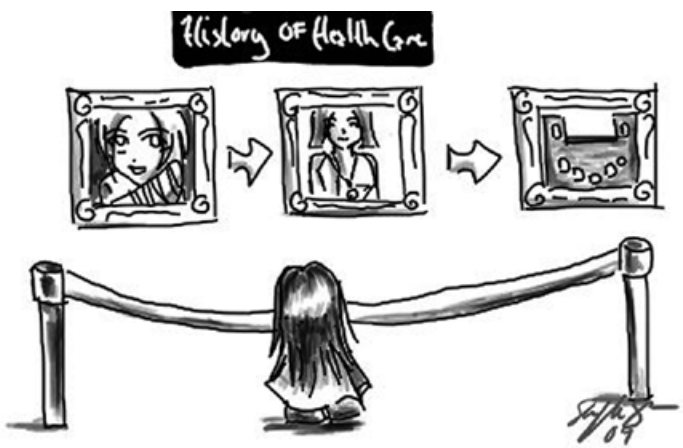
CHAPTER 3

# Historical Overview of U.S. Health Care Delivery




## Introduction

Knowledge of the history of health care is essential for understanding the main characteristics of the medical delivery system as it exists today. For example, the system's historical foundations explain why a government-run national health care system has not materialized in the United States. This is unlike what exists in Canada and Great Britain, for instance. Instead, the United States has predominantly a private health care industry that also receives a fairly substantial amount of financing from the government.

Traditionally held American cultural beliefs and values, the social fabric of the American society, technological advances, economic constraints, political opportunism, and ecological forces are the main historical factors

that have continued to shape U.S. health care delivery; examples are provided in **EXHIBIT 3.1**. The ebb and flow of the same forces will shape health care's future direction.

The agents of change just mentioned often interact in a complex manner. For example, President Barack Obama's political agenda trumped economic constraints and led to the enactment of the Affordable Care Act (ACA; nicknamed "Obamacare") in 2010 through ideological and political maneuvering. Historically, the beliefs and values espoused by the majority of Americans—such as capitalism, self-reliance, and limited government—have been primarily responsible for shielding the U.S. health care system from a major overhaul. Conversely, social, political, and economic forces led to certain compromises, as seen in the creation of Medicare and Medicaid and other public programs to extend health care to certain defined groups of people. The growing political clout of

**EXHIBIT 3.1** Major Forces of Change in U.S. Health Care Delivery

- Cultural beliefs and values
  - Self-reliance
  - Welfare assistance for the needy
- Social makeup
  - Demographic shifts
  - Immigration
  - Health status
  - Urbanization
- Technological advances
  - Scientific research
  - New treatments
  - Training of health professionals
  - Facilities and equipment
  - Information technology
- Economic constraints
  - Health care costs
  - Private and public health insurance
  - Family incomes
- Political opportunism
  - President's agenda
  - Political party ideology
  - Political maneuvers
  - Power of interest groups
  - Laws and regulations
- Ecological forces
  - New diseases
  - Drug-resistant infections
  - Global travel and transport

the elderly population in the United States, for example, was instrumental in the addition of a prescription drug benefit to Medicare in 2003.

Advancements in science and technology have played a major role in shaping the U.S. health care delivery system. As a result, medical practice in the United States is highly specialized, while basic and routine primary care is given only secondary importance.

This chapter traces the evolution of health care delivery through four recognizable historical periods, each demarcating a major change in the structure of the medical delivery system. The first phase is the *preindustrial era*, which lasted from the middle of the 18th century until the latter part of the 19th century. The second phase is the *postindustrial era*, which began in the late 19th century. The third phase—called the *corporate era*—includes developments that started around 1970 and continue into the 21st century. The fourth phase, which is still in its infancy, is characterized by health care reform—namely, the passage of the ACA and its potential repeal and replacement.

## Medical Services in Preindustrial America

From colonial times to the late 1800s, medical education and practice were far more advanced in Great Britain, France, and Germany than they were in the United States. The practice of medicine in the United States had a strong domestic—rather than professional—character because medical procedures were rather primitive. The nation had only a handful of hospitals. There was no health insurance, private or public. Therefore, health care had to be purchased using personal funds, and health care was delivered in a free market. The main characteristics of health care delivery during this period are summarized in **EXHIBIT 3.2**.

### Medical Training

Until around 1870, medical training was largely received through individual apprenticeship with a practicing physician rather than through university education. It is ironic that many of the preceptors under whom medical students apprenticed were themselves poorly trained (Rothstein, 1972, p. 86). Only a small number of medical schools existed at that time. To train a larger number of students than was possible through apprenticeship, American physicians began opening medical schools, albeit mainly to supplement their incomes by collecting student fees that were paid directly to the physicians.

These physicians did not have classroom facilities at their disposal, however, nor did they have the authority to confer the doctor of medicine (MD) degree. Hence, they had to affiliate with local colleges to use

**EXHIBIT 3.2** Health Care Delivery in Preindustrial America

- Medical training and education were not grounded in science.
- Primitive medical procedures were practiced.
- Intense competition existed because any tradesman could practice medicine.
- People relied on family members, neighbors, and publications for domestic remedies.
- Physicians' fees were paid out of personal funds.
- Health care was delivered in a free market.
- Hospitals were few in number and located only in big cities.
- Hospitals had poor sanitation and unskilled staff.
- Almshouses served the destitute and disruptive elements of society and provided some basic nursing care.
- State governments operated asylums for patients with untreatable, chronic mental illness.
- Pesthouses quarantined people with contagious diseases.
- Dispensaries delivered outpatient charity care in urban areas.

their facilities and confer degrees. As part of this approach, four or more physicians would get together to form a faculty. Medical schools were inexpensive to operate and often quite profitable. It is estimated that 42 such schools were in operation in the United States in 1850 (Rothstein, 1972, p. 91).

