon’s Cabinet, the president approved the plan. In a message to Congress February 6, 1974, he described national health insurance as “an idea whose time has come in America.” Asked about the costs of the program, which were estimated to be about as high as Kennedy’s, Weinberger replied at a press conference the next day, “I consider the total [cost] as not a very significant figure.” This was an unusual attitude for the secretary. Many in Congress were so mean-spirited as to suspect that President Nixon was trying to divert attention from the Watergate affair.

Meanwhile, Senator Kennedy joined with Representative Wilbur Mills to support a plan that would allow private insurers to act as fiscal intermediaries and thereby retain some self-respect, not to mention a profitable rate of return. Like the administration’s bill, the Kennedy-Mills plan required copayments of 25 percent; no individual or family would have to pay more than $1,000 in any year. In June, Senator Kennedy announced, “A new spirit of compromise is in the air” and suggested a bill could reach the president’s desk by the fall.

The labor unions and liberal organizations, however, refused to accept any compromise and insisted on the original Health Security plan. Anticipating a liberal sweep after Watergate in the 1974 elections, the director of the Committee for National Health Insurance announced,
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"We will resist action this year because we need a veto-proof Congress to get a bill past Nixon." Also anticipating a more liberal Congress, the commercial health insurance companies tried to get a modified version of Senator Long's "catastrophic" insurance plan adopted. Ironically, the usual roles were reversed: Now the insurance companies were in a hurry to get a bill passed, while labor wanted to wait. Without labor's support, Kennedy's attempt at compromise had no chance. Even though opposition to national health insurance had "melted" away (as the economist Alice Rivlin put it), none of the proposals could command a majority.

If the name on the administration's plan had not been Nixon and had the time not been the year of Watergate, the United States might have had national health insurance in 1974. But if it were not for Watergate, Nixon might never have endorsed a bill that nearly all his Cabinet considered reckless. Soon not only Nixon, but also Representative Mills ended his political career in scandal. This was the last moment in the 1970s when any such program had a serious chance of adoption. The conservative assimilation of reform had stopped just short of national health insurance.

HEALTH POLICY IN A BLOCKED SOCIETY, 1975–1980

An Obstructed Path

When the blizzard of regulation stopped, the federal government found itself snowed in. Between 1971 and 1974 Congress had passed a great deal of complicated legislation. The laws were especially detailed because of Democratic reluctance to trust the Nixon administration with much discretion. Some were so severely compromised in passage as to be nearly unworkable. And each provoked bureaucratic conflict and litigation that took years to resolve. Meanwhile, little was accomplished and the impression was conveyed that the reforms were a failure.

In 1974-75 a severe economic recession, accompanied by soaring inflation, arrested new initiatives to expand medical care and other social programs. Throughout the advanced capitalist societies, the first brush with the energy crisis and the ensuing economic slowdown brought about a backlash against the welfare state. In the United States, the recession was also a political watershed, marking the end of the postwar growth of social entitlements.
The rise in the inflation rate was particularly steep in health care. Price controls had been kept on the industry for over a year longer than on the rest of the economy when they were finally removed April 30, 1974. Since August 1971, increases in the price of medical services had been kept to an annual rate of 4.9 percent, while other services had risen 5.2 percent a year. Then, in the last eight months of 1974, the inflation rate in medical services hit an annual rate of 12.1 percent (compared to 9.5 percent for other services). In 1975 medical care continued to run about three points ahead of the economy’s 6.8 percent inflation rate. Inflation in the health sector was having “serious repercussions throughout the economy,” the President’s Council on Wage and Price Stability warned in 1976.47

In the early 1970s, rising costs made public efforts to improve access to medical care seem all the more urgent; now they made such efforts seem all the more risky. Efficiency and redistribution had been coequal concerns in health care politics. Increasingly, the political preoccupation became cost containment alone.

The combined impact of recession and inflation hopelessly stalled the movement for national health insurance after 1974, despite the election of a heavily Democratic Congress. In his first message to Congress August 12, 1974, President Ford had asked for passage of national health insurance. But in his 1976 State of the Union Address, he withdrew the administration’s plan, saying it would make inflation worse. Privately, economic advisors, such as Treasury Secretary William Simon, were arguing that national health insurance would be “an unmitigated disaster that could bankrupt the country.”48

The seemingly inexorable rise in entitlement programs gave Congress pause about any further additions to government responsibility. By fiscal year 1977, Medicare and Medicaid outlays were double what they had been only three years earlier.49 This spectacular growth left little money for discretionary health care programs, some of which were aimed at organizing medical care more efficiently. Rising costs had driven health policy in the early seventies. Now, as one HEW official remarked, they were driving and paralyzing policy at the same time.

In the federal health bureaucracy, while the entitlement programs ate up money, the formulation of regulatory policy ate up time. It took almost two years for HEW to issue proposed regulations for utilization review under the PSRO program. An obscure provision of the HMO law led to a protracted conflict between HEW and the Labor Department over collective bargaining rights; two years elapsed before HEW could release the dual-choice regulations that enabled HMOs to offer
their services to employees receiving health insurance as a fringe benefit. The health planning guidelines were not published until September 1977, more than two and a half years after the bill had been signed into law. And, when published, they unleashed a storm of protest from rural areas that thought their hospitals might be in jeopardy.

In health reform, a little known law of nature seems to require that every move toward regulation be followed by an opposite move toward litigation. The Association of American Physicians and Surgeons, a right-wing faction in the AMA, sued the government over the constitutionality of PSROs. The AMA itself sued when the proposed utilization review regulations were issued. It sued again to block the health planning law from being carried out. The Association of American Medical Colleges sued over regulations imposed on medical schools. These lawsuits did not reverse the tide of regulation, but they slowed it down.

The alternative to regulation was supposed to be the competition stimulated by the rise of health maintenance organizations. But the HMO strategy had wilted before the immense structural and political barriers to innovation in the health industry. No upheaval of the sort the Nixon administration originally envisioned could have been accomplished except by undermining the autonomy and power of private practitioners. The doctors felt directly threatened, and the AMA mounted an aggressive campaign against the program, stalling passage of legislation in Congress and persuading the White House to cut back its plans. Several other developments slowed the program. Congressional committee chairmen were upset about Secretary Richardson's decision to carry on the program without authorization and requested in the spring of 1972 that further grants for HMO projects be halted. The departure of Richardson from HEW was a damaging blow; his successor, Caspar Weinberger, regarded HMOs as one of many demonstration programs. Instead of adopting the HMO idea as a long-run strategy, as the administration had at first suggested, Congress agreed to adopt it only as an experiment.

Experiments may be framed in ways that critically affect their success. So it was with the 1973 HMO Act. The original bills in Congress had followed one of two approaches. The first essentially called for high subsidies and high requirements for HMOs; the second for low subsidies and low requirements. Either of these probably would have been more workable than the final legislation, which called for low subsidies and high requirements. As originally passed, the act required qualifying HMOs to offer a broad range of minimum services, open enrollment, and community rating and to undertake complex and costly new administrative tasks. These requirements, as I've indicated, threatened
The struggle for medical care to handicap HMOs in competition with conventional insurance. The open enrollment requirement threatened to prevent the plans from prudently controlling their own rate of growth.

The immediate impact of the law was damaging. The dual-choice provision, which should have given HMOs access to consumers, turned out to have the opposite effect in the short run. In the two years before HEW issued final regulations, employers held up making any arrangements with HMOs because of uncertainty about which plans would qualify under the statutes. The restrictive statutory definition of HMOs discouraged any revival of the HMO assistance program, which had been halted in mid-1972. Some money appropriated for the program had to be returned to the Treasury. Most important, the administration had lost interest in an initiative that aroused much political opposition and seemed to offer little immediate return.

HMOs take years to develop. They require major infusions of capital and trained, professional managers. Neither the capital nor the management skills were readily available. Even under the most salutary conditions, some enterprises in an emerging industry will fail. HMOs were no exception. Moreover, most hospitals and doctors had no particular interest in starting up HMOs or seeing them succeed. In some cases, they were outright hostile. In view of the contradictory requirements of federal legislation, the meager effort by HEW, the intrinsic risk in starting new business organizations, and the lack of motivation in the industry to initiate HMOs or to cooperate with them, the slow development of HMOs in the mid-1970s should hardly have been a surprise. Nonetheless, along with the slow progress of the regulatory and planning programs, the undelivered health system seemed one more piece of evidence that reform of the health care delivery system would not work.

The Generalization of Doubt

In the mid-1970s the criticism of medical care took a new turn. Instead of merely questioning whether hospitalization and surgery were excessive, critics began to ask whether medical care made any difference in the overall health of the society. The nineteenth-century doctrine of therapeutic nihilism—that existing drugs and therapies were useless—was revived in a new form. Now the net effectiveness of the medical system as a whole was called into question.50

The doubts that suddenly enveloped medical care reflected a broader current of skepticism about the value of the social services. The schools were as much the target as medical care. So were efforts to rehabilitate
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criminals. In each case, the criticism came from both the left and right. Radicals characteristically charged that the service—schooling, rehabilitation, medical care—was basically a form of social control. Conservatives objected to the growth of government. These criticisms were amplified by empirical studies questioning the long-run effects of schooling on economic status, of rehabilitation on ex-convicts, and of medical care on health. Economists argued that the growing social investments were simply not cost effective.

The attack on medical care originated with increasing criticism in the 1960s of psychiatry and mental hospitals. The work of Thomas Szasz and Erving Goffman and books and movies like *One Flew Over the Cuckoo’s Nest* portrayed institutional psychiatry as an instrument of therapeutic oppression. Mental health programs, radicals said, channel social discontent into self-reproach and help label as “deviant” people who have “the right to be different.” Social scientists conducted empirical studies casting doubt on the long-term effectiveness of psychotherapy. Psychoanalysis, sad to say, had trouble passing the test of cost-benefit analysis. Politically irrelevant in the sixties, cost-ineffective in the seventies, psychiatrists took it on the chin from all sides.

From psychiatry criticism spread to medicine at large. It had long been known that medical care, especially when compared with the environment or social behavior, has relatively modest effect on mortality rates. Nonetheless, the idea that Americans were getting a diminishing return from their increasing investment in medical care hit with the force of a thunderclap in the mid-1970s. It suddenly struck intellectuals and policy makers of diverse persuasions that this was the answer to those who constantly wished to expand access to medical care. “The marginal value of one—or one billion—dollars spent on medical care will be close to zero in improving health,” wrote the neoconservative Aaron Wildavsky in a clever essay that gave the title *Doing Better and Feeling Worse* to an influential volume on health care sponsored by the Rockefeller Foundation. In that same volume, the foundation’s president, John Knowles, called for greater emphasis on changing unhealthy individual behavior. And in another emblematic book of the period, *Medical Nemesis*, the radical social critic Ivan Illich argued that medical care caused more disease than it cured and that people would be healthier if they liberated themselves from dependence on the entire malignant apparatus of modern medicine. Less extreme, but in the same vein, the economist Victor Fuchs argued that medical care had contributed to health early in the twentieth century, but that more medical care now would reduce neither mortality nor disease.

Ironically, these conclusions were drawn at a time when America was
making exceptional advances in health. From the mid-1950s until 1968, age-adjusted death rates had been relatively stable. The lack of progress in that period seemed to confirm skepticism about the value of medical care. But from 1968 to 1975, death rates dropped 14 percent—or from 747 to 642 people a year in a population of 100,000. As David E. Rogers and Roger J. Blendon have pointed out, "This rate of decrease is as high as we have seen anytime this century." Among the fifteen top causes of death, ten have declined, and as Karen Davis and Cathy Schoen note, those that have declined are more sensitive to medical treatment, while those that have not, such as homicide, suicide, and cirrhosis, are most sensitive to social pathology. Deaths from heart disease fell 23 percent in fifteen years—5 percent from 1963 to 1968 and another 15 percent by 1975. Between 1960 and 1975 infant mortality rates were down 38 percent (from 26 to 16 infant deaths per 1,000 live births), and maternal mortality dropped 71 percent (from 37.1 to 10.8 deaths per 100,000 live births). Studies of specific areas where neighborhood health centers or other programs introduced special efforts to improve prenatal, child, and maternal health showed clear evidence that the services did make a difference. Undoubtedly, some share of this improvement was due to other measures besides medical care, such as pollution controls due to new environmental regulation and better nutrition as a result of the food stamp program. No one has yet teased out the relative effects of different variables. Moreover, much of what medical care provides is not lifesaving, but reduces disability, disfigurement, and confusion about the nature of experience. These restorative and educational functions make up most of physicians' routine work, but the new therapeutic nihilism did not wish to acknowledge that they had any value. Just as medicine used to be uncritically given credit for gains in health that had other causes, so medicine was now disparaged without prudent regard for its benefits.

If the First Revelation of the seventies had been that a "health care crisis" existed, the Second Revelation was that health care hardly affects health. The Second Revelation obviously made the First Revelation seem less important. In other areas, too, the generalization of doubt undermined the generalization of rights. Distributive justice is a morally compelling concern, after all, only when what there is to distribute, or redistribute, is genuinely valuable. If it is irrelevant or harmful to human welfare, the poor would be better off without it. This was Illich's conclusion: "To give the lower class greater access to health care, he wrote, "would only equalize the delivery of professional illusions and torts." The recognition of medical care's limited effects on health did not
necessarily favor a conservative political viewpoint. While it encouraged more conservative views of medical care, it also might have encouraged more liberal views of public health. But the most immediate political impact of the new therapeutic nihilism on health policy was to concentrate attention on cost control. If the case for improving access had been weakened, the case for reducing costs was stronger than ever. Thus the change in intellectual fashions complemented the dismal new economic conditions. Together, they set up two formidable roadblocks in the path of national health insurance.

*The Liberal Impasse*

The politics of health care in the second half of the 1970s mirrored a general political stalemate in the society. In health care, as in energy and economic policy, opposing interests were sufficiently strong to block almost any coherent course of action, conservative or progressive. While liberals could maintain old programs, they lacked the power to initiate new ones or to make old ones work well. Until 1976 the split between a Republican president and a Democratic Congress seemed to retard any effective political response to the nation’s social and economic problems, but the election of a Democratic president in 1976 did not end the stalemate. Elected as an outsider, Jimmy Carter was unable to get cooperation on key domestic issues from a Congress controlled by his own party. Despite the Democrats’ primacy, the political climate was turning more conservative; in a sense, the situation was exactly the opposite of that of the early seventies, when Republicans had to respond to a liberal consensus. As inflation and energy became larger preoccupations, the Democratic leadership began to regard any further liberal initiatives as impractical. The various movements for civil and social rights were increasingly treated not as just causes but as special interests, like dairy farmers or the shoe industry. Yet the Democrats were wedded to all these interests. Torn by conflicting pressures, under the shadow of rising inflation, the Democrats proved incapable of effective action in health care as in other areas of social policy.

Candidate Jimmy Carter pledged himself to a comprehensive national health insurance plan at a point in his campaign when he was anxiously courting union support. But President Carter was not anxious to press ahead because of budgetary pressures and the risk a program might pose to his anti-inflation effort. In its first two years, the Carter administration let health insurance get backed up behind its proposals for welfare reform and hospital cost containment. Carter’s economic
advisors, like Ford’s, urged that a health plan be postponed or dropped entirely.

Soon after Carter took office, a division opened up between the president and Senator Kennedy. The new HEW secretary, Joseph A. Califano, Jr., indicated that a plan would take at least a year to prepare. “The issue isn’t working up a new program,” Kennedy told Califano, “We already have a program we’ve been working on for years. What we need is a political negotiation.” Kennedy also strenuously objected to the president’s wish to phase in a plan gradually over several years; in Kennedy’s view, there had to be a comprehensive reform of the system when national health insurance was inaugurated.57

Both the Carter administration and Kennedy recognized that any program for expanded health insurance would simultaneously have to be a program for cost containment. Public and private third-party payers already covered, to varying degrees, 90 percent of the population; a national health plan was now a matter of completing a journey well under way. Nor did it necessarily have to cost any more than America currently spent on medical care. At over 8 percent of GNP, America was already outspending most other countries that had comprehensive national health plans. At the beginning of the 1970s, when Canada introduced a comprehensive plan, it was spending as much as the United States on health care—about 7.3 percent of GNP. At the end of the decade, while health care costs approached (and then passed) 9 percent of GNP in the United States, they stabilized at about 7.5 percent in Canada. The United States maintained its fragmented, cost-based reimbursement system, while the Canadian provinces controlled costs by setting rates in negotiations with health care providers.58

Yet it was a fixed preconception of public debate in America that national health insurance would mean sizeable new expenditures. And though additional costs were not inherently necessary, they were likely, since Congress may well have been incapable of adopting the structural reforms necessary to control expenditures, which is to say, to control the incomes of all those with interests in the health care industry.

The response to Carter’s proposal for hospital cost containment seemed to confirm this estimate. In 1977 the president asked Congress to limit increases in hospital charges to about one and a half times the rate of growth in the consumer price index. Hospital charges in 1977 rose 15.6 percent over 1976 levels, compared to an overall inflation rate of 6 percent; Carter’s program would have put a flat cap on hospital rate increases at 9 percent. Though the measure passed the Senate, it died in the House, the victim of a massive lobbying effort by the hospital industry.
By early 1978 Kennedy was becoming increasingly impatient with the administration's progress on national health insurance as well as its performance on other health issues. In July, after a year and a half in office, the president allowed only general principles for a health plan to be released. A legislative proposal was to follow a year later. Sensing that the administration was stalling, labor leaders and other liberals, led by Senator Kennedy, decided to go their own way.

The new proposal they fashioned was a striking departure from earlier liberal programs. Instead of a public system, it called for private health plans (HMOs, independent practice associations, Blue Cross, commercial insurance) to compete for subscribers, who would receive a health insurance card entitling them to hospital and physicians' care and a variety of other basic health services. The cost of the card would vary according to income; employers would bear 65 percent of the cost for their workers, while the government would pick up the cost for the poor. Since the insurance card would not identify the source of payment, the poor would not be channeled through a separate payment system, as they were under Medicaid. To discourage insurers from only enrolling the affluent and the healthy, they would be paid according to the actuarial risk that their subscribers represented (more for the aged, the poor, and so on.). On the other hand, consumers would receive rebates or extra services if they chose to enroll in more efficient plans. Fixed negotiated rates would replace cost-based reimbursement for hospitals and usual and customary fees for doctors. The entire system would be forced to operate within a budget constraint.

The administration regarded the new Kennedy plan as unworkable and politically impractical. Instead, it proposed requiring businesses to provide a minimum package of benefits for their employees, expanding public insurance for the aged and the poor, and creating a new public corporation to sell coverage to the rest of the population. After two and a half years, the Carter administration had succeeded in rewriting the Nixon plan of 1974, which it proposed not go into effect until 1983.

There was a basic difference in outlook between the Kennedy and Carter approaches. Kennedy saw national health insurance as an opportunity to reconstitute the health system on a new framework of incentives and bargaining relationships; improvements in cost control would accompany improvements in access. Hence national health insurance could resolve problems of individual and social cost simultaneously. Carter, on the other hand, regarded national health insurance as an onus the system could bear only if cost controls preceded it and the economy prospered. So the administration approached a plan reluctantly and never aggressively sought its enactment.
Neither program had any chance. In May 1979 a senior HEW official insisted, "We are going to Congress at the outer limits of political possibility." But the Democratic leadership in the House had already told Califano they did not even want a plan submitted. When Kennedy released his program May 14 and Carter his a month later, the press paid more attention to the political rivalry between the two than to their plans for health care. Soon Kennedy was defeated by Carter and Carter by Reagan, and once again national health insurance vanished like a mirage from American politics.

In the fall of 1979, hospital cost containment met the same fate, in what proved to be a turning point in government regulation of the health care industry. In response to the prospect of federal controls, the hospitals had started a voluntary effort to keep down their costs, which rose 12.8 percent in 1978. In early 1979 the administration introduced a modified bill that would have imposed controls on hospitals only if their cost increases exceeded a specified limit. The limit would vary according to the cost of the goods and services a hospital bought, the population it served, and the cost of new technology.

But these concessions to flexibility made the regulations more complex, and the new bill drew quick fire from the growing anti-regulatory forces in Congress. By 1979 the reputation of health care regulation was none too good. Some early evaluations of the PSRO program suggested that it cost more than it saved. A study of the effects of certificate-of-need programs found that they slowed construction of hospital beds, but that other capital expenditures increased and the net effect was negligible. Other studies were more positive about both programs, and an analysis of hospital rate regulation found that after 1975, six states where the programs were given broad authority had held increases in hospital costs 14 percent below the national average. Califano claimed that the administration cost containment measure would save $53 billion over five years. But to its opponents, led by Representative David Stockman of Michigan, the bill was a symbol of overregulation, a blind intrusion by government into the private sector which would penalize hospitals that had been efficient and could only reduce the quality of hospital services. The hospital associations saw to it that congressmen were lobbied by hospital officials from their own districts. The opposition prevailed, and on November 15, 1979, the House voted 234 to 166 to defeat the measure.

To the supporters of regulation, the hospital lobby’s opposition epitomized the ability of organized groups with highly concentrated interests to block measures that would benefit the public at large. But the bill itself testified to the limits of the Democrats’ capacity to deal with
the underlying problems in health care. This was, after all, their major legislative effort in health care, but it would have left unchanged the skewed incentives of the reimbursement system and only superimposed a new layer of controls.

However, the major attempts at structural reform, begun earlier in the decade were not successfully restraining the growth of national medical expenditures. Of all the initiatives, HMOs and health planning had been introduced with the greatest expectations. To their advocates, they were not simply new programs but strategies for changing the fundamental organization of the medical care system.

The HMO program did pick up momentum about 1976. That year Congress reduced the mandatory benefits and other stringent requirements that had been hobbling the program. Then in May 1977—after seeing some routine data on federal employees showing that for every 1,000 people, Kaiser plan subscribers had only 349 days of hospitalization a year, compared to a national average of 1,149—Secretary Califano called for a review to see what needed to be done to revive federal HMO assistance. In 1978 Congress again amended the law to increase federal aid, and in that year HMO enrollment increased 1.4 million over the year before.

By mid-1979, there were 217 HMOs, far less than the 1,700 the Nixon administration originally foresaw. Yet the total enrollment of 7.9 million people was twice as many as in 1970, and HMOs continued to perform well, providing medical care at significantly lower expense mainly because of reduced hospitalization. In California, the upper Midwest, and several cities in the Northeast, HMO development seemed to reach a “take-off” point. Some evidence indicated that in Minneapolis-St. Paul the rapid spread of HMOs had kept down prices in the fee-for-service sector. But HMO enrollment was still only 4 percent of the nation’s population, and the administration projections gave them less than 10 percent by 1990.52

The new health planning agencies, Congress had said in 1974, were supposed not only to control costs, but also to improve the accessibility, acceptability, continuity, and quality of services. “Scientific planning with teeth” had been the motto, but skeptics argued they would be little different from planning efforts in the past: No matter what the distribution of representatives on HSAs, the providers would still prevail, and there would be little restraint on costs. Critics predicted gullible consumers on the boards would easily be swayed by authoritative doctors and hospital administrators; besides, consumers had no incentive to oppose projects that would bring jobs and services to their communities, while the costs would be spread over the state or the nation.
The new planning programs turned out to be more devoted to cost control than their critics initially expected—or the industry wanted. The early analyses underestimated the commitment to cost containment of both the professional planners on the staff and community activists on the boards. The providers were often split—for example, between public and private institutions, or along geographical lines. Also, many of the nonelite provider representatives, especially the nurses, allied themselves with consumers. So the hospitals and doctors did not dominate the planning process as easily as they had in the past.  

Nonetheless, however diligent in reviewing applications, the HSAs had limited impact. Their recommendations could be overturned by the states and often were. In Massachusetts some nursing homes that had been denied certificates of need were able to secure legislative exemptions. Most important, the planning agencies were still scarcely planning at all. They were mainly reacting to the plans of others. Preoccupied with project review, they could not take the initiative, nor did they have the funds to open new health care programs. Though they could review the “appropriateness” of existing facilities, they could do nothing about those they judged unnecessary. They could hold up or veto projects, but the underlying incentives of the reimbursement system were beyond their purview.

Reform had succeeded in many of its original aims to improve access to health services. The concerns of 1970 about a shortage of doctors, particularly family practitioners, were now much alleviated. American medical schools had responded to capitation grants by increasing their enrollments; family practice had grown, faster than expected, into a major specialty. Despite cutbacks, Medicaid and other programs were also continuing to improve access to medical care among the poor.

But by the end of the 1970s, equal access to health care was no longer a governing concern for those who governed. HSAs had been launched both to control costs and to improve access, but the evaluations now paid attention only to their success in cost containment. Other programs, like the PSROs, which were partly aimed at quality control, were also evaluated on the narrow grounds of cost control—and found wanting.

Political roles had switched. By the late seventies, reformers—forced to justify the expansion of bureaucracy and regulation in health care—were on the defensive, while the health care providers denounced the excesses, duplication, and irrationality of government. When the decade began, reformers were criticizing the inefficiency of the health care industry; when it ended, the industry was criticizing the inefficiency of reform.
There remained roughly 26 million people in 1978 who had no insurance protection, public or private, and many more who had limited coverage that would prove inadequate if they fell seriously ill. The corridor between private insurance and welfare medicine was especially wide in the states, many of them in the South, that severely restricted Medicaid eligibility. Despite general agreement about the irrationality of this system, the financial insecurity it created, and its effects on the use of primary and preventive health services, the Democrats were unable while in power from 1976 to 1980 to do anything about it. And, because they also could not deal with the underlying contradictions of accommodation, they put in jeopardy the gains that reform had made. They had succeeded in making health care part of the public household, but they had failed to put the household in order.

THE REPRIVATIZATION OF THE PUBLIC HOUSEHOLD

The redistributive and regulatory reforms of the 1960s and 1970s greatly expanded the boundaries of the political in health care. Once the government assumed a large share of the financial burden for medical services, conservatives cooperated on grounds of fiscal prudence in the expansion of political authority. Initially, the resistance came mainly from physicians, who feared government would restrict their autonomy and income. Their opposition, while influential, was no longer sufficient to hold back state intervention. But by the late 1970s, the opposition assumed more formidable proportions in American politics. A newly revived conservatism sought to throw back the boundaries of the political, to return tax money and government functions to the private sector—in short, to reprivatize much of the public household.

The case for reprivatization rests on several arguments. In the view of its critics, the welfare state has become "overloaded" and Western democracies have become "ungovernable." The increasing role of the state in the allocation of resources and distribution of income has aroused unrealistic expectations. By shedding some of its functions, government can gain respite from the demands for unlimited entitlements and the conflicts that such demands inevitably generate. In addition, these conservative critics say, government is inherently incompetent at certain tasks. The requirements of politics conflict with the demands of efficiency. For example, the government cannot close down an unproductive plant, like an outmoded hospital. The instruments of public
policy are also said to be insufficiently sensitive to variations in individual preferences and local conditions. And, finally, government creates a "new class" with an interest in more government, financed by increased taxation, which then becomes a burden to the private economy and dampens the fires of innovation and investment.

This is the by now familiar neoconservative case. Although the public did not exactly understand, much less endorse, the larger program of reprivatization, much of the public—a majority in 1980—clearly shared a general antipathy to government. Inflation gave arguments against deficit spending a seemingly urgent rationale, and interventionist liberal social policies, such as affirmative action and school busing for desegregation, had burned up much of the good will liberalism had inherited from the New Deal. This combination of circumstances gave conservatives an opportunity to carry out broad cutbacks not only in government expenditures but also in government functions.

In medical care, conservative ideas have undergone three important changes over the past two decades. Until the 1970s, conservatives had argued against government intervention in health care mainly on the grounds of voluntarism. Although a few devotees of the free market, notably Milton Friedman, criticized the medical profession as a cartel and called for the abolition of licensing, this was primarily an intellectual amusement. No one seriously tried to carry it out. The health maintenance strategy was the first sign of a shift of emphasis in conservative thought about health policy from voluntarism to competition.

Yet, the HMO program, while initially successful in gaining presidential support, soon became a burden to the advocates of competition. It seemed apparent, as HMO development slowed down in the mid-seventies, that the program would not answer the demand for a comprehensive remedy to rising costs. So the second adaptation of advocates of competition was to generalize the idea beyond HMOs. For example, Clark Havighurst, a law professor at Duke, formulated proposals for expanding antitrust activity in the health care field, which the Federal Trade Commission entered in 1975. Alain Enthoven, an economist at Stanford, developed a competitive model for national health insurance. Though Califano originally sponsored Enthoven's work, the Carter administration did not endorse it. Nonetheless, Enthoven's ideas became widely influential as the most sophisticated statement of a "market" approach to health policy.

By the late 1970s the third adaptation of conservative thought was under way: Nixon's Tory reformism gave way to a new fundamentalism in politics and economics. In health care, the hospital cost-containment battle helped mobilize anti-regulatory sentiment. And now conserva-
tives had their revelation, the Third Revelation of the decade: The problems of health care in America could be cured by relying on competition and incentives, if only government’s role were reduced to a minimum. When Ronald Reagan was elected president in 1980, it appeared this view would guide policy. President Reagan chose for top positions two of the leading congressional advocates of a competitive strategy in health care—Representative David Stockman, to be director of the Office of Management and Budget, and Senator Richard Schweiker, to be secretary of Health and Human Services. The administration immediately sought to abolish the HSAs and PSROs, to consolidate federal health programs in “block grants” to the states, and to “cap” federal support for Medicaid.

But conservatives, like liberals, have trouble carrying out an ideologically faithful policy; they, too, have interest groups to worry about. The insurance companies and medical profession have shown relatively little enthusiasm for the conservative program of intensified competition. And while the doctors and hospitals welcomed relief from regulation, they could not be entirely happy about plans to reduce the federal aid that they were now accustomed to receiving. Cutbacks bring constraint, and competition does, too; strong organizations take over the weak. And, as one president of a county medical society said at an AMA meeting soon after Reagan took office, “Our mentor has always been Hippocrates, not Adam Smith.” These sources of opposition have blocked any quick action to carry out a serious competitive strategy. Indeed, in its second year, the Reagan administration was backing away from the competitive approach, even as it continued to cut back public regulation, public health services, and public financing for the personal health services of the poor.

The consequences of reprivatization, if it can be carried out, are almost certainly going to be different from the public’s expectations. In its rejection of “big government” the public seems to be expressing a desire to return to older and simpler ways. Similarly, the medical profession, in protesting against government regulation, wants a return to the traditional liberties and privileges of private practice. But at least in medical care, the reliance on the private sector is not likely to return America to the status quo, but rather to accelerate the movement toward an entirely new system of corporate medical enterprise.
The Coming of the Corporation

THE INDEPENDENT small businessman is firmly rooted in the American imagination. His misfortune is that he is much less firmly rooted in the American economy. As large corporations have risen to dominate economic life, the myth and the ideal of the entrepreneur have persisted—and not only in the daydreams of men on assembly lines who want a business of their own. Among economists, competition among numerous small firms remains the norm of analysis, from which all other conditions are distressing aberrations. In sociology, the independent practitioner is similarly the point of departure in the study of the professions. Bureaucratic professionals still seem anomalous even though they now represent the overwhelming majority of professionals in the modern world.

In the twentieth century, medicine has been the heroic exception that sustained the waning tradition of independent professionalism. Physicians not only escaped from corporate and bureaucratic control in their own practices; they channeled the development of hospitals, health insurance, and other medical institutions into forms that did not intrude upon their autonomy. But the exception may now be brought into line with the governing rule.

Unless there is a radical turnabout in economic conditions and Ameri-
can politics, the last decades of the twentieth century are likely to be a time of diminishing resources and autonomy for many physicians, voluntary hospitals, and medical schools. Two immediate circumstances cast a shadow over their future: the rapidly increasing supply of physicians and the continued search by government and employers for control over the growth of medical expenditures. These developments promise to create severe strains throughout the medical system. They may prepare the way, moreover, for the acceleration of a third development, the rise of corporate enterprise in health services, which is already having a profound impact on the ethos and politics of medical care as well as its institutions.

Throughout Book One I argued that sovereignty of the medical profession entailed the restriction of competition, the limiting of regulation by government or private organizations, and authority to define and interpret the standards and the understandings that govern medical work. Emerging developments now jeopardize the profession's control of markets, organizations, and standards of judgment. The profession has benefited from state protection and political accommodation of its interests, but government is no longer so sympathetic and physicians are no longer the single, dominating claimant in the medical industry. The rise of the profession required internal cohesiveness and strong collective organization, yet rising pressures now threaten to drive a wedge between different segments of the medical profession. The prospect is not simply for the weakening of professional sovereignty, but for greater disunity, inequality, and conflict throughout the entire health care system.

ZERO-SUM MEDICAL PRACTICE

_The Doctor “Surplus” and Competition_

While market-oriented policy makers debate how to make health care more competitive, competitive pressures are building up as a result of earlier liberal programs aimed at alleviating the “doctor shortage.” Between 1965 and 1980, federal aid succeeded in increasing the number of medical schools from 88 to 126 and raising the number of graduates from 7,409 to 15,135. By 1985 graduates will rise to 17,000 a year.¹ Despite new immigration policies adopted in 1976 to reduce the influx of foreign physicians, doctors in active practice in the United
States increased from 377,000 in 1975 to nearly 450,000 in 1980 and are projected to rise to nearly 600,000 by the end of the decade. This rapid expansion coincides with a slowdown in population growth. For every 100,000 people, the United States had 148 doctors in 1960, 177 in 1975, and 202 in 1980. In 1990 the rate per 100,000 people is expected to jump to 245, making America one of the countries in the world most heavily populated with physicians.²

By 1990 the aging of the population will increase demand for only a small proportion of these additional doctors. It is unclear whether other changes, such as in income, insurance coverage, or technology, will lead Americans to use more—or fewer—physicians' services per capita. In 1979 the Bureau of Health Manpower estimated that the demand for physicians would continue to match the supply at the end of the eighties because of a trend toward increased use of medical services that had been evident from 1968 to 1976. However, as the Congressional Office of Technology Assessment pointed out, Medicare and Medicaid produced a rapid and exceptional rise in utilization in the late 1960s. After 1971 demand appears to have stabilized. (It may actually have dropped after 1977, when Medicaid enrollments began to be cut.) If utilization does not increase, according to the Office of Technology Assessment, the “surplus” might be as high as 185,000 in 1990.³ In 1980, another group, the Graduate Medical Education National Advisory Committee (GMENAC), projected a possible surplus of 70,000 over the “need” for physicians in 1990—and this estimate assumed no socioeconomic barriers to service whatsoever.⁴

Estimating whether a “surplus” will develop is as much a political as a technical assessment. The future demand for physicians will depend on uncertain political developments, such as the fate of national health legislation. Future demand might be stimulated by greater public or private health insurance; or conversely, it might be reduced by cutbacks in public financing or in the tax subsidies to private plans. The demand for doctors’ services might also be reduced by the incursions of related professionals and paramedical workers; or increased, if those alternatives are cut off by restrictive licensing and reimbursement practices. It might rise if fee-for-service prevails, or it might drop if prepaid plans succeed. By using paramedical workers, keeping surgeons working full time, and monitoring physician performance, HMOs operate successfully with significantly lower ratios of doctors to patients than did the United States as a whole even before the current surge in physician supply. If economic pressures force greater rationalization of health services, the “surplus” could be significantly greater than projections based on current patterns.
On the other hand, changes in the composition of the medical profession may reduce the impact of its growing numbers. Competitive pressures may be relieved by the women who make up one quarter of new doctors. Some evidence suggests that, on the average, women physicians work fewer hours per week and see fewer patients per hour. In addition, if private practice becomes more competitive, more doctors may move into managerial roles. The growth of administrative and corporate medicine may also provide a convenient "retreat from patients" for cases of professional "burn-out" in clinical practice.

These contingencies, affecting both demand and supply, make any prediction of a "surplus" risky. Medical unemployment is now commonplace in much of Western Europe and Latin America; whether it will reach the United States is uncertain. But there is already evidence of significant slack in the demand for doctors. Between 1970 and 1980, according to AMA data, patient visits per doctor dropped 12 percent from 132.5 to 116.6 a week. This decline may have been due not just to growing numbers of physicians, but to declining per capita use of physicians' services. According to federal surveys, between 1975 and 1979 physician visits per person in America dropped 8 percent from 5.1 to 4.7 per year. A 1979 survey indicated that only 57 percent of office-based practitioners believed they were working at full capacity. While some were satisfied working less, 25 percent wanted to see more patients.

Many economists and policy makers have argued that the peculiar structure of the medical market would allow doctors to compensate for this slack by raising fees and performing additional tests, operations, and other services. Some evidence lends support to this view, but the ability of physicians to induce demand is not unlimited. Between 1971 and 1974, during President Nixon's Economic Stabilization Program, doctors responded to fee controls by increasing volume (especially return visits and diagnostic tests), but they were able only partially to offset losses in income. From 1974 to 1977, when patient visits declined, they increased fees but again only partly compensated for the loss. According to surveys by both the AMA and Medical Economics, doctors' incomes fell somewhat, though not seriously, behind inflation in the 1970s. By 1979 recruiters for physician group practices were reporting that it was a buyer's market: More doctors were applying for jobs than there were openings. Some groups had not raised starting salaries for several years in spite of inflation.

The eighties are likely to bring a more serious squeeze. In the postwar decades (1945-1980), medical expenditures, adjusted for inflation, grew more rapidly than the number of physicians. Hence each doctor
worked in a world where resources were expanding. In the 1980s the physician supply will grow more rapidly and medical expenditures more slowly. In constant dollars, medical expenditures per physician may not grow at all. In 1975 there were 565 Americans per doctor; by 1990 there will be only 404—a reduction of nearly 30 percent in the potential clientele for the average physician. For 404 people to spend the equivalent of 565 on doctors’ bills would require a substantial growth in personal income, a shift of expenditures from other goods and services to health care, or a shift of the “health care dollar” from hospitals and other providers to physicians. The economic and political climate—slow economic growth and growing opposition to higher medical expenditures—makes it difficult to envision either of the first two taking place.

Increasingly, the gains of one physician, or group of physicians, will have to come at the expense of other physicians or other providers. In the language of game theory, medical services in the 1980s will become more of a zero-sum game. New physicians may no longer be able to introduce an additional layer of specialized services into a community on top of what other practitioners offer. They will have to take business away from someone else. One third of the physicians practicing in 1990 will have finished their training in the eighties. Losses of income may fall most heavily on this huge baby-boom generation in the medical profession. Young doctors, the least attached to current practices, will be under the greatest pressure to break with them.

Some responses to competition may benefit patients. Doctors may hold more convenient office hours, make house calls, locate in rural areas, and take more time with their patients as they try to cultivate a practice. In short, there may be a shift to greater dependence on patients, as in the nineteenth century.

But a zero-sum situation may also mean increasingly bitter competition among groups of physicians allied with different types of health plans. It may pit established insiders against newcomers, as doctors in some communities close ranks. If they follow a protectionist strategy, established doctors may fight to curtail the spread of HMOs, to deny admitting privileges for younger colleagues at local hospitals, and to maintain restrictions on licensing authority and third-party reimbursement for psychologists, optometrists, nurse practitioners, and others competing for medical expenditures.

The doctor “glut” of the eighties will probably contribute to the

*The baby boom is hitting medicine later because of the length of medical training and the delay in the expansion of medical schools until years after other forms of graduate education expanded.
growth of organizations in medical care. Many young doctors, coming out of medical school heavily in debt, may find the expense of establishing a practice beyond their means. They will be more inclined to take salaried positions with hospitals, group practices, and HMOs than their forerunners, and they will have less bargaining power because of their numbers.

The rising supply of physicians is likely to affect fee-for-service medicine and HMOs in opposite ways. An increasing supply will raise costs in the fee-for-service sector because of doctors' incentive to create demand. More fee-for-service surgeons will do more surgery and produce higher premiums for health insurance. On the other hand, prepayment plans should be able to hire physicians on more favorable terms. The rising doctor supply may, therefore, increase the price advantage of HMOs over conventional insurance.

Physicians may respond to competitive pressures by forming more group practices. The proportion of doctors in groups has increased steadily. Group physicians, who were only 1.2 percent of the profession in 1940, rose to 2.6 percent in 1946, 5.2 percent in 1959, and 12.8 percent by 1969. Postwar growth of group practice has followed its earlier pattern. Group practices developed most in rural areas and small towns, especially in the West, where hospital development was initially delayed. By 1980 the 88,000 doctors in groups represented a quarter of the doctors in active practice. From the physicians' viewpoint, a major advantage of group practice is that it enables them to capture directly the profits from ancillary services that provide some of the most lucrative sources of hospital revenue. As Jeff Goldsmith, a business consultant, points out, group practices are vertically integrated forms of production with two outputs, physicians' services and ancillary services, such as X-rays and laboratory tests. The economies of scale in physicians' services are limited; the optimal size of a physician group may be only about six doctors. But large groups may generate substantial profits from ancillary services. "Ancillary profits," notes Goldsmith, "are a significant incentive for the formation of groups, one which is likely to become more powerful as market pressures reduce the profitability of the physicians' services component of what a practice produces."

Collision Course

If physicians respond to their growing numbers by trying to garner a larger share of health care expenditures, the effects may ricochet through the medical system. Doctors who develop group practices to
capture ancillary profits represent an economic threat to hospitals. So, too, do the doctors who form HMOs that may reduce the demand for inpatient hospital services. On the other hand, hospitals are developing satellite clinics and other outpatient facilities to assure themselves of a steady flow of referrals. As a result, doctors and hospitals may be on a “collision course” as doctors invade institutional services and hospitals invade ambulatory care.

Private doctors have several critical advantages in such a conflict. Their established relations with patients still give them leverage over the hospitals; hospitals that challenge doctors in their own market may risk a boycott. Private practitioners also have less overhead, and because they are not reimbursed on the basis of costs, they can adjust prices more flexibly to compete with hospitals. In addition, doctors have been exempted from certificate-of-need regulation.17

Hospitals, on the other hand, may enjoy some advantages because of the growing supply of physicians. Like other organizations, hospitals may find themselves in a stronger bargaining position in negotiations over compensation with staff physicians. Furthermore, if practitioners grow in number while state laws continue to restrict hospital expansion, doctors will be forced to compete for access to hospital beds.

The growing supply of doctors is almost certain to increase tensions between hospitals and their medical staffs. From the administration’s viewpoint, any given physician will represent progressively fewer patients. Hence the interest of the hospital will be to expand its medical staff to keep as many beds filled as possible, while the interest of staff physicians will be to restrict privileges to keep down competition. There will be continuing struggles about which doctors will have admitting privileges and permission to do surgery and complicated diagnostic tests.18

Teaching hospitals may have especially serious problems. They have been training their own competition. More specialists are dispersing into the suburbs and smaller towns, where they may provide services previously available only in large medical centers. At the same time, closer scrutiny of reimbursement levels by third-party payers may make it harder for teaching hospitals to continue to cross-subsidize education and research out of patient revenues. Cutbacks in Medicaid may hit them especially hard because of the large number of poor patients in inner-city areas where many teaching hospitals are located. Teaching hospitals have already begun to respond by providing more ambulatory care to bring in patients from other neighborhoods. Like physician groups, they are interested in participating in HMOs to “lock in” patient populations. Thus pressures from a rising physician supply are like-
ly, as Paul Ellwood and Linda Ellwein suggest, to “throw teaching hospitals into a more intense, competitive relationship with nonteaching hospitals.”

Throughout the medical world, the rising numbers of physicians mean renewed conflict and fragmentation.

The 1960s and 1970s broke down the uniformity and cohesiveness of the profession. The postwar development of medicine opened up divisions among institutionally based academic physicians, office-based private practitioners, and the “Third World of medicine” (older general practitioners and foreign-trained doctors, many in rural or inner-city areas with large Medicaid populations). Oddly enough, as a result of the influx of foreign doctors, medicine is now one of the most ethnically diverse of the upper-income occupations, with large numbers of Koreans, Indians, and others from abroad. Today one fifth of American doctors are immigrants. The 1970s also opened the gates to women and saw growing numbers of doctors go to work for HMOs and other organizations.

To maintain its claim to represent American physicians, the AMA will have to develop “advocacy services” for these groups. Women are a case in point. Forty-eight percent of men in the profession, but only 26.6 percent of women doctors belong to the AMA. An AMA committee recently pointed out that AMA membership will not keep pace with rising number of doctors unless the organization increases its appeal to women doctors. It recommended that the AMA endorse the Equal Rights Amendment, support day care, and vigorously respond to medical issues of concern to women, including unnecessary hysterectomies and the overprescription of tranquilizers and antidepressants. Another AMA committee has recommended policies to attract foreign medical graduates. James Sammons, executive vice president of the AMA, sees the AMA as representing doctors in negotiations with hospitals and HMOs. If it assumes the function of bargaining agent, it will obviously become more like a union. The growth of corporate medical organizations may push it in this direction. However, since some of its members are likely to be the owners and managers of such organizations, the AMA will find it difficult to represent both sides in labor negotiations. Of all the forces fragmenting the profession in the 1980s, none promises to introduce more antagonistic divisions than the growing presence of corporations in medical care.
THE GROWTH OF CORPORATE MEDICINE

Elements of the Corporate Transformation

Although physicians and voluntary hospitals have been preoccupied with government regulation, they may be on their way to losing their autonomy to another master. Medical care in America now appears to be in the early stages of a major transformation in its institutional structure, comparable to the rise of professional sovereignty at the opening of the twentieth century. Corporations have begun to integrate a hitherto decentralized hospital system, enter a variety of other health care businesses, and consolidate ownership and control in what may eventually become an industry dominated by huge health care conglomerates.

This transformation—so extraordinary in view of medicine’s past, yet so similar to changes in other industries—has been in the making, ironically enough, since the passage of Medicare and Medicaid. By making health care lucrative for providers, public financing made it exceedingly attractive to investors and set in motion the formation of large-scale corporate enterprises. Nursing homes and hospitals had a long history of proprietary ownership, but almost entirely as small, individually owned and operated enterprises. One of the first developments in the corporate transformation was the purchase of these facilities by new corporate chains. This, in a sense, was the first beachhead of for-profit corporations in the delivery of medical care. Paradoxically, the efforts to control expenditures for health services also stimulated corporate development. The conservative appropriation of liberal reform in the early seventies opened up HMOs as a field for business investment. And in ways entirely unexpected, the regulation of hospitals and other efforts to contain costs set off a wave of acquisitions, mergers, and diversification in the nonprofit as well as profit-making sectors of the medical care industry. Pressure for efficient, business-like management of health care has also contributed to the collapse of the barriers that traditionally prevented corporate control of health services.

These are the outlines of a process that has now gone considerably beyond what observers have described, at least since the early 1970s, as the rise of a “medical-industrial complex.” In its original sense, the medical-industrial complex referred to the linkages between the doctors, hospitals, and medical schools and the health insurance companies, drug manufacturers, medical equipment suppliers, and other profit-making firms. Their interests seemed so closely interlocked that they constituted a single system, a seamless web of influence, a common
front for a particular style, structure, and distribution of medical care. This early usage emphasized the hidden connections between industry and a medical system that was still made up almost entirely of independent practitioners and local, nonprofit institutions. As of the early seventies, profit-making hospital and nursing home chains were visibly on the rise but still marginal to the health care system as a whole.\textsuperscript{23}

Ten years later, this is no longer the case: Large health care corporations are becoming a central element in the system. Arnold S. Relman, editor of \textit{The New England Journal of Medicine}, alerted his readers in 1980 that the rise of a "new medical-industrial complex" was the "most important health-care development of the day." Relman wanted to distinguish the growing businesses that sell health services to patients for a profit, such as chain hospitals, walk-in clinics, dialysis centers, and home care companies, from the "old" complex of firms that sell drugs, equipment, and insurance.\textsuperscript{24}

But the change goes beyond the increased penetration of profit-making firms directly into medical services. By the growth of corporate medicine, I refer also to changes in the organization and behavior of nonprofit hospitals and a general movement throughout the health care industry toward higher levels of integrated control. Five separate dimensions need to be distinguished:

1. \textit{Change in type of ownership and control}: the shift from nonprofit and governmental organizations to for-profit companies in health care

2. \textit{Horizontal integration}: the decline of freestanding institutions and rise of multi-institutional systems, and the consequent shift in the locus of control from community boards to regional and national health care corporations

3. \textit{Diversification and corporate restructuring}: the shift from single-unit organizations operating in one market to "polycorporate" and conglomerate enterprises, often organized under holding companies, sometimes with both nonprofit and for-profit subsidiaries involved in a variety of different health care markets

4. \textit{Vertical integration}: the shift from single-level-of-care organizations, such as acute-care hospitals, to organizations that embrace the various phases and levels of care, such as HMOs

5. \textit{Industry concentration}: the increasing concentration of ownership and control of health services in regional markets and the nation as a whole

Although changes are taking place along all these dimensions simultaneously, they vary in their origins and significance. The growth of multi-
institutional systems is a distinct issue from the shift from nonprofit to for-profit ownership. The emergence of diversified health care companies is not the same as the spread of vertically integrated HMOs. Each of these developments in the corporate transformation of American medicine has somewhat different implications for the medical profession and medical care.

The Consolidation of the Hospital System

Unquestionably the most dramatic corporate expansion has taken place in hospital care. The traditional freestanding general hospital, governed by its own board, administrators, and medical staff, is now giving way to larger multihospital systems run by an increasingly powerful corporate management. In 1961 there were only five consolidations of hospitals in the United States; by the early 1970s, the number had grown to about fifty a year. In its 1980 survey of multihospital systems, the trade journal *Modern Healthcare* found 176 systems owning or managing 294,199 beds. Another survey, conducted under the auspices of the American Hospital Association, found 245 multihospital systems with 301,894 beds. These estimates, based on somewhat different definitions, indicate that by 1980 about 30 percent of the nation’s 988,000 community hospital beds were in multi-institutional corporations. The distribution ranged from only about 10 percent of hospital beds in New England to about 40 percent in the Far West.

Nonprofit organizations account for the majority of beds in multihospital systems. In 1980 the nonprofits operated 57.6 percent of the beds in multihospital systems, the investor-owned chains 35.1 percent, and public systems (excluding federal hospitals) 7.3 percent. But the for-profit chains account for most of the recent growth. Nearly 65 percent of the 20,000 beds added by multihospital systems in 1980 were added by the for-profit companies.

After their emergence in 1968, the profit-making hospital chains grew faster in the 1970s than the computer industry. In 1970 the largest for-profit chain controlled twenty-three hospitals; by 1981 the same company, Hospital Corporation of America, owned or managed more than three hundred hospitals with 43,000 beds. In 1981 the profit-making chains owned or managed hospitals with 121,741 beds, up 68 percent over the total of 72,282 beds they had held five years earlier.

Not all of these beds were in the United States. Several of the chains have become multinational corporations. American Medical International owns or manages facilities in England, Spain, Switzerland, Singapore, France, and Venezuela as well as the United States. In 1979 Hospi-
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tal Corporation of America purchased a prepaid health plan in Brazil with five hospitals, forty-two clinics, 780 doctors, and an enrollment of over a half million people.30

In the United States, the chain hospitals are concentrated in the South and Southwest in such states as Florida, Texas, and California. The hospitals are typically medium in size, ranging from 100 to 200 beds, and do not have residency programs.

One of the largest chains, Humana, Inc., exemplifies the rise of the hospital corporations. Humana started out in Louisville in 1968 with a few nursing homes and $4.8 million in revenues. Shifting to the more lucrative acute-care business, the company cashed in on its nursing homes and began buying and building hospitals. According to its president, the firm wanted to provide as uniform and reliable a product as a MacDonald’s hamburger coast to coast. By 1980 it had ninety-two hospitals and $1.4 billion in revenues; an original share, which cost $8 in 1968, was now worth $336.31

Most of the early growth of the profit-making chains came as they bought up individually owned proprietary facilities. Hence the growth of the for-profit chains has not meant a commensurate expansion of the proprietary sector. The emergence of the chains arrested a decline in the proprietary hospital sector that had been continuing steadily over the previous half century. After dropping from 2,435 in 1928 to 735 in 1972, the number of investor-owned hospitals held steady in the 1970s. However, the average size of these hospitals increased more than 50 percent. The share of community hospital beds owned by proprietary hospitals increased from 6.5 to 8.8 percent between 1972 and 1980; the proportion of beds in hospitals owned by investors or managed by investor-owned companies rose to 12.4 percent.32

The statistics understate the significance of the change. The old independent proprietary hospitals were typically small institutions owned and controlled by physicians. They were not really that different from many nonprofit hospitals equally dominated by their medical staff. The rise of the for-profit chains has, for the first time, introduced managerial capitalism into American medicine on a large scale.

Multihospital systems vary in the degree of centralization across a spectrum that ranges from fairly loose affiliations to tight management by corporate headquarters. Strong central management is the pattern among the for-profit chains. The majority of for-profit companies report that the power to set hospital budgets, plan capital investments, appoint chief hospital administrators, and make other key decisions rests with management at corporate headquarters. The profit-making chains have also adopted standardized management procedures, standardized ac-
counting, and other uniform practices. These tendencies are, as a rule, less advanced in the nonprofit systems.\textsuperscript{33}

There are two distinct aspects to patterns of control: Decisions may be local or centralized; and, if centralized, they may rest with a corporate board or corporate managers. One survey reports that local board responsibility for budgets and other key matters is the modal pattern only in the religious (mainly Catholic) multihospital systems. Among the secular nonprofits, such decisions more commonly rest with corporate boards, but in the for-profit chains, power usually lies with corporate management. The limited role of the boards of for-profit hospital companies suggests that, like most other large corporations, they are controlled by their inside directors.\textsuperscript{34}

The greater power of corporate management may reflect how the hospital chains were built. Another reason for greater centralization and standardized management may be size. The average number of hospitals in investor-owned chains in 1980 was 23.5, compared to an average of between 6 and 7 hospitals in nonprofit systems.\textsuperscript{35}

However, the differences in size and management may be diminishing. In the late seventies, some nonprofit systems adopted a more aggressively expansionist strategy and began bidding against the for-profits for new acquisitions. In 1981 Fairview Community Hospitals, a nonprofit system founded in 1973 and based in Minneapolis, bought a for-profit chain, A. E. Brim of Portland, Oregon. The purchase gave Fairview a total of 41 hospitals with 2,165 beds. As of 1979, the largest nonprofit was Sisters of Mercy Health Corporation (founded in 1976), with 23 hospitals and 5,584 beds.

Ownership and control are much more highly concentrated in the for-profit sector. By 1981, after several large mergers, nearly three quarters of the beds in for-profit multihospital systems were operated by the top three companies (Hospital Corporation of America, Humana, and American Medical International). On the other hand, the top three nonprofits (Kaiser Foundation Hospitals, Sisters of Mercy Health Corporation, and Sisters of Charity of Houston) operated less than a tenth of the beds in nonprofit systems.\textsuperscript{36} The for-profits and nonprofits also differ in their patterns of development. While the leading profit-making chains are national, the nonprofits typically operate in one area or contiguous states. The for-profits show a stronger tendency toward "horizontal" growth through the hospital industry; the nonprofits, toward "vertical" growth through different levels of care in health services. While most of the for-profit chains have restricted themselves to acute care facilities, many of the nonprofits have built satellite clinics and operate nursing homes in their areas.\textsuperscript{37}
Some might assume, given their growth, that multihospital systems are more efficient than independent hospitals and that, given their incentives, for-profit hospitals are more efficient than nonprofits. But this is to assume that the incentives facing hospitals reward efficiency.

There are many reasons why multihospital systems might be more efficient. David Starkweather, a professor of hospital administration, points out that the average American hospital is about half the minimum optimal size. As hospitals increase in size up to about 300 beds, their unit costs drop. (However, once past 600 or 700 beds, their costs begin to increase again.) Economies of scale up to 300 beds arise for several reasons: Small hospitals tend to have higher excess capacity, in part because their occupancy rates are less stable; larger size permits cheaper purchasing in volume and makes capital available at lower cost; and the feasibility of using specialized services increases with size.35

But while the potential efficiencies are impressive, the evidence of actual savings is not. One study, comparing a matched sample of merging and independent hospitals, found that the merged hospitals actually experienced greater increases in average cost per case and other indicators of expense.35 Some savings seem to develop over time. Starkweather observes that “research suggests an initial period of inefficiency after a merger, when unit costs are even higher than they would have been otherwise. The period of greater inefficiency can last eight to twelve years.”40 Among the reasons are the costs of buying off opposition. Physicians are rarely displaced if they duplicate services. If one of two merging hospitals has lower standards in physical resources or in pay, the merger will usually require leveling standards up rather than down. These changes are not necessarily bad, but they rarely result in significantly lower costs.

There is even less evidence to suggest that the for-profit companies achieve any savings over nonprofits. A 1981 study by the consulting firm Lewin and Associates covers a matched sample of fifty-three hospitals owned by for-profit chains in California, Florida, and Texas and fifty-three nonprofits in the same states. The authors caution that it is difficult to extrapolate to the country as a whole because these are all states with little hospital regulation; however, since the chains deliberately locate in such states, this is not a limitation that studies can easily overcome.

Lewin and Associates wanted to find whether the for-profits and nonprofits differed in their cost to purchasers of health care and, if so, whether the differences were due to operating costs, markup of charges over costs, or differences in service. They found that the investor-owned hospitals had slightly higher costs, charged considerably more,
and had higher revenues per day and per case. For cost payers (Medicare and Medicaid), the for-profit hospitals were only a bit more expensive per day and about the same per hospital admission. But for charge payers (such as subscribers to private health insurance), the for-profits were 23 percent more expensive per day and 17 percent more costly per admission. Routine charges were similar; the big difference was in the for-profits' high markup of such ancillary services as drugs and supplies. “Administrative and general service costs” were also 13 percent greater in the profit-making hospitals, due to higher “home office” costs, such as interest expenses, financial services, and data processing. Contrary to the expectation that the chains would achieve economies of scale, the study concluded that “home office expenses do not produce equivalent savings in individual local hospitals.” National data also indicate that, for every bed-size category, for-profit hospitals have higher costs than the overall average for community hospitals.

Even if larger hospital systems, or for-profit hospitals, were to produce hospital care more economically, they would still have the same incentives as freestanding hospitals to admit patients not needing hospitalization. They would still be likely to overuse technological services that receive disproportionately high reimbursement. And they would continue to duplicate expensive equipment available elsewhere in the community because the costs can be recovered through the insurance system. Though they may be exceedingly efficient in maximizing reimbursement rates, this sort of efficiency does not necessarily benefit their patients or the rest of society.

Why, then, have the multihospital systems grown? Expanding private insurance and Medicare gave the initial financial impetus to proprietary chains. Even though multihospital systems may not return savings to the public, their larger size may still give them advantages in the marketplace and the legislatures. They may answer demands for power, profit, and institutional survival that freestanding hospitals cannot satisfy. In recent years, closer regulation, tighter reimbursement, and higher interest rates seem to have stimulated the process of consolidation. Financial straits have obliged a growing number of voluntary and public hospitals to surrender some of their autonomy, look for stronger management, or pursue acquisitions and diversification themselves. Barred by regulatory agencies from expanding, some voluntary hospitals have sought acquisitions and mergers as an alternative. Also, public regulation may have stimulated hospitals to hire planners, lawyers, and financial advisors, who then found new functions for themselves in arranging mergers and acquisitions. Limits on new construction have also restricted competition, making existing hospitals attractive as an invest-
ment. And, in addition, the increasing complexity of the regulatory environment gave a growing advantage to large organizations, which can more easily influence and adapt to new regulations. As one hospital expert puts it, “Whenever government mandates a new report or establishes a new regulation, the administration needs better information and is more receptive to joining a chain.” As financing became more difficult and complex with high interest rates in the late seventies, the multihospital systems gained a critical advantage because they could secure easier access to debt markets than single hospitals.

Industry experts anticipate rapid growth of multihospital systems, especially the for-profits. Some are predicting that the for-profit chains will double in size in the eighties while the hospital industry as a whole will experience little growth. The gloomy economic forecast for voluntary hospitals is a boon to the multihospital systems. The greater the squeeze in reimbursements, the more pressure there will be on the relatively weak, freestanding institutions to sell out to multihospital systems with greater financial resources. Some local governments, meeting stiff resistance to higher taxes or bond issues, are finding it more attractive to sell public hospitals. A vice president of American Medical International explains, “Where historically government officials felt it was improper to sell their hospitals, many now feel that it’s inappropriate for government to be in the business of operating them.”

The profit-making chains also have a need to grow. Continued growth is necessary to keep up the price of their stocks and postpone tax liabilities. But they do face some limits. The independent proprietary hospitals that provided the basis for their early growth are becoming more scarce. The chains do not want to own hospitals in depressed areas with large numbers of Medicaid patients. Nor are they likely to buy up teaching hospitals. But there is probably ample room for growth in the medium-size hospitals in the more attractive neighborhoods, if the boards of voluntary hospitals can be convinced to sell.

This may ultimately prove to be the limiting factor. The growth of national hospitals chains promises to withdraw control of a civic institution from local authorities. The chains, as Starkweather points out, “transfer ownership out of the local community, increasing the difficulty of achieving local . . . reorganization of health care delivery.” Companies may shut down local services that do not yield enough revenue to the corporation, just as industrial conglomerates sometimes close plants that do not make a “hurdle” (return on investment) that may be as high as 20 to 25 percent. Plant shutdowns have yet to arise in the commercial hospital industry, but they are not hard to imagine. Nor is it hard to imagine the concessions that multinational hospital corpora-
tions will be able to extract from local communities by threatening to close down their hospitals.

The implications for the future distribution of hospital care may also arouse opposition. The for-profit chains have an undisguised preference for privately insured patients. As *Fortune* explained in an article on Humana,

Privately insured patients can be charged what the market will bear. When a hospital has empty beds, Medicare and Medicaid patients are better than cold sheets, and Humana charges off every penny of overhead on them the government will allow. But if it isn’t trying to fill a lot of empty beds, Humana treats as few of those patients as possible.

Humana prefers to own facilities in suburbs where young working families are having lots of babies. Though young people use hospitals less than the elderly, they are more likely to be privately insured and in need of surgery, which makes the most money. The babies provide a second generation of customers.48

Humana’s policy is to treat all emergency cases. However, if a wallet biopsy—one of the procedures in which American hospitals specialize—discloses that the victims are uninsured, it transfers them to public institutions. As a Humana official explained, in regard to a patient who died after being transferred within one day of suffering a heart attack, “These freebies cost $2,000 or $3,000 a day. Who’s going to pay for them?”48 The chains certainly aren’t.

**The Decomposition of Voluntarism**

The 1970s and 1980s have brought harsher times for many public and nonprofit hospitals. The tilt of postwar policy toward the hospital has become a tilt away from hospital care. Funds for capital investment are no longer abundant. Cutbacks in reimbursement rates under government programs threaten the survival of institutions with large numbers of poor patients. New organizations, such as HMOs, reduce the demand for hospital care, and the growing supply of physicians encourages doctors to “invade” services performed by hospitals to capture a larger share of ancillary profits. Hospitals face a more competitive market, and many may not endure.

In response, many voluntary hospitals are diversifying into other health care businesses. Administrators see diversification as a way to generate new revenues and raise additional capital for renovation and expansion. Often they are reorganizing their corporate structures at the same time. In one model, the hospital becomes the parent corporation
for a variety of subsidiaries; in another, it establishes a parent holding company, which owns the hospital as well as other subsidiaries. These new legal arrangements protect the hospital’s tax-exempt status while it diversifies and ensures that reimbursements for hospital care will not be cut because of revenues from new businesses. The “polycorporate” structure, says an enthusiastic hospital consultant, Montague Brown, makes it possible for hospitals “to build thriving business ventures [to] generate profits that the parent corporation can use wherever it chooses.” While the hospital subsidiary continues to operate as in the past, the new holding company can pursue acquisitions and spin off new subsidiaries. “The chief executive officer of the new polycorporate enterprise,” writes Brown, “may well be the former president, or even the current president, of the hospital but his or her work will resemble less and less the traditional task of the hospital administrator.” It will be more like managing a conglomerate.50

Under the umbrella of this new polycorporate enterprise, the tax-exempt, nonprofit hospital can operate taxable, for-profit businesses. In early 1981 the IRS agreed that a voluntary hospital in California did not lose its tax-exempt status after undertaking various profit-making ventures, which included a medical office building, a shopping center, a restaurant, and a contract management consulting firm. It even appears that the profit-making subsidiaries of a nonprofit hospital can sell stock to investors, as long as the tax-exempt and taxable organizations are kept separate.51

By early 1981 several hundred corporate reorganizations of hospitals had taken place. In Pittsburgh, Pennsylvania, for example, the nonprofit Allegheny General Hospital created a new parent holding company, Allegheny Health Education and Research Corporation, to generate new revenues and capital. Among its subsidiaries is a for-profit company, Allegheny Diagnostic Services, Inc., which sells cardiac rehabilitation, sports medicine, and laboratory services. In Berkeley, California, the nonprofit Alta Bates Hospital created a holding company to operate the hospital, another hospital it had acquired, a management services firm, a foundation, a group of nursing home and retirement centers, and Alta Bates Ambulatory Health Services, Inc., which operates a dialysis center, home care services, a pathology institute, a hospice, and a sports medicine unit.52

The ambitions of hospital administrators now go considerably beyond the traditional hospital functions. In Kansas City, Missouri, the 600-bed, nonprofit Research Medical Center operates a profit-making subsidiary, Health Services Management, Inc., which sells assertiveness training, stress management, continuing medical education, and speech and lan-
guage group therapy for children. After reorganizing, Research Medical's president indicated that among the new ventures being considered were a chain of health food restaurants, retail pharmacies, and hearing aid and eyeglass stores. "We have only about two years in which to do this," explained the company president, since hospitals that fail to diversify "are going to be gobbled up in mergers and acquisitions."53

Corporate reorganizations of hospitals often involve what consultants call "unbundling." Suppose a hospital has a laboratory that has been providing services to other hospitals. When unbundled, the department becomes a separate corporation, which can then pursue business on its own. The profits it generates for the parent holding company do not reduce the hospital's reimbursement rates.

Conversely, the hospital may contract out part of its own operations to independent corporations. Voluntary hospitals have long served as nonprofit shelters for the highly profitable businesses operated within them by radiologists and pathologists. Now they are increasingly contracting with physician groups to provide patient care. These groups, organized as professional corporations, may then hire their own employees and expand their operations to other institutions. Some may grow into substantial corporate enterprises. Many hospitals already buy coverage of their emergency rooms from a company that supplies physicians and operates the entire service. As the principle is extended, it may turn the nonprofit hospital into a beehive of corporate activity.

The extension of the voluntary hospital into profit-making businesses and the penetration of other corporations into the hospital signal the breakdown of the traditional boundaries of voluntarism. Increasingly, the polycorporate hospitals are likely to become multihospital systems and competitors with profit-making chains, HMOs, and other health care corporations. The president of one nonprofit multihospital system, which has profit-making subsidiaries, comments that "it may be increasingly difficult to distinguish those chains with voluntary origins from those which have been built with stock ownership."54 Eventually, it may also be difficult to distinguish those health care conglomerates that began as hospital systems from those that began in other markets.

Corporate activity in other medical services has been considerable. About 77 percent of the nursing homes in the United States are proprietary, and an increasing proportion are being bought up by large corporate chains. The nursing home chains are also going into the "life care" business, constructing retirement apartments next to nursing homes. Other companies provide home care, which involves home-making as-
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sistance, physiotherapy, and nursing and medical services. Compared to nursing homes, which generated about $19 billion in revenues in 1980, home care is still a small business, worth perhaps $3 billion, with about a half billion dollars going to ten large companies in 1980.55

There are also dozens of other related health care businesses, such as dental care, optical services, weight-control, rehabilitation, CAT scanning, and various kinds of laboratory services. Emergicenters—also called minor emergency centers, convenience clinics, or walk-in clinics—are typical and perhaps the most important. Often located in shopping centers, they provide immediate treatment for any medical problem, generally without an appointment. The owner of two emergicenters in Massachusetts calls them “the fast-food concept applied to medicine.” Such centers increased in number from about fifty to over two hundred nationwide between 1978 and 1981. In several states, chains operate clinics often in partnership with physicians; one company has begun to create a national franchise. A vice president of Merrill, Lynch gushes that emergicenters “can attract as much as 25 percent of the approximately $45 billion that Americans spent on physician and hospital outpatient services last year. That’s more than $10 billion—bigger than the fast-food industry. And with centralized management and economies of scale, they can prove highly attractive to entrepreneurial capital.”56

Large, multi-unit corporations are also gaining a major position in the organization of HMOs. At the beginning of the 1970s, the prepayment plans, except for Kaiser, were locally controlled. None were profit-making companies. By 1980 the majority of HMOs were being drawn into several large networks run by Kaiser, Blue Cross, INA, and Prudential. Without extensive government aid for start-up capital, the consumer-run, cooperative organizations are certain to decline, and the surviving HMOs will increasingly become part of large corporate networks.

The Trajectory of Organization

Throughout much of this work I have been concerned with the social selection of organizations. I have asked what explains the forms of medical practice, hospitals, private health plans, and public programs that emerged in America out of the diverse possibilities that were historically available. The reader may wonder, of the many kinds of organization that now exist (or might appear) in medical care, which are likely to prevail in the future? And what effects are they likely to have on the medical profession and the society?

The array of organizational forms in medicine is now extraordinarily
complex. On all the dimensions I listed earlier—type of ownership and control; extent of horizontal integration; diversification; vertical integration; and overall levels of concentration in regional health care markets—there is tremendous ferment and variety through the United States. The traditional private practitioner, freestanding voluntary hospital, and indemnity or service-benefit health insurance plan continue to be the norm, but they are losing their former dominance. In the future, more doctors will be in group practice; more hospitals will be in multihospital systems; and more insurance companies will be directly involved in providing medical care through HMOs. The traditional boundaries among these three sectors are being challenged: Doctors are integrating “backward” into institutional services; hospitals are integrating “forward” into ambulatory care; insurance companies are adopting new arrangements with “preferred providers” to create hybrid prepayment plans. No one today could safely predict the outcome of these developments.

However, most observers would agree that the movement toward integrated control will continue. Starkweather suggests that the roughly five thousand different corporations responsible for the nation’s hospitals will be reduced to about two thousand by 1990.57 Another analyst suggests that by the year 2000, health care conglomerates, each with revenues of over $500 million a year, will account for about a fifth of all spending on hospitals and nursing homes.58 These are relatively modest projections. A radical Reaganite program could accelerate the movement. Before being appointed director of the Office of Management and Budget, David Stockman declared that “under the kind of system that I’m talking about . . . I think most hospitals will become parts of for-profit marketing operations or they will become for-profit on their own.”59

The long-run question is which form of integration will predominate. Several major types have now appeared: (1) the academic medical “empire,” with its extended network of affiliation agreements; (2) the regional, nonprofit multihospital system; (3) the national, for-profit hospital chains; (4) HMOs, both independent and in chains; and (5) the diversified health care “conglomerate” with different lines of business in health care, but not offering comprehensive services to a defined population as in an HMO.

These different forms of corporate health care will be engaged in both economic and political competition with one another. If the financing system for medical care rewarded economic performance, both the academic medical empires and the for-profit chains would be handicapped by their higher costs. But this is not necessarily a fatal dis-
advantage as long as the reimbursement system permits higher-cost institutions to receive additional funds. The for-profit chains’ higher markups on ancillary services, along with their superior access to private capital, actually provide them with funds for expansion. The academic medical centers are in more serious difficulty because of their higher costs, but they may be able to persuade government, perhaps after a few threatened bankruptcies, to accept more of the burden of financing medical education.

As I’ve already indicated, there is no evidence for significant savings from for-profit over nonprofit organizations and little evidence for savings from multihospital systems over freestanding institutions. Horizontal integration has more advantages for the organizations than for the society. Similarly, corporate restructuring—the emergence of the poly-corporate enterprise—has as its main motive the maximization of reimbursement. These are primarily adaptations to an incentive system that continues to be skewed; there is no reason to expect that they will meet the demands of the government or employers for containment of medical costs.

On the other hand, vertical integration—comprehensive prepayment—has the potential to yield significant savings of money and improvements in effectiveness. There is clear and convincing evidence for substantial savings from HMOs; the main reason is the reduction in expensive hospital care—hardly surprising in view of the effects on the rest of the health care system of the long-standing tilt toward hospitals in government policy, private insurance, and relative prices paid physicians for hospital and office services.60

Many observers, more confident of the rationality of the medical system than I am, foresee a shift from horizontal to vertical integration. In this view, the regional, nonprofit multihospital systems will be precursors to comprehensive health care plans, and even the for-profit hospital chains will eventually turn toward HMOs.61

There is precedent for this view. In his history of the rise of corporate management, Alfred Chandler notes that there were two paths to the modern corporation in America. One was to expand by merger. This was basically a strategy of horizontal integration, aimed at increasing profits by controlling price and output. The other was to combine a system of mass marketing with mass production; this was a strategy of vertical integration aimed at raising profits by cutting costs. In the long run, the first strategy could not succeed alone. “The firms that first grew large by taking the merger route remained profitable only if after consolidating they then adopted a strategy of vertical integration,” writes Chandler.62
The reasons for the lower costs of vertically integrated health care enterprises are not the same as for vertically integrated manufacturing companies. But if government and employers paying fringe benefits put pressure on American medicine to minimize its costs to society, the movement toward vertical integration (that is, to HMOs) will ultimately predominate. In that event, the likely trajectory of organization will lead increasingly toward corporate HMO networks.

But there is no reason to assume that cost minimization will prevail. Doctors continue to hold strategic position through their established relations with both patients and hospitals. The major block to HMO development is the unwillingness of potential subscribers to break long-standing ties with their doctors. The relations between hospitals and their medical staffs—particularly the fact that doctors have admitting privileges only at certain hospitals and that hospitals draw their patients through their doctors' practices—also tend to block the substantial reduction of hospital capacity that would be the outcome of HMO development.

The competition among types of corporate medical care is extraordinarily sensitive to the vagaries of politics. Changes in the details of reimbursement policy have immense implications for the profitability of different types of organizations. Highly organized lobbies may be able to recover through the manipulation of public policy what they could not otherwise achieve. This is the problem of political feedback: Once powerful organizations become established, they find the political means to sustain themselves.

Kidney dialysis centers provide a particularly graphic example of the rise of a private industry in response to public financing and then the manipulation of public policy by the industry it originally created. In 1972 Congress extended Medicare to one group of patients under age sixty-five: the victims of end-stage renal disease. At the time, about nine thousand patients were receiving long-term renal dialysis, 37 percent at home and almost all through nonprofit programs, which were attempting wherever possible to arrange kidney transplants as a more permanent solution.

By 1976 the proportion on home dialysis dropped to less than 10 percent, as dialysis centers proliferated. According to a 1975 congressional study, dialysis then cost between $4,000 and $6,000 a year if done at home, between $14,000 and $20,000 at a clinic, and about $30,000 at a hospital. Congress had been told in 1972 that four years later the cost of the program would be $200 million; it turned out to be about twice that amount. Among the more benign explanations for the decline of home dialysis was the increased proportion of elderly and very sick pa-
patients receiving dialysis as the program expanded. But it was also apparent that Congress had helped create the problem by providing incentives for institutional dialysis to both doctors and patients. Apart from deductibles, the government paid the entire cost of treatment at a clinic or hospital but only about 80 percent of the cost of treatment at home. It had also encouraged doctors who specialized in the field to set up profit-making centers to which they could refer their own patients. Opponents of the centers pointed to the huge disparities in rates of home treatment between different areas of the country. In Seattle, Washington, where the Northwest Kidney Center strongly favored home treatment, 100 percent of the dialysis patients were being treated at home, whereas in Los Angeles, 95 percent of the patients received institutional dialysis. A medical professor from the University of Washington explained that many doctors were reluctant to give their patients the responsibility of self-treatment. “If the physician also happens to own the dialysis center, he’s pretty interested in keeping that center full, the motivation is pretty small to get the patients home, and that’s essentially what’s been happening in Los Angeles County.”

In 1976 several Democrats in the House of Representatives sought legislation equalizing government reimbursements for home and institutional dialysis and requiring that by 1980 half of dialysis patients be on home treatment or “self-care” at institutions. However, National Medical Care, Inc., the leading operator of for-profit dialysis centers, weighed into the battle, hiring Reagan’s 1976 campaign manager John Sears as its chief lobbyist. On emerging from the House, the 50 percent requirement of home dialysis had become a “goal.” When the bill left the Senate, even the goal had disappeared. Congress just expressed its “intent” that as many patients as possible receive home dialysis. “The lobbyists gutted the hell out of [the legislation],” one Social Security official commented.

By 1980 National Medical Care owned 120 dialysis centers and treated 17 percent of the nation’s 48,000 dialysis patients. In several cities, including Boston, Washington, and Dallas, it controlled the dialysis market. Very few of its patients are dialyzed at home. The company is vertically integrated: One subsidiary makes dialysis supplies and equipment; another performs the laboratory tests for dialysis patients. NMC has also branched out into obesity control, psychiatric care, and respiratory therapy—another emerging health care conglomerate.

This kind of conglomerate development may well prevail over the development of comprehensive medical care through HMOs. The industrialization of episodic medicine was not the original intent of the market idealists of the early 1970s who favored health maintenance or-
ganizations. Many of them regard chain hospitals and emergicenters as the antithesis of what they had in mind. They wanted corporate involvement to change the nature of health care; it seems more likely, in the foreseeable future, to reproduce the defects of the traditional system on a grander scale.

DOCTORS, CORPORATIONS, AND THE STATE

The great illusion of physicians and the hospital industry in the 1970s was that liberal government was causing their troubles. The real threat to their autonomy lay in the demands they were placing upon private health insurance as well as public programs. Private insurers and employers want medical expenditures to be controlled. And though business has become more wary of planning and regulation, it wants medicine put under constraint of some kind.

In the early 1980s, spokesmen for business are calling for control over costs by the private sector. Though this approach has ideological affinities with the competitive model in health policy, the two are not exactly the same. The chief instance of private-sector regulation is the business coalition. In 1974 the Business Roundtable, whose members consist of the chief executive officers (CEOs) of the largest corporations in the United States, created a new organization called the Washington Business Group on Health. The initial purpose was to defeat national health insurance, but the group increasingly became involved in other medical policy issues, particularly cost containment. Local business coalitions to encourage containment of medical costs have been the next step. By early 1982 about eighty such coalitions were in process of formation around the United States. Their agenda includes such issues as utilization review and review of capital spending by medical institutions, not altogether different from the concerns of the PSROs and HSAs that the Reagan administration was intent on dismantling. The attack on regulation may not presage its disappearance but rather a transfer of functions from federally-sponsored organizations to business-sponsored organizations and the states. It is not difficult to imagine a situation in which some corporations (i.e., employers) lean on other corporations (i.e., insurers, HMOs, hospital chains), which, in turn, lean on the professionals to control costs. However, some critics object the employers won’t lean hard enough because their stake is too small.
The emergence of corporate enterprise in health services is part of two broad currents in the political economy of contemporary societies. The older of these two movements is the steady expansion of the corporation into sectors of the economy traditionally occupied by self-employed small businessmen or family enterprises. In this respect, the growth of corporate medical care is similar to the growth of corporate agriculture. The second and more recent movement is the transfer of public services to the administrative control or ownership of private corporations—the reprivatization of the public household.

As I've already indicated, liberal and conservative policies, in opposite ways, have both promoted corporate health care. Medicare and Medicaid stimulated the huge growth in proprietary nursing homes and hospitals and later the rise of dialysis clinics, home care businesses, and emergicenters. Cutbacks in financing have encouraged the same developments. This shift was not inevitable. The legal rule against the corporate practice of medicine might conceivably have been steadfastly enforced by the courts. The early liberal programs might have emphasized neighborhood health centers instead of Medicaid and more generally have fostered public facilities instead of public financing for private health care. The great irony is that the opposition of the doctors and hospitals to public control of public programs set in motion entrepreneurial forces that may end up depriving both private doctors and local voluntary hospitals of their traditional autonomy.

The profession was long able to resist corporate competition and corporate control by virtue of its collective organization, authority, and strategic position in mediating the relation of patients to hospitals, pharmaceutical companies, and use of third-party payment. Today, physicians still hold authority and strategic position, but these have eroded. Specialization has diminished the scope of relations between doctors and patients. Although patients who have established satisfactory relationships with private physicians are less likely to enroll in HMOs, HMOs have been developing more rapidly than before partly because ties between doctors and patients are so much weaker. (The rise in malpractice suits against private physicians has the same cause.) Employers and the government have become critical intermediaries in the system because of their financial role, and they are using their power to reorient the system.

In addition, the profession is no longer steadfastly opposed to the growth of corporate medicine. Physicians' commitment to solo practice has been eroding; younger medical school graduates express a preference for practicing in groups. The longer period of residency training may cultivate more group-oriented attitudes. Young doctors may be
more interested in freedom from the job than freedom in the job, and organizations that provide more regular hours can screen out the invasions of private life that come with independent professional practice.

The AMA is no longer as devoted to solo practice either. "We are not opposed to the corporate practice of medicine," says Dr. Sammons of the AMA. "There is no way that we could be," he adds, pointing out that a high proportion of the AMA's members are now involved in corporate practice. According to AMA data, some 26 percent of physicians have contractual relationships with hospitals; three out of five of these doctors are on salary. About half the physicians in private practice have set up professional corporations to take advantage of special tax-sheltering provisions. Many physicians in private practice receive part of their income through independent practice associations, HMOs, and for-profit hospitals and other health care companies. The growth of corporate medicine has simply gone too far for the AMA to oppose it outright. Dr. Sammons explains that the AMA would oppose any interference by organizations in medical decisions, but says that he is satisfied that none of the forms of corporate practice currently threaten professional autonomy. However, at the local level, medical societies often still vigorously oppose HMOs and other forms of integrated control.

Doctors are not likely, as some sociologists have suggested, to become "proletarianized" by corporate medicine. "Proletarianized" suggests a total loss of control over the conditions of work as well as a severe reduction in compensation. Such a radical change is not in prospect. Corporations will require the active cooperation of physicians. Profit-making hospitals require doctors to generate admissions and revenues; prepaid health plans, while having the opposite incentives, still require doctors' cooperation to control hospital admissions and overall costs. Because of their dependence on physicians, the corporations will be generous in granting rewards, including more autonomy than they give to most other workers. The new generation of women physicians may find the new corporate organizations willing to allow more part-time and intermittent work than is possible in solo practice.

Nonetheless, compared with individual practice, corporate work will necessarily entail a profound loss of autonomy. Doctors will no longer have as much control over such basic issues as when they retire. There will be more regulation of the pace and routines of work. And the corporation is likely to require some standard of performance, whether measured in revenues generated or patients treated per hour. To stimulate admissions, Humana offers physicians office space at a discount in buildings next to its hospitals and even guarantees first-year incomes of $60,000. It then keeps track of the revenues each doctor generates.
"They let you know if you’re not keeping up to expectations," says one young physician. Humana’s president is frank about what happens if they fail to produce: “I’m damn sure I’m not going to renegotiate their office leases. They can practice elsewhere.”

Under corporate management, there is also likely to be close scrutiny of mistakes, if only because of corporate liability for malpractice. An enthusiastic management consultant writes that “individual incompetence and sloppy clinical performance will be less tolerated there than in freestanding large voluntary hospitals. . . . The large conglomerate can purchase and/or develop sophisticated quality-of-care control programs managed by statisticians. Working at corporate headquarters, the statisticians will not be concerned about individual physicians’ reactions. Their reports, however, will supply individual hospitals with results about physicians who are not measuring up. . . . Senior management at the corporate level will constantly be mindful that the corporation’s reputation comes first . . .” This, of course, may be management fantasy, but unlike PSROs, which this control system resembles, it cannot be denounced as government regulation.

New distinctions will need to be made among owning, managing, employed, and independent physicians. The rise of corporate medicine will restructure the profession. A key question will be the control over the appointment of managing physicians. If the managers are accountable to doctors organized in medical groups, the profession may be able to achieve some collective autonomy within the framework of the corporation (as they do in Kaiser). Another key issue will be the boundary between medical and business decisions; when both medical and economic considerations are relevant, which will prevail and who will decide? Much will depend on the external forces driving the organization. Thus far, conflict has been muted by affluence. A regime of medical austerity will test the limits of professional autonomy in the corporate system.

One reason that there will be a loss of autonomy is that the organizations in which physicians work are themselves likely to become heteronomous—that is, the locus of control will be outside the immediate organization. Professional autonomy has been protected by the institutional autonomy of hospitals. In the multihospital systems, centralized planning, budgeting, and personnel decisions will deprive physicians of much of the influence they are accustomed to exercise over institutional policy.

Perhaps the most subtle loss of autonomy for the profession will take place because of increasing corporate influence over the rules and standards of medical work. Corporate management is already thinking
about the different techniques for modifying the behavior of physicians, getting them to accept management's outlook and integrate it into their everyday work. That way they do not need to be supervised and do not sense any loss of control. Sociologists have long talked about the "professional socialization" that takes place in medical school as students acquire the values and attitudes of mature physicians. Now they will have to study "corporate socialization" as young doctors learn to do things the way the plan or the company has them done.72

The rise of a corporate ethos in medical care is already one of the most significant consequences of the changing structure of medical care. It permeates voluntary hospitals, government agencies, and academic thought as well as profit-making medical care organizations. Those who talked about "health care planning" in the 1970s now talk about "health care marketing." Everywhere one sees the growth of a kind of marketing mentality in health care. And, indeed, business school graduates are displacing graduates of public health schools, hospital administrators, and even doctors in the top echelons of medical care organizations. The organizational culture of medicine used to be dominated by the ideals of professionalism and voluntarism, which softened the underlying acquisitive activity. The restraint exercised by those ideals now grows weaker. The "health center" of one era is the "profit center" of the next.

No less important than its effect on the culture of medical care institutions is the likely political impact of the growth of corporate enterprise. As an interest group, the new health care conglomerates will obviously be a powerful force. In one case—the renal dialysis clinics—the influence of one corporation prevented Congress from adopting legislation that would have cut federal health care costs, which is to say corporate profits. The profit-making hospitals clearly benefit from the structure of private health insurance and can be counted on to oppose any national health program that might threaten to end private reimbursement. The corporate health services industry will also represent a powerful new force resisting public accountability and participation.

A corporate sector in health care is also likely to aggravate inequalities in access to health care. Profit-making enterprises are not interested in treating those who cannot pay. The voluntary hospital may not treat the poor the same as the rich, but they do treat them and often treat them well. A system in which corporate enterprises play a larger part is likely to be more segmented and more stratified. With cutbacks in public financing coming at the same time, the two-class system in medical care is likely to become only more conspicuous.

This turn of events is the fruit of a history of accommodating profes-
sional and institutional interests, failing to exercise public control over public programs, then adopting piecemeal regulation to control the inflationary consequences, and, as a final resort, cutting back programs and turning them back to the private sector. The failure to rationalize medical services under public control meant that sooner or later they would be rationalized under private control. Instead of public regulation, there will be private regulation, and instead of public planning, there will be corporate planning. Instead of public financing for prepaid plans that might be managed by the subscribers' chosen representatives, there will be corporate financing for private plans controlled by conglomerates whose interests will be determined by the rate of return on investments. That is the future toward which American medicine now seems to be headed.

But a trend is not necessarily fate. Images of the future are usually only caricatures of the present. Perhaps this picture of the future of medical care will also prove to be a caricature. Whether it does depends on choices that Americans have still to make.