

# Medical Care in the USA—1932-1972.

## Problems, Proposals and Programs

### *from the Committee on the Costs of Medical Care to the Committee for National Health Insurance*

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*Current interest in the development of a national health insurance in the United States invites a clear determination of objectives through identification of the problems to be resolved by a new program and an understanding of how these problems came about and why. Historical review of the background and the evolution of the current medical care scene provides perspective. Critical review may also contribute to better design of what should be intended by new undertakings and to utilization of lessons from the past in order that the specifications should minimize mistakes for the future.*

*Here, therefore, is a review of major events and the lessons they taught (or should have taught), from the Final Report of the Committee on the Costs of Medical Care (1932) to Medicare and Medicaid (1965) and their early operational years through 1972. It is a personal review but by an author who was privileged to be a participant in many of the studies and legislative campaigns as well as a continuous observer of the evolving scene.*

*This historical review was planned as prologue to a course of action. The author therefore comments on various current legislative proposals and indicates why he and others advocate the Health Security Bill — principally because its scope embraces not only the financing of comprehensive personal health services for the whole population but, equally and simultaneously, the improvement of the medical care system as well.*

*This review and the presentation of a rationale for action are timely, since diverse and conflicting proposals are now engaging national attention and are being debated in the Congress.*

## Introduction: The CCMC Final Report and Its Recommendations

Forty years have elapsed since November 1932 when the Committee on the Costs of Medical Care (CCMC) published its Final Report "Medical Care for the American People,"<sup>1</sup> the result of the first

<sup>1</sup>"Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care." Committee Publication No. 28, Adopted October 31, 1932. University of Chicago Press, 1932, 213 pp. Long out-of-print and not readily available, it was reprinted by the Community Health Service, HSMHA, Public Health Service, U.S. Department of Health, Education, and Welfare, with a Foreword by John W. Cashman and a Preface by I. S. Falk, GPO, Washington, D.C., 1970.

general national review, assessment and planning for medical care in the United States. This report has certainly changed perspectives — and in some measure it has also altered the course and the pace of evolution — for health services in the United States. It serves as a useful benchmark from which we can initiate a topical review of past happenings in terms of future events. Another reason for the current utility of this Report is, as you will see upon closer investigation, that many of its analyses and all of its major recommendations are still pertinent today. Indeed, I suggest that the guidelines in its chapter on “The Essentials of a Satisfactory Medical Program” and the vision of its chapter “An Ultimate Objective in the Organization of Medicine” are viable.

It is important to be aware that the CCMC was a self-constituted private organization. About 50 persons from various disciplines concerned with public health and medical care organized themselves in 1927 into a committee “to study the economic aspects of the care and prevention of illness.” They were concerned that the rapidly developing health services and medical care of the time were already showing strains from increasing unavailability and inadequacy. Even more important, they perceived serious threats for the future of medical care in the United States from a worsening outlook in the 1920s:

1. An expanding technology would bring more specialization and, in turn, more fractionation of medical care services.
2. The prospective supply of physicians and other health manpower was of uncertain adequacy.
3. Heightening financial barriers and enlarging burdens from the rising costs of medical care would entail widespread distress.
4. The already evident need for better organization of services and for better assurance of quality in care would become more difficult to resolve.

With support from eight private foundations, the Committee undertook — through its own staff and jointly with many collaborating agencies — a broad series of studies over a 5-year period. It produced a veritable library on the medical care circumstances and

problems of its times, and it developed perspectives for so much of the future as it could discern.

The organization of the CCMC and the program to which it committed itself reflected a deep-seated confidence that concerted study, analysis, and reflection on the part of knowledgeable and concerned people could result in a program useful for dealing with problems that called for societal resolution.

The Committee's staff and collaborators' studies were well received by the Committee members and by many groups in the nation, but the Committee, itself, could not achieve unanimity on recommendations. The schismatic outcome — as we shall see — was prologue for many of the major problems and issues that were to dominate the medical scene for decades ahead and indeed for today. Disregarding the details and the supporting explanations, the Committee's Majority Report made five basic recommendations. Three were concerned with the strengthening of public health services, of coordination among all health services, and of health manpower education and training. Keep in mind that this was late 1932 when medical care was almost totally in the hands of "solo" practicing physicians compensated by fee-for-service and when there was very little private health insurance. Two other recommendations, equally important for the future of medical care, therefore deserve fuller mention:

Comprehensive medical care should be provided largely by organized groups of practitioners, organized regionally and preferably around hospitals, encouraging high standards and preserving personal relations; and

Medical care costs should be placed on a group payment basis, whether through insurance, taxation, or both; and payment through individual fee-for-service should continue to be available for those who prefer it.