Medical education at this point was still seriously lacking in science. The 2-year MD degree required attending courses for 3 to 4 months during the first year and then essentially repeating the same coursework during the second year. Because fees were paid only as the student passed each course, low standards and a less-than-rigorous curriculum were necessary to attract and retain students. Even the best medical schools admitted students without a high school diploma. Training in the biological sciences was considered useful but not essential. Laboratories were nonexistent. Library facilities were inadequate, and clinical observation and practice were not part of the curriculum (Starr, 1982).

## Medical Practice

The early practice of medicine can be regarded more as a trade than as a profession, because medical education was not grounded in science. It most assuredly lacked the prestige it has today. First, it did not require a rigorous course of study, clinical practice, residency training, board exams, and licensing, without all of which it is impossible to practice medicine today. Second, medical procedures were primitive because medical science was still in its infancy. Bleeding, use of emetics, and purging with enemas and purgatives were popular forms of clinical therapy in early medicine.

Treatment of mentally ill patients was even more inhumane compared to current practices. Mental illness was often viewed as aberrant behavior, for which the treatment was to apply penal methods to restore sanity. Dr. Benjamin Rush (1749–1813), known as the father of American psychiatry, believed that mental illness was caused by irritation of the blood vessels in the brain. His treatment methods included bleeding, purging, hot and cold baths, and mercury (National Library of Medicine, 2014).

Surgery was limited because anesthesia had not yet been developed, and antiseptic techniques were not known. The stethoscope and x-rays had not been discovered. The clinical thermometer was not in use, and the microscope was not available for medical diagnosis. Physicians mainly relied on their five senses and experience to diagnose and treat medical problems. Hence, in most cases, physicians did not possess technical expertise any greater than that possessed by family members at home and experienced neighbors in the local community.

One of the main consequences of nonprofessional medicine was that anyone—trained or untrained—could practice as a physician. The clergy, for example, often combined medical services and religious duties. The generally well-educated clergymen and government officials were actually more learned in medicine than many physicians (Shryock, 1966, p. 252). Tradesmen such as tailors, barbers, commodity merchants, and those engaged in numerous other trades also practiced the healing arts by selling herbal prescriptions, nostrums, elixirs, and cathartics. The red-and-white striped poles (symbolizing blood and bandages) outside barber shops today are reminders that barbers also functioned as surgeons at one time, using the same blade to cut hair, shave beards, and perform bloodletting.

This system of free entry into medical practice created intense competition. Physicians did not enjoy the status, influence, and income that they do today. Indeed, many physicians found it necessary to engage in a second occupation because income from their medical practice alone was inadequate to support a family. It is estimated that most physicians' incomes in the mid-1800s put them in the lower echelon of the middle class (Starr, 1982, p. 84).

In the small communities of rural America, a spirit of strong self-reliance prevailed. Families and communities treated the sick using folk remedies that were passed on from one generation to the next. It was common for people to consult published books and pamphlets on home remedies (Rosen, 1983, p. 2). The market for physicians' services was also limited by affordability. Most families simply could not afford the cost because they had to pay for services out of pocket, without the help of health insurance. Also, most Americans resided in small rural communities, and summoning a physician could require traveling for several hours, and sometimes an entire day, which resulted in loss of work and income.

## Medical Institutions

Before the 1880s, the United States had only a few isolated hospitals, which were found in large cities such as New York, Boston, New Orleans, St. Louis, and Philadelphia. In France and Great Britain, in contrast, general hospital expansion began long before the 1800s (Stevens, 1971, pp. 9–10). In Europe, medical professionals were closely associated with hospitals and readily adopted new advances in medical science. The situation was much different in the United States, where hospitals were characterized by deplorable sanitary conditions and poor ventilation. Unhygienic practices prevailed because nurses were generally unskilled and untrained. It was far more dangerous to receive care in a hospital than at home. Hospitals had a popular image as houses of death and institutions of welfare. People went to hospitals only because of dire circumstances, not by personal choice.

The forerunner of today's hospitals and nursing homes in the United States was the *almshouse* (also called a *poorhouse*). Almshouses existed in almost all cities of moderate size and were run by the local government. The almshouse was not a health care institution in the true sense, but rather a place where the destitute and disruptive elements of society were confined. The inmates, as they were called, included many of the elderly, the homeless, orphans, the ill, and the disabled of the community. They were given food, shelter, and some basic nursing care if needed. In many cases, the almshouse was an infirmary, old-age facility, mental asylum, homeless shelter, and orphanage all rolled into one institution. Living conditions in these institutions were squalid, and they were a far cry from today's health care facilities. Thus the early health care institutions emerged mainly to take care of indigent people who could not be cared for by their own families.

An *asylum*—commonly referred to as a *lunatic asylum*—was the forerunner of today's inpatient psychiatric facilities. Although almshouses were used to accommodate some mental patients, asylums were built by state governments for patients with untreatable, chronic mental illness. Actually, asylums were established out of humanitarian considerations; they were intended to prevent aimlessly wandering people with serious mental illness from being put in jail (Norris, 2017). Attendants in these asylums employed physical and psychological techniques in an effort to return patients to some level of rational thinking. Dr. Benjamin Rush, for example, invented a tranquilizer chair[1] and a spinning gyrator for psychiatric patients that induced vertigo, perspiration, and nausea.

1 The online *Psychology Dictionary* describes it as a heavy wooden chair in which the patient would be strapped across his or her chest, abdomen, knees, and ankles, with his or her head inserted into a wooden box (https://psychologydictionary.org/tranquilizer-chair/).

Another type of institution, the *pesthouse*, was operated by local governments to isolate people who had contracted a contagious disease such as cholera, smallpox, typhoid, or yellow fever. Their main function was to contain the spread of communicable disease and protect the inhabitants of a city.

*Dispensaries* were established as outpatient clinics to provide free care to those who could not afford to pay. They provided basic medical care and dispensed drugs to ambulatory patients (Raffel, 1980, p. 239). Around 1900 in the United States, approximately 100 dispensaries were located in large cities (Madison, 1990). Generally, young physicians and medical students desiring clinical experience staffed the dispensaries (as well as hospital wards) on a part-time basis for little or no income (Martensen, 1996). The dispensary can be regarded as the forerunner of today's more than 1,200 free and charitable clinics where services are delivered mainly by trained volunteer staff to the poor, the homeless, and the uninsured.

## Medical Services in Postindustrial America

The postindustrial era was marked by the growth and development of a medical profession that benefited from urbanization, new scientific discoveries, and reforms in medical education. American physicians formed professional organizations that acted as a powerful force in resisting proposals for a national health care program. The private practice of medicine, free from employment by hospitals and corporations, became firmly entrenched as physicians organized into a cohesive profession, opted for specialization, and gained power and prestige. The hospital emerged as a repository for high-tech facilities and equipment. Private and public health insurance took roots. Notable developments of this era are summarized in **EXHIBIT 3.3**.

### Medical Profession

Notably, much of the transformation in U.S. medicine occurred in the aftermath of the American Civil War (1861–1865), as the country transitioned from a rural agricultural economy to a system of industrial capitalism. Urban development attracted increasingly more Americans to the growing towns and cities. In 1840, only 11% of the U.S. population lived in urban areas; by 1900, that share had increased to 40% (Stevens, 1971, p. 34).

Urbanization created increased reliance on the specialized skills of paid professionals, as this trend distanced people from family-based care. At the same time, urbanization led to the concentration of medical practice in cities and towns, where office-based practice began

**EXHIBIT 3.3** Notable Developments During the Postindustrial Era

- Urbanization
- Scientific discoveries and their applications in medicine
  - Advanced science-based treatments
  - Rising health care costs
  - Imbalance between specialists and generalists
- Medical education reform
- Power and prestige of physicians
- Organized medicine
  - Control over medical training
  - Powerful political interest group
  - Support of licensing laws
  - Opposition to national health insurance proposals
  - Support of private entrepreneurship in medical practice
- Hospitals became true medical care institutions
- Reform of mental health care
- Growth of private health insurance
- Creation of Medicare and Medicaid

to replace house calls. Closer geographic proximity to their patients enabled physicians to see more patients in a given amount of time. Their greater productivity, in turn, produced higher incomes for the physicians.

As medicine became increasingly driven by science and technology, lay people could no longer deliver legitimate medical care. Science-based medicine also created an increased demand for the advanced services that only trained professionals could provide. Developments in bacteriology, antiseptic surgery, anesthesia, immunology, and diagnostic techniques, along with a growing array of new drugs, helped bring medical practice into the category of a legitimate profession. **EXHIBIT 3.4** summarizes some of the groundbreaking early scientific discoveries in medicine made during this era.

The preoccupation with science and technology in the American culture brought numerous benefits, but also produced some undesirable effects. For example, an overemphasis on the use of technology in medical care delivery created a bias toward specialization in medical training, which ultimately ended up creating far too many specialists in relation to generalists. Technology and specialization also increased the cost of medical care, but without significantly improving the health status of Americans. In contrast, other developed nations emphasized primary care in which, apart from delivering routine and basic care, a primary care physician and trained nurses ensured the continuity, coordination, and appropriateness of medical services received by a patient.

**EXHIBIT 3.4** Groundbreaking Medical Discoveries

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

## The American Medical Association

The American Medical Association (AMA) historically played a critical role in galvanizing the medical profession and in protecting the interests of physicians. The concerted activities of physicians through the AMA have been collectively referred to as *organized medicine* to distinguish them from the uncoordinated actions of individual physicians competing in the marketplace (Goodman & Musgrave, 1992, pp. 137, 139). Although it was founded in 1847, the AMA did not attain real strength until it delegated regional control by organizing its members into county and state medical societies. It first consolidated its power by controlling medical education. The AMA also vigorously pursued its objectives by supporting states in the establishment of medical licensing laws that made it illegal to practice medicine without a state-issued license.

In the postindustrial era, employment of physicians by hospitals and insurance companies was frowned upon. Physicians who attempted to seek salaried employment in a corporate setting were chastised by the medical profession and pressured into abandoning such practices. Independence from corporate control promoted private entrepreneurship and put American physicians in an enviable strategic position in relation to organizations such as hospitals and insurance companies.

Thanks to the AMA's concerted activities, physicians' incomes grew dramatically, and the supremacy of the profession was fully realized. The sphere of physicians' influence expanded into nearly all aspects of health care delivery. For example, laws were passed that prohibited individuals from obtaining certain classes of drugs without a physician's prescription. In addition, health insurance paid for treatments only when they were rendered or prescribed by physicians.

## Educational Reform

Advances in medical science necessitated the reform of medical education, which started around 1870 when medical schools began affiliating with universities. In 1871, Harvard Medical School completely revolutionized the system of medical education. The academic year was extended from 4 to 9 months, and the length of medical education was increased from 2 to 3 years. Following the European model, laboratory instruction and clinical courses such as chemistry, physiology, anatomy, and pathology were added to the curriculum.

Johns Hopkins University took the lead in further reforming medical education when it opened its medical school in Baltimore, Maryland, in 1893. For the first time, medical education became a graduate training program requiring a college degree—not a high school diploma—as an entrance requirement. Johns Hopkins also pioneered the practice of complementing classroom education with residency training in its own teaching hospital. Standards at Johns Hopkins became the model of medical education in other leading institutions around the country. Even so, in the early 1900s, fewer than half of the medical schools provided acceptable levels of training.

In 1910, a widely acclaimed report was published by Abraham Flexner under the auspices of the Carnegie Foundation for the Advancement of Teaching. The *Flexner Report*, as it came to be known, was based on an inspection of medical schools. It found widespread inconsistencies in medical education. By this time, the AMA had gained a firm foothold in medical training by creating the Council on Medical Education. It pushed for state laws that required graduation from a medical school accredited by the AMA as the basis for a license to practice medicine

(Haglund & Dowling, 1993). Educational standards were formalized, and schools that did not meet the proposed standards were forced to close.

As a note of interest, Howard University School of Medicine (1869) and the Meharry Medical College (1876) were established at the end of the American Civil War specifically to prepare black physicians to practice medicine.

## Development of Hospitals

As had already occurred in Europe, the growth of hospitals in the United States came to symbolize the institutionalization of health care (Torrens, 1993). The hospital became the center around which other medical services were organized.

Advancements in medical science created the need to centralize expensive facilities and equipment in a medical institution, reflecting the reality that physicians could no longer afford to have the needed equipment and facilities in their own offices. The hospital became the center for advanced technology used in medical diagnosis and treatment and for the training of various types of health care personnel. The expansion of surgery also became centered in the hospital. Alongside these developments came remarkable progress in sanitation practices. The professionalization of nursing promoted healing and improved patient recovery. As a result of these changes, the growing appeal of hospital services in communities, sick patients' increasing need for hospital care, and the increasing professionalization of medical practice became closely intertwined. Physicians began to play a dominant role in hospital affairs, even though they were not employees of the hospitals. Employment of physicians as hospitalists is a recent phenomenon.

## Reform of Mental Health Care

At the turn of the 20th century, federal policy in the United States promoted education and research in psychiatry. By the 1960s, the concept of community mental health was born, and deinstitutionalization became a major thrust of mental health reform. This trend coincided with not only a better understanding of mental health, but also the availability of new drug therapies. Thus, the core of mental health care shifted from mental asylums to community-based mental health services. The deinstitutionalization movement further intensified after the U.S. Supreme Court's 1999 decision in *Olmstead v. L.C.*, which directed the states to provide community-based services, wherever appropriate, to people with mental illness. Today, mental institutions deliver services mainly for those with severe and persistent mental illness (Patrick et al., 2006).

# History of Health Insurance

There are several reasons why private health insurance (also called *voluntary health insurance*) took root and expanded in the United States. Much later, the struggle to meet the medical needs of the elderly and the poor in an environment of rising health care costs prompted the U.S. Congress to create the publicly financed Medicare and Medicaid programs in the 1960s.

## Worker's Compensation

The first broad-coverage health insurance in the United States emerged in the form of worker's compensation. This system was originally designed to make cash payments to workers for wages lost because of job-related injuries and disease. Later, compensation for medical expenses and death benefits for survivors were added.

Between 1910 and 1915, worker's compensation laws made rapid progress in the United States (Stevens, 1971, p. 136). In view of its widespread acceptance, some reformers believed that because Americans had been persuaded to adopt compulsory insurance against industrial accidents, they could also be persuaded to adopt compulsory insurance against sickness. Worker's compensation served as a trial balloon for the idea of government-sponsored health insurance. However, the growth of private health insurance, along with other key factors discussed here, prevented any proposals for a national health care program from taking hold in the United States.

## Emergence and Rise of Private Health Insurance

During the early 1900s, medical treatments and hospital care became a more entrenched part of American life. At the same time, they became increasingly more expensive. Because people could not predict their future needs for medical care or its costs, some kind of insurance was needed to spread an individual's financial risk over a large number of people. Between 1916 and 1918, 16 state legislatures, including those in New York and California, attempted to enact legislation compelling employers to provide health insurance, but their efforts were unsuccessful (Davis, 1996).

## First Hospital Plan and the Birth of Blue Cross

The dire economic conditions of the Great Depression set the stage for innovation in health insurance to cover hospitalization costs. On the one hand, hospitals were vulnerable to economic instability when they relied too much on philanthropic donations. On the other hand, individual patients faced not only loss of income from illness but also burdensome debt from medical care costs when they needed hospitalization.

In 1929, the blueprint for modern health insurance was conceived when Justin F. Kimball began a hospital insurance plan for teachers at Baylor University Hospital in Dallas, Texas. Within a few years, it became the model for Blue Cross plans around the country (Raffel, 1980, p. 394). At first, other independent hospitals copied Baylor and started to offer single-hospital plans. Within a few years, plans sponsored by groups of hospitals became more popular because they offered consumers a choice of hospitals. The American Hospital Association supported these hospital plans and became the coordinating agency that united the plans into the Blue Cross network. The Blue Cross plans were nonprofit; that is, they had no shareholders to receive profit distributions. Later, control of the plans was transferred to a completely independent body, the Blue Cross Commission, which subsequently became the Blue Cross Association (Raffel, 1980, p. 395).

Hospital insurance quickly grew in popularity. In 1946, Blue Cross plans in 43 states served 20 million members. Within a few years, lured by the success of the Blue Cross plans, commercial insurance companies also started offering hospital insurance. Between 1940 and 1950 alone, the proportion of the U.S. population covered by hospital insurance increased from 9% to 57% (Anderson, 1990, p. 128). Private health insurance had received the AMA's endorsement, but the AMA had also made it clear that health insurance plans should include only hospital care, not physicians' fees.

## First Physician Plan and the Birth of Blue Shield

In 1939, the California Medical Association started the first Blue Shield plan, which was designed to pay physicians' fees. By endorsing hospital insurance and by actively developing the first plans that covered physicians' services, the medical profession protected its own financial interests. The AMA ensured that private health insurance would be preserved, and the organization remained adamantly opposed to government-run national health insurance.

Starting in 1974, Blue Cross and Blue Shield plans began to merge. Now, in nearly every state, Blue Cross and Blue Shield plans are joint corporations or have close working relationships (Davis, 1996).

## Employment-Based Health Insurance

Three main factors explain how health insurance in the United States became employer based:

- During the World War II period, the U.S. Congress imposed wage freezes in an attempt to control wartime inflation. In response, many employers started offering health insurance to their workers to compensate for the loss of raises in their salaries.

- In 1948, the U.S. Supreme Court ruled that employee benefits were a legitimate part of union–management negotiations. Health insurance, in turn, became an important component of collective bargaining between unions and employers.
- In 1954, Congress amended the Internal Revenue Code to make employer-paid health coverage nontaxable. In economic value, employer-paid health insurance was equivalent to getting additional salary without having to pay taxes on it, which provided an incentive to obtain health insurance as an employer-furnished benefit.

In subsequent years, employment-based health insurance expanded rapidly, and private health insurance became the primary vehicle for the delivery of health care services in the United States.

## Failure of National Health Insurance in the United States

Industrialization of Western Europe meant that a large segment of the populations worked as hired laborers, in countries such as England, and later in Germany. Unification of Germany under Otto von Bismarck led to rapid industrialization, but labor unrest threatened political stability. Universal health insurance for all citizens was seen as a means to obtain workers' loyalty and thwart any labor uprisings.

By 1912, national health insurance had spread throughout Europe, but political conditions in the United States were quite different. Unlike the situation in European countries, the American government was highly decentralized and engaged in little direct regulation of social welfare. Despite this fact, Theodore Roosevelt ran for the U.S. presidency in 1912 on a platform of social reform—and, perhaps not surprisingly, was defeated by Woodrow Wilson. Even so, the Progressive movement favoring national health insurance remained alive for several more years.

The entry of the United States into World War I in 1917 dealt a political blow to the national health care movement, as anti-German feelings were aroused and the U.S. government denounced German social insurance. Opponents of national health care disparaged it as a Prussian menace that was inconsistent with American values (Starr, 1982, pp. 240, 253). Any subsequent attempts to introduce national health insurance were met with the stigmatizing label of *socialized medicine*—a term that has since become synonymous with any large-scale government-sponsored expansion of health insurance. The traditional American values based on capitalism, self-determination, distrust of big government, and reliance on the private sector to address social concerns stood as a bulwark against broad-based government interventions. Conversely, during times of national distress, such as the Great Depression, pure necessity may have legitimized the advancement of social programs, such as Social Security and unemployment compensation.

The AMA played a leading role in opposing national health care, seeing it as a potential threat to the private practice of medicine. For example, the AMA was instrumental in the demise of several bills related to national health insurance that were introduced in Congress in the early 1940s during Franklin Roosevelt's presidency. In 1946, Harry Truman became the first president to make a direct appeal for a national health care program (Anderson, 1990, p. 119). Initial public reaction to Truman's plan was positive, but when a government-controlled medical plan was compared with privately obtained insurance, polls showed a drastic decline in public support. The AMA was once again vehement in denouncing the plan. Other powerful health care interest groups, such as the American Hospital Association, also opposed the proposal. In 1948, Truman was reelected while promising national health insurance, which actually came as a surprise to many political observers. This time, the AMA launched what was to become one of the most expensive lobbying efforts in U.S. history. Its campaign directly linked national health insurance with communism until the idea of socialized medicine was firmly implanted in the public's minds. By 1950, national health insurance was a dead issue, and it remained so for several decades.

In 1993, President Bill Clinton made national health insurance one of his top priorities, but his proposal was largely rejected by the American people. Defeat of the Clinton plan furnished another lesson on the power of beliefs and values prevalent in the United States. As a matter of principle, Americans have endorsed tax-supported health insurance to help needy citizens, but they also have been unwilling to pay, in the form of higher taxes, for what a universal health insurance program could realistically cost. Moreover, Americans have been uneasy about more government regulation and interference with employment-based private health insurance. **EXHIBIT 3.5** provides a summary of the main historical reasons for the failure of national health insurance in the United States.

## Creation of Medicare and Medicaid

Before 1965, private health insurance was the only widely available source of payment for health care, and it was available primarily to middle-class working people and their families. The elderly, the unemployed, and the poor had to rely on their own resources, on limited public programs, or on charity from hospitals, clinics, and individual physicians.

The earlier debates over national health insurance had made one thing clear: Most Americans did not desire government intervention in how they received health care, with one exception—they would be less opposed to reform initiatives for the underprivileged classes. In principle, the poor were considered a special class who could be served through a government-sponsored program. The elderly—those

**EXHIBIT 3.5** Reasons Why National Health Insurance Has Historically Failed in the United States

- Unlike in Europe, national health care failed to get an early footing because of labor and political instability in the United States.
- The decentralized American system gave the U.S. federal government little direct control over social policy.
- The German social insurance system was denounced during World War I. Since then, the term "socialized medicine" has been used as a synonym for "national health insurance."
- The AMA opposed national health care initiatives.
- Middle-class Americans have traditionally espoused beliefs and values that are consistent with capitalism, self-determination, and distrust of big government.
- Middle-class Americans have been averse to higher taxes to pay for the increased cost of a national health care program.

65 years of age and older—were another group that started to receive increased attention in the 1950s. On their own, most of the poor and the elderly could not afford the increasing cost of health care. Also, because the health status of these population groups was significantly worse than that of the general population, their medical needs were more critical. The elderly, in particular, had a higher incidence and prevalence of disease than did younger age groups. Despite their greater need for health care, fewer than half of all elderly persons were covered by private health insurance. Even if they could afford it, many of them were unable to obtain private health insurance because of their poor health status. At the same time, the growing elderly middle class was becoming a politically active force.

A bill introduced in Congress by Aime Forand in 1957 started the momentum for including necessary hospital and nursing home care as an extension of Social Security benefits (Stevens, 1971, p. 434). The AMA, however, undertook a massive campaign to portray a government-run plan as a threat to the physician–patient relationship. The bill stalled initially, but public hearings around the country, which were packed by the elderly, produced an intense grassroots support to push the issue onto the national agenda (Starr, 1982, p. 368). Compromise legislation, the Medical Assistance Act, also known as the Kerr-Mills Act, was passed and went into effect in 1960. Under this act, federal grants were given to the states so they could extend health services under their welfare programs to low-income elderly persons. However, enrolling the elderly in a welfare program became controversial, as liberal congressional representatives voiced their opposition by claiming that it was a source of humiliation to the elderly (Starr, 1982, p. 369). Within 3 years, the program was declared ineffective because many states did not even implement it (Stevens, 1971, p. 438).

In 1964, health insurance for the aged and the poor became a top priority of President Lyndon Johnson's Great Society programs. Eventually, Congress approved a three-part program that provided publicly financed health insurance to all elderly individuals, regardless of their incomes. Part A and Part B of Medicare (also known as *Title 18* of the Social Security Act of 1965) became the first two layers. *Part A* of Medicare was designed to use Social Security funds to finance hospital insurance and short-term nursing home coverage after discharge from a hospital. *Part B* of Medicare was designed to cover physicians' bills through government-subsidized insurance, for which the elderly would pay a small portion of the premiums. The *Medicaid* program (*Title 19* of the Social Security Act of 1965) was the third layer. It covered the eligible poor and was based on the earlier Kerr-Mills Act program. It would be financed through federal matching funds to the states in accordance with each state's per capita income.

Although adopted together, Medicare and Medicaid reflected sharply different traditions. Medicare enjoyed broad grassroots support and, being attached to Social Security, had no class distinction. Medicaid, in contrast, carried the stigma of public welfare. As a federal program, Medicare had uniform national standards for eligibility and benefits; the state-administered Medicaid programs, however, varied across states in terms of eligibility and benefits. Medicare covered anyone age 65 or older, whereas Medicaid became a *means-tested program*, which confined eligibility to people below a predetermined income level. Consequently, many of the poor did not qualify because their incomes exceeded the means-test limits.

Initially created to cover only the elderly, Medicare was expanded in 1973 to cover two other categories of people: (1) nonelderly disabled people receiving Social Security for at least 24 months and (2) people with end-stage renal disease who needed dialysis or a kidney transplant. In 1997, Medicare added coverage options under *Part C*, and in 2003 a prescription drug benefit (*Part D*) was passed into law. The main distinctions between Medicare and Medicaid are summarized in **EXHIBIT 3.6**.

Soon after their inception, Medicare and Medicaid became instrumental in covering millions of Americans. By 1970, 20.4 million individuals received health care through Medicare and another 17.6 million through Medicaid. The increased coverage, however, came at a high price—namely, unrelenting government regulations and uncontrolled public expenditures.

The Medicare and Medicaid programs are financed by the government, but most beneficiaries receive health care services from private hospitals, physicians, and other providers. As a major payer of health care services, the government has implemented numerous regulations that govern the delivery of services and reimbursement to providers. As a result, the regulatory powers of government have increasingly encroached on the private sector. In 1977, the Health Care Financing

**EXHIBIT 3.6** Comparisons Between Medicare and Medicaid

| Medicare | Medicaid |
|---|---|
| ■ Covers all elderly persons, nonelderly disabled persons on Social Security, and nonelderly persons with end-stage renal disease | ■ Covers only the very poor |
| ■ No income/means test | ■ Income criteria established by states (means test) |
| ■ No class distinction | ■ Public welfare |
| ■ Part A for hospitalization and short-term nursing home stay; Part B for physician and other outpatient services; Part C for managed care; and Part D for prescription drugs | ■ All services are covered under one program |
| ■ Nationally uniform federal program | ■ Program varies from state to state |
| ■ Title 18 of the Social Security Act | ■ Title 19 of the Social Security Act |
| ■ Part A financed through a payroll tax paid by employees, employers, and the self-employed; Part B subsidized through general taxes, but the participants pay part of the premium cost; cost-sharing in Parts C and D | ■ Financed by the states, with matching funds from the federal government according to each state's per capita income |

Administration (now called the Centers for Medicare and Medicaid Services) was created to manage Medicare and Medicaid separately from the Social Security Administration.

The creation of Medicare and Medicaid had a drastic impact on both federal and state budgets, but the federal government bore the brunt of this burden. As shown in **TABLE 3.1**, the U.S. gross domestic product—representing total economic consumption—grew at an average annual rate of 7.6% between 1965 and 1970. By comparison, total state and local government expenditures for health care grew at a rate of 12.5%. In the case of the federal government, however, health care expenditures increased at an average annual rate of 30%. Hence, the federal government bore most of the expenditures for Medicare and Medicaid.

**TABLE 3.1** Average Annual Percent Increase in Gross Domestic Product and Federal and State Expenditures Between 1965 and 1970

| | Total (%) | Health Care (%) |
|---|---|---|
| Gross domestic product | 7.6 | — |
| Federal government expenditures | 11.3 | 30.0 |
| State and local government expenditures | 13.6 | 12.5 |

Data from National Center for Health Statistics. Health, United States, 1995, p. 235.

# Medical Services in the Corporate Era

The latter part of the 20th century and the beginning of the 21st century have been marked by the growth and consolidation of large business corporations and tremendous advances in global communications, transportation, and trade. These developments have changed the way health care is delivered in the United States and, indeed, around the world. The rise of medical corporations, the information revolution, and globalization have been interdependent phenomena.

## Corporatization of Health Care Delivery

Corporatization here refers to the ways in which health care delivery in the United States has become the domain of large organizations. Since the 1990s, managed care has become the primary source for health insurance and the delivery of medical services to the majority of Americans. The emergent managed care organizations (MCOs) wielded their immense purchasing power to obtain health care services at discounted prices and used the strength accorded by their consolidation to implement various types of controls to reduce the rising costs of health care. To counteract this imbalance, providers began to consolidate as well, and larger, integrated health care organizations began forming. Large *integrated delivery systems* (IDSs) can provide a full array of health care services, including hospital inpatient care, surgical services in both inpatient and outpatient settings, primary care and multispecialty outpatient services, home health care, long-term care, and specialized rehabilitation services. Together, MCOs and IDSs have corporatized the delivery of health care in the United States. At the same time, though, they have made the health care system extremely complex.

In a health care landscape increasingly dominated by corporations, individual physicians have struggled to preserve their autonomy. As a matter of survival, many physicians had to consolidate into larger group practices, form strategic partnerships with hospitals, or start their own specialty hospitals. A growing number of physicians have become employees of hospitals and other large medical corporations.

## Information Revolution

The delivery of health care is being transformed in unprecedented and irreversible ways by telecommunications. For example, telemedicine and e-health have been on the rise. *Telemedicine* came to the forefront in the 1990s with technological advances in the distant transmission of image data. This technology has made it possible to provide health care at a distance, such as real-time transmission of video examinations as well as telesurgery. *E-health* refers to health care information and services offered over the Internet by professionals and nonprofessionals alike (Maheu et al., 2001). These services include medical information from reliable sources such as the prestigious National Institutes of Health and the world-renowned Mayo Clinic through their websites, online purchase of health care products, online consultations with physicians, and online interactions with other consumers about health-related matters. The Internet revolution has put more decision-making power into the hands of patients and their surrogates about what they may think is best for them. Access to expert information is no longer strictly confined to the physician's domain, which in some ways has led the patient to be less dependent on health care professionals.

## Globalization

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

From the standpoint of cross-border trade in health services, Mutchnick and colleagues (2005) identified four different modes of economic interrelationships:

- Cross-country telemedicine and outsourcing of certain medical services have been made possible by advanced telecommunications technology. For example, teleradiology (the electronic transmission of radiological images over a distance) enables physicians in the United States to transmit radiological images overseas, where they are

interpreted and reported back either the same or the next day. The radiologists residing overseas are licensed and credentialed in the United States.

- Consumers travel abroad to receive medical care (sometimes referred to as medical tourism). For example, countries such as India and Thailand offer surgeries in state-of-the-art medical facilities to foreigners at a fraction of what it would cost to have the same procedures done in the United States or Europe.
- Foreign direct investment in health services enterprises has become common. For example, Chindex International, a U.S. corporation, provides medical equipment, supplies, and clinical care in China. American providers such as Johns Hopkins Medicine International, the Cleveland Clinic, and Duke University's Global Health Institute support innovation and delivery of quality medical services through collaborative arrangements with other countries.
- Health professionals are choosing to move to other countries that offer high demand for their services and better economic opportunities than their native countries. Migration of physicians from developing countries helps alleviate at least some of the shortage in underserved locations in the developed world. On the downside, the developing world pays a price when emigration leaves these countries with shortages of trained professionals.

## Era of Health Care Reform

*Health care reform* refers to major changes through government policy to expand health insurance to the uninsured. Recent efforts to reform health care were based on government intervention in the financing and delivery of health care. Most notably, the ACA represents the most sweeping reform undertaken since the creation of Medicare and Medicaid in 1965. At the time of the highly controversial ACA's passage, the presidency and the majority membership in both the U.S. House of Representatives and Senate were in the hands of the Democratic Party, and the legislation failed to win a single vote from Republicans. Perhaps surprisingly, the AMA supported the legislation. Since its heyday in political activism, the AMA has become a much weaker organization, supported by only 17% of U.S. doctors (Scherz, 2010).

After the ACA's enactment, more than half of the states and some private parties filed lawsuits challenging the constitutionality of the legislation. In 2012, the U.S. Supreme Court rendered a 5–4 decision, which was split over the two main parts of the ACA. First, the law's mandate requiring all Americans to have health insurance was upheld

as constitutional. In part, the majority opinion read, "The Affordable Care Act's requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax" (Liptak, 2012). Thus, the Court's decision on this issue was based on Congress's power to impose new taxes—in this case, for not having health insurance. In the second part of the Court's decision, it struck down as unconstitutional the federal government's attempt to coerce states into expanding their Medicaid programs by threatening to eliminate federal funding for those states that chose not to expand Medicaid coverage under the ACA (Anderson & Health Policy Institute of Ohio, 2012).

In 2014, in *Burwell v. Hobby Lobby Stores, Inc.*, the U.S. Supreme Court ruled against a controversial ACA requirement that forced certain employers to provide contraceptives that might be deemed to induce abortions. In a 5–4 decision, the Court ruled that in the case of a closely held corporation, the owners of which may have deeply held religious convictions against providing drugs or devices that may destroy an embryo, the ACA violated the Religious Freedom Restoration Act of 1993. Hobby Lobby had claimed that it faced annual fines of $475 million for failure to comply with the ACA (Liptak, 2014). The Court argued that the ACA imposed a substantial burden on religious liberty.

## Health Care Reform in a Flux

Even before the ACA was fully implemented, health policy researchers Nardin and colleagues (2013) had stated:

> Our finding … runs counter to the common perception that the ACA will cover virtually all legal residents. The ACA will leave tens of millions uncovered. It will do little to alter racial disparities in coverage. … The ACA, whatever its merits, will fall well short of its stated goal of providing affordable care for all Americans.

This insight largely proved correct, even though the number of uninsured was markedly reduced under the ACA, particularly among low-income people who became newly eligible for Medicaid[2] and those who became eligible for tax credits to purchase private health insurance through government-established exchanges. Nevertheless, in 2017, health care reform once again became an issue for national debate.

2 Thirty-one states and the District of Columbia expanded their Medicaid programs, as intended under the ACA.

Inability to obtain health insurance and affordability remained thorny issues even after the ACA's implementation. With each passing year, fewer insurers have participated in the exchanges where people can buy private insurance, and the cost of insurance has been rising sharply. In the market for employer-based health insurance, fewer small employers with less than 50 workers were able to offer insurance to their workers. For example, 59% were able to offer health insurance in 2012; by 2017, only 50% could do so (Claxton et al., 2017). The cost of insurance and worker contributions toward that cost have also risen dramatically. For example, between 2012 and 2017, total employment-based health insurance costs rose 19%, whereas worker contributions increased by 32% for family coverage (Claxton et al., 2017).

Despite the issues just pointed out, and promises by politicians to reform the system, the U.S. Congress failed to pass a broad health care reform bill in 2017. However, the Tax Cuts and Jobs Act of 2017, passed and signed into law in December 2017, effectively repealed the mandate in the ACA that required all Americans to have health insurance. The mandate to either have health insurance or pay a tax penalty was one of the main anchors of the ACA, although this provision did not actually promote the expected growth in the purchase of health insurance. The second main anchor of the ACA, requiring employers to offer health insurance to the workers, could not be repealed through the tax law.

At the time of this text's writing, it was unclear how Congress would address the lingering issues with health insurance, in terms of both coverage and cost. With a partially repealed ACA, however, the urgency to address health care reform in 2018 had only intensified.

## Conclusion

In a little more than 100 years, health care delivery has come a long way in the United States, evolving from a primitive and family-oriented craft to a technology-driven service and the largest industry in the country. In the process, many medical procedures and services have become increasingly unaffordable. Both private and public health insurance have become firmly entrenched mechanisms to pay for costly health care. Medicare, Medicaid, and other public programs, however, cover only those individuals who meet established criteria for eligibility. Efforts to create a national health insurance program have repeatedly failed.

The late 20th century and early 21st century have been characterized as the corporate era in the delivery of medical care. Corporatization has put the delivery of health care into the hands of large managed care and integrated health care organizations, and it has turned the delivery of

medical care into a complex enterprise. The information revolution has created advanced telecommunication technologies, whose application in medical care has made the distant delivery of certain health care services possible. E-health has given consumers access to health care information over the Internet. Globalization has added a worldwide dimension to the delivery of medical care through telemedicine, outsourcing, and foreign direct investment in health care delivery.

An era of health care reform was inaugurated in the United States with the passage of the Affordable Care Act in 2010. However, contrary to the promises made by its supporters, the law failed to provide affordable coverage to millions of Americans, although it did significantly reduce the number of uninsured. One major anchor of the ACA—the mandate to have health insurance or pay a penalty tax—was repealed under the Tax Cuts and Jobs Act of 2017. In contrast, nagging concerns regarding coverage and costs have not been resolved and remain in a state of flux.

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