These two, spelled out in considerable detail in the Report, taken together constituted basic recommendations for comprehensive group practice linked with comprehensive prepayment. On these two, the Committee divided despite the fact that most of the members who endorsed them favored voluntary as against legally compulsory organizational developments and insurance.

The principal (First) Minority Report, though in general

accord on the other recommendations, took sharp issue with the recommendations for encouragement of group practice and of group payment. Instead, it recommended continuance of the solo practice of the times and the trial of payment methods that would fit into the then current professional institutions and practices.

The discussions immediately became sharp and indeed acrimonious, mainly because the principal Minority Report was formally endorsed by the American Medical Association with especially vigorous condemnation of the proposals for group practice and for group payment. Thus, the professional leadership of that time turned away from what might have been a high road. This fateful decision and schismatic outcome — from which the nation has not yet escaped or recovered — was all the more disappointing because at that time there was no adequate or even substantial counter-vailing force in our society.

Two conclusions were soon evident from the CCMC experience:

Objective technical studies of the medical care problems and voluntarism in the development of a constructive course of action had failed.

The leadership of America's "organized medicine" had committed the profession to preservation of the inherited and then prevailing system of medical care, based on solo practice and fee-for-service payment, and to the continuing professional domination and control of the system, deaf to appeals from other professional disciplines and from spokesmen for the consumers of medical care, and blind to the needs for better design of organization and for more adequate methods of payment.

## CCMC to Medicare: 1932-1965

An influential editorial spokesman for the American Medical Association had consigned the CCMC Final Report to "innocuous desuetude," but unfortunate developments in the national economy almost immediately defeated his cavalier counsel. Instead, the Report was destined to provide guidelines for major efforts and undertakings in the years immediately ahead; and many who had participated in the CCMC effort and many more who subscribed to the Majority Report's objectives were to be actors on the prospective scenes.

## *The Social Security Act, 1935*

The CCMC had come into being over problems that were already plaguing medical care even in the affluent society of the mid-1920s and that many thought could be resolved before they became more acute. When the Committee began its studies in 1927, our national economy was climbing toward a high peak of prosperity. Five years later, near the end of 1932, when the Committee completed its Final Report, we were plunging toward the depths of an economic depression — a depression so severe that tens of millions were being deprived of all the necessities of life, including medical care, and drastic measures to meet essential wants had to be taken at once. Since private resources and local and state governments were not equal to the task, *national* governmental emergency interventions provided funds for the support of people in need, for relief of destitution and for work relief, to pay for jobs through public works, and for medical care services. And by mid-1934, President Roosevelt had initiated under a (Cabinet) Committee on Economic Security the studies which were to lead in the following year to Congressional consideration of proposals for a long-term social security program to supersede the emergency measures. The risks arising out of sickness were embraced within those explorations, but owing to widespread and intemperate objections from medical leaders and medical societies and to fears and timidities at high political levels, the recommendations which had been developed for health care benefits were not even submitted to the Congress for inclusion in what became the Social Security Act of 1935. This is the episode which various recent writers have termed “the missed opportunity” and “the lost reform.”

The outcome, however, was by no means all negative. The exclusion of medical care benefits from the original Social Security Act had demanded some compromises in the Congressional committees. As a result, we got the enactment of Title V (establishing the maternal and child health and welfare and the crippled children’s programs) and of Title VI (providing the first permanent authorization for public health grants-in-aid to the states and for funds to support intramural research in the Public Health Service), and the retention of language in Title VII which was to serve as authorization for continuing national study and program development on medical care. Two important consequences flowed from these enactments:

Public health, including medical care, had long been primarily the concern of state and local governments and of voluntary (private) agencies and institutions; but now the locus for the major planning and development of public health and of the system of medical care *had moved to Washington*.

The needs with respect to medical care, which had long been left almost totally to private individuals and institutions controlled or dominated by the medical care professions, had now begun to involve the non-professional sectors of society and the active participation of the *national* government.

We shall see that, through a long and troubled history, these developments would lead to the present scene and to what is ahead.

*National Health Conference (1938)  
and the First Wagner Bill (1939)*

The years immediately following the Social Security enactment (1935) were lively with many proposals and developments for medical care. Extensive national health surveys performed by the Public Health Service under the direction of Dr. Joseph Mountin and Mr. George Perrott confirmed in 1935–1936 the worsening situation. A national health program, embracing public health and medical care, was formulated by a (Federal) Interdepartmental Committee and served as the agenda for a (first) National Health Conference in 1938. Its mild proposals for evolutionary developments, mainly through federal grants-in-aid to the states, won wide spread support at that Conference from spokesmen for nearly all major sectors of society, but not from “organized medicine.” Further moderated proposals were then embodied in the first Congressional bill for a “national health program,” S. 1620 of 1939, introduced by Senator Wagner of New York; and extensive hearings on it were held in the Senate under the chairmanship of Senator Murray of Montana. But the AMA adhered to the positions it had taken with respect to the CCMC Final Report, and its constituent state societies supported the national posture. The controversy between “organized medicine” and many major interests in our society became intensified, and a dichotomy of national proportions began to take shape.

A Congressional Committee Report, 1939, promised further study but there was no legislative enactment.<sup>2</sup>

### *1939 to Post-World War II*

This chapter of defeats at the national level in 1935–1939 led in the next few years to an important change of perspective in the design of a national health insurance among those who doubted the potential of the medical profession and of the rapidly growing private health insurance, severally or together, to deal with needs that were either already current or were clearly emerging. In the view of these doubters, nothing of constructive value had been achieved by the moderation they had practiced in their first design of a national health program. They had adhered to the commitment for an evolutionary course. They had proposed reliance on modest federal grants-in-aid to the several states for elective program developments for medical care of such kind and scope as the several states might choose. It was now evident that those precepts had achieved nothing in avoiding differences or attaining consensus toward a program with national promise. The opposition of “organized medicine” had not been avoided or even weakened; perhaps, on the contrary, the milder the proposals the stronger had become the opposition — and, at the same time, the weaker the support from others who thought that proposals which promised achievements more expeditiously were needed.

Also, in this period from 1939 into and through the years of World War II and beyond, perspectives for national action on medical care were being influenced by observation of operations under the Social Security Act and related programs. The newer federal-state programs (public assistance, unemployment compensation, and public health) were developing fitfully, unevenly among the states, and poorly; while, at the same time, the completely national program of old age and survivors insurance was over its developmental humps and was operating effectively and efficiently throughout the nation. Consequently, those advocating a national

<sup>2</sup> A national health insurance of delimited coverage had been proposed by Representative Treadway of Massachusetts in 1938; but it had received no further Congressional attention. Also, Senator Capper of Kansas persisted in offering Federal grant-in-aid bills for state health insurance systems in 1939, 1940 and 1941; but they generated no major support or enthusiasm and did not influence the further course of events.

health program began to proceed on the acceptance of two newly learned lessons:

The elements of a national health program whose functional performances depended on state and local agencies or facilities (community-wide public health, maternal and child health, crippled children's services, health manpower education and training, operation of hospital services and other facilities, environmental and sanitary protections, etc.) should continue to be advocated through federal-state grants-in-aid, with wide options retained for the several states.

Personal health services, as broad and comprehensive as feasible, should be made available through the national social insurance system, with the services to be furnished by private personal and institutional providers but with financing through taxes earmarked for the system's trust funds.

These lessons were reflected in legislative proposals which began to take shape in 1942. Ever since then, the discussion, debates, legislative enactments and nonenactments have proceeded according as sufficient consensus was reached or failed of attainment along these guidelines. There was then a long succession of bills proposing comprehensive national health insurance in the national social security pattern, to provide comprehensive health and medical care benefits for persons covered by the social insurance system — with buy-in provisions for eligibles under state welfare programs and with election by the states to participate as administrative agents of a national health insurance agency. These were the Wagner-Murray-Dingell bills which began in 1943 and which, in their early years, were acceptable to President Roosevelt and were strongly supported by President Truman beginning with his National Health Program Message of November 9, 1945, to Congress and his subsequent health messages in 1947 and 1949. This succession of bills stretched on to 1957, and they were the main focal points for about 15 years of debate, Congressional hearings and controversy—but not enactments.<sup>3</sup>

In this period, the grant-in-aid categorical health programs initiated with the Social Security Act of 1935 had been growing and functioning — even if always smaller and more inadequate than demanded by the national needs. The Hospital Survey and Construction (Hill-Burton) Act was enacted in 1946; and soon there-



after came the beginning of Federal health manpower supports. It is worth noting that, at this point, every major *categorical* health service element proposed first in the CCMC Final Report, 1932, and subsequently in the National Health Program, 1938, had been undertaken, albeit with longer gestation, with more severe birthpains and with higher frequency of stillbirths and underweights than wiser or more effective obstetrics might have yielded.

However, the proposal for the availability of the *personal health services* through social insurance was destined to be sterile for many years after World War II — indeed, until the enactment of Medicare in 1965. But those were not quiet years. Legislative proposals were before the Congress every year; and controversies raged, year in and year out, continuously, principally over two major issues: *comprehensive group payment*, to be implemented through the *public* sector; and *improvement in the delivery of medical care*, especially through increase in personnel resources and through the development of group practice for comprehensive care, to be provided within the *private* sector.

The legislative course did not, however, flow in a single stream; rather, it was determined by the confluence of many streams, reflecting diverse developments in our society generally. Throughout the years in which “organized medicine” played a dominant professional role, other professional disciplines — including those embraced within the multiple fields of the American Public Health Association — became restless about their impotence; and then they found ways to enter the arena. Also, the impasse in developing rational, adequate and acceptable nation-wide provisions for the availability of the personal health services precipitated increasingly acute needs and demands for the medical care of the poor, the near-poor and other disadvantaged groups. At the same time, failure to deal adequately

<sup>3</sup>It might be noted that an effort to avoid AMA opposition had been made much earlier by President Roosevelt in his Budget Message of January 1942, and then in 1942-1945 by Representative Eliot of Massachusetts and by Senator Green of Rhode Island, through the device of limiting the benefits to national hospitalization insurance and omitting physician and other services. But this approach had failed both because the hospital associations were still firmly wedded to Blue Cross and the insurance companies, and the AMA—fearing that even a limited national enactment would mean that the camel was getting his nose into the tent—would not withhold its fire despite the limited scope of the proposed benefits.

with the problems of individual and family medical care costs left a vacuum into which commercial and quasicommercial groups rushed. All this while the technology of medicine was continuing to grow, to encourage specialization and to precipitate complexity at unprecedented rates and while the organization of medical care kept falling further and further behind the potential for its availability and delivery. These diverse but related developments began to have large impacts on the legislative proposals for medical care and on their receptions in the Congress.

### *APHA and the Medical Care Section, 1926–1948*

There is, of course, a special interest in what was happening in the American Public Health Association (APHA). During the years to which I have been referring, the APHA had not been indifferent to developments on the national scene. The first effective challenge that the APHA become concerned with the personal health services had been posed by Professor C.E.A. Winslow of Yale in his presidential address, 1926 (*American Journal of Public Health*, 1926: 1075-1085). Soon thereafter, APHA leaders were active in the CCMC (1927-1932), and then they helped in the design and development of the health program proposals for the Social Security Act (1934-1935). After some of those proposals failed of enactment, the Association strongly supported the National Health Program of the 1938 Conference (*American Journal of Public Health*, 1938: 1441, 1442) and testified to that effect at Senate hearings on the Wagner bill, 1939.

Through the late 1920s and throughout the 1930s, the Association's Committee on Administrative Practice (CAP) had been of divided opinions about the APHA's concern with medical care. But in 1940-1943, it began to be ready for the Association to face the need for a decision with respect to the place of the personal health services in the spectrum of public health from which they had been largely excluded throughout the Association's history.

In 1944, the CAP established, under the Chairmanship of Dr. Joseph W. Mountin, PHS, a Subcommittee on Medical Care with broad and flexible terms of reference, and thereafter supported the Subcommittee's program of studies and its formulations of an Association policy for program action with respect to medical care (*American Journal of Public Health*, 1944a: 984-988). First the

CAP and then the Association's Governing Council took a formally supporting stand on the Subcommittee's recommendations of policy in October 1944 (American Journal of Public Health, 1944b: 1252-1256). Intensive discussions and debates over the next four years culminated in historic action on November 10, 1948, when the Governing Council of the Association by a vote of 55 to 16 approved a petition to establish the Medical Care Section (Visel tear, 1972).

On that day, the APHA embraced medical care as within the spectrum of public health concern. This marked the end of an artefactual dichotomy which long had divided the community-wide from the personal health services generally and which had permitted the vested interest of private medical practice, mainly fee-for-service "solo" practice, to restrain and restrict progress toward national health.

### *Other Simultaneous Developments, 1935–1949*

We should take note of at least four other important simultaneous developments in the years to which I have been referring, each stemming from or affected by — in greater or lesser measure — the disputed Final Report of the CCMC and from the enactments in the original Social Security Act.

1. *The categorical health programs*, to which I have already referred and which had been established on a firm and continuing basis through the Social Security Act of 1935, were carrying on — general public health, including grants to the states and some initial support for intramural research in the Public Health Service, and the Maternal and Child Health and Welfare and Crippled Children programs. The emerging needs of the public health program engendered subcategorical programs for cancer, heart disease, etc.; and these were rounded out immediately after World War II by Federal support for facilities construction and equipment through the Hill-Burton Act, 1946. But the reach of each of these programs remained within its category, each of the categories functioning within the inherited separate "systems" of public health and medical care, and the Federal fiscal commitments growing apace.

2. *Bio-medical research*, for which a minuscule but durable authorization was made through Title VI of the Social Security Act, then burgeoned as the long-established and distinguished USPHS Hygi-

enic Laboratory became the National Institute of Health (NIH) which had been authorized by the Ramsdell Act of 1930. As the Federal fiscal supports in the health and medical field multiplied a hundred fold (from a few millions to over a billion) and invited other governmental and private commitments, the resources for research, development and evaluations expanded, and vast technological progress resulted — with great augmentation in the potential of medical care. Expanding knowledge of that progress led to widespread increase in public expectations. But, almost inevitably, there also came some disappointments in the public and in the Congress about actual applications of newer knowledge and skill in the delivery of care, raising the traditional conflict as to emphasis between basic and applied research. In some measure, this reflected a consequence of the considerable separateness of the NIH from other branches of the Public Health Service. In greater measure, it resulted from the aloofness of the extramural research institutions, mainly the medical schools, from the prevailing patterns in the delivery of medical care and from the studied indifference of the medical education system to the preparation of the health manpower needed for more adequate availability of the care wanted by the public. Some of these consequences were to be remedied after 1965 by the programs for Community Health Services, Partnership for Health, Regional Medical Programs, Planning for Health, etc.; but the problems of categorical scatter, program overlaps and needs for coordination were destined to persist.

3. *The public assistance programs*, involving aid for the aged, the blind and the families with dependent children, had provided open-end Federal grants to the states to share in money payments for subsistence, but had made no allowance initially for the special financial needs of medical care. The inadequacy of the original tight provisions for unrestricted money payments to individuals bred its own remedies, even if very slowly: first by permitting special “averaging” of medical care costs; then by providing special global financing for these costs; and, finally, by allowing the states to use the Federal funds in (ungraciously-named) “vendor payments” for medical care. But these relaxations did not come to grips with the basic inadequacies in making medical care available to the indigent, and they did even less for the medical care needs of the larger numbers who were medically indigent. As indignation mounted,

“organized medicine” and the insurance industry began to be troubled that need to assure medical care for the poor and the near-poor was generating support for proposals toward a medical care program for everybody. Frightened by these signs, even opponents of a general population-wide program of national health insurance or of any further governmental interventions began to endorse and to advocate better Federal and state provisions for the indigent and the medically indigent, and especially for the aged.

4. *Private insurance* of medical care costs was growing rapidly. The failure to provide medical care benefits under the Social Security Act of 1935, and the defeat of Federal grant-in-aid medical care programs through the states under the Wagner bill of 1939, had left the need for insurance against the costs of medical care to the enterprise of private insurance. At that time, about 10 million persons in a population of about 130 million had some private health insurance coverage. Then, an expanding war-time economy, labor-force and civilian health manpower shortages, and need to control prices and profits began to have large impacts on the economics of medical care. Wages and salaries were substantially “frozen” but not fringe benefits. As a result, the provision of private health insurance through the employment contract had a phenomenal growth (from about 10 million in 1939 and 12 million in 1940 to about 32 million in 1945), especially because employer expenditures for health insurance were accepted as a business operation cost, tax exempt to the insured, and thus subsidized by the U.S. Treasury.

This growth seemed to vindicate the views of those who had been arguing for a decade or longer that the financing problems of medical care would be solved if “government” would stay out of the picture and leave the field to the private sector and to the dynamics of the marketplace. And this rapid growth of private insurance in war-time was destined to continue long after the end of the war, principally through employment-based group insurance contracts and otherwise through vigorously sold individual insurance policies. However, the limited potential of private insurance for solving the financing problems that had become chronic and its almost unlimited potential for creating newer problems were already becoming evident. Nevertheless, the massive growth of Blue Cross, Blue Shield and the indemnity contracts of the commercial insurance companies

fitted the fiscal needs of the hospitals and of the physicians and other personal providers of medical care within the patterns of the prevailing medical care system. Indeed, private health insurance rapidly became a financial bulwark for that system, even though the underwriting policies invited or required distortions in many practices of the providers to fit the terms of the insurance contracts and the convenience of the insurance carriers. The providers continued to be comfortable with the prevailing patterns for the availability and provision of medical care and for its financing; and the health insurance industry flourished.

The comfort enjoyed by the medical care providers and the insurance industry did not, however, extend to the insured. Dissatisfactions with private health insurance began to become widespread, especially because it was not comprehensive enough and because it did not reach many who were poor, near poor or out of the active labor force. The ineffectiveness of the insurance protection would become a major issue later; the inadequacy of the population coverage and the rising costs of the insurance began to raise a clamor sooner. There was, therefore, an interlude in which conservative leadership in the Senate, led by Senator Robert A. Taft of Ohio, undertook to divert the legislative course away from national health insurance by using public funds to moderate deficiencies in the reach of private insurance. He proposed support (through Federal grants-in-aid to the states) for subsidized state voluntary insurance plans for persons who could not pay the whole cost of needed services. Bills introduced in 1946-1949 were subjected to extensive hearings at which sharp differences of opinion were recorded, and the proposals could not muster enough support to achieve Senate passage even in the Republican-majority 80th Congress.

Thus, for as long as the expansion of private insurance population coverage continued to serve their purposes, a strong and mutually profitable alliance persisted between the principal organized providers of medical care and the health insurance industry; and that alliance extended to commonalty of efforts to resist change in the medical care system itself as well as in its financing.

### *Tactical Retreat to a Narrowed Health Insurance, 1949-1961*

Concurrently with these diverse developments in the 1930s and 1940s, those who continued to think more adequate measures were

needed for the availability and financing of medical care persisted in devising proposals for the expansion of the national social insurance system to embrace medical care. As remarked earlier, the legislative battles were waged principally around the Wagner–Murray–Dingell (WMD) bills which were proposing supports for health personnel and facilities, enlarged supports for major categorical programs, and as comprehensive national insurance as feasible for personal health services needed by the population embraced by national social security. The sponsors continued to lose those battles. But the needs persisted, and the deficiencies in the *status quo* grew in magnitude and acuteness.

Then, in 1949–1951, while a new national assessment was in progress through President Truman’s Commission on the Health Needs of the Nation, under the chairmanship of Dr. Paul B. Magnuson (and which finally submitted its report “Building America’s Health” in 1952), some of the proponents of national health insurance decided upon a tactical retreat. They based a new course on the increasingly extensive and intensive concern about the medical care needs of the aged and of other disadvantaged groups. Instead of continuing to focus on a national health insurance for people generally, they proposed a much narrower program: paid-up health insurance benefits for beneficiaries of the social security program—that is, for the aged, survivor, and disability pensioners. At an early stage, the proposal which originally extended to comprehensive medical care benefits was limited to hospitalization benefits only; at a later stage, the eligibles were confined to the aged. A new series of health insurance bills along these lines became the focus of legislative issues for the years 1952–1965. These bills received progressively increasing support from the Democratic administrations in the White House, from many groups in the public and from members of the Senate (Murray, Humphrey, Lehman, *et al.*) and of the House (Dingell, Celler, *et al.*); and the growing support for these bills frightened the opponents.

There were diversionary interludes, which had begun in 1949–1950 in the Truman years and were then pursued vigorously throughout President Eisenhower’s administrations, to encourage the extension and improvement of private health insurance through relatively inexpensive federal supports. One such movement was to provide federal subsidy for private insurance carriers, spearheaded

by the Flanders–Ives and the Hill–Aiken bills of 1949–1955. Another was to provide federal legal and other resources to encourage insurance carrier reinsurance or pooling of risks, with waiver of antitrust restrictions. Legislative pressures and extensive Congressional hearings produced enlivened debates and increasing public interest but not consensus or enactments. Years were passing, the medical care scene was worsening, and attention began to concentrate increasingly on a true national health insurance through a beginning by provision for social security pensioners.

In an attempt to stem a tide, a countervailing measure took the form of an enactment to finance medical care for indigent and medically indigent aged 65 and over, the (Kerr–Mills) Medical Assistance for the Aged, 1960, through very generous grants-in-aid to the states. Within about two years, however, this program was evidencing its failure for two opposite reasons: It was growing to very large proportions in a few relatively wealthy states that could provide their share of the costs; and it was largely stillborn in most of the other states despite the federal fiscal generosity. In addition, the demands for improved provisions for the population *under* 65 were continuing unabated as self-maintaining groups persisted in eschewing welfare programs and demanded better access to medical care on an insurance basis. The Congressional sponsors of the Kerr–Mills program were deeply chagrined that most of the states, the medical profession, and the insurance industry had failed them. And the legislative bodies began increasingly to be converted to the conclusion that a better answer had to be sought in the national social insurance pattern, with its connotations of benefits by “right,” rather than in the public assistance pattern, with its dependence on state fiscal and administrative participation and the “means test.”

### *Enactment of Medicare and Medicaid, etc., 1965*

The next three years, 1962–1965, witnessed the legislative battles that were to end with the enactment of *Medicare*, *Medicaid*, and a potentially expanded program for Maternal and Child Health and Welfare and for Crippled Children conditioned, however, on annual federal appropriations yet to be won under the original Title V of the Social Security Act.

In those three years, the legislative course was hectic indeed. It had begun earlier with the maneuverings to press forward a bill,



sponsored by Representative Aime J. Forand of Rhode Island, which had reverted to medical as well as hospital benefits and for all social security beneficiaries—not the aged alone. This bill had had only a temporary setback from the 1960 enactment of Kerr–Mills. It was to have new vigorous support: from President Kennedy and then from President Johnson—through the bills sponsored by Representative King of California and Senator Anderson of New Mexico; at a late stage, through compromises with Senator Javits of New York and others; and, finally, the acceptance by Representative Wilbur D. Mills, Chairman of the House Committee on Ways and Means. It was to involve the complex gamesmanship of the American Medical Association, the American Hospital Association, the Chambers of Commerce, the insurance industry and many other groups long opposed; of the AFL–CIO, the organizations representing the special interests of the aged, many others representing consumers, and of the American Public Health Association, nursing groups and many other provider groups equally strongly in favor; and it was to involve the divided positions of those who followed the opinion polls and bent to the political winds.

The outcome: first a passage of the King–Anderson–Javits bill in the Senate on September 2, 1964 (the first federal legislative approval of a national health insurance program); after the landslide election of President Johnson in 1964, the overwhelming passage of a Mills bill in the House on April 8, 1965, and in the Senate on July 9, 1965; then, after conference to resolve differences, passage in the House on July 27 and in the Senate on July 28; and, finally, signature into law by President Johnson in the presence of ex-President Truman at Independence, Missouri, on July 30, 1965 (Corning, 1969).

The 1965 enactments were intended to be compromise solutions to assuage friend and foe: a national health insurance in the social insurance pattern under a new Title XVIII of the Social Security Act (Medicare), but for the aged only (the proposed coverage for survivor and disability pensioners had been compromised away in the legislative course); a better but still separate system of means-test medical care for the indigent and medically indigent under a new Title XIX (Medicaid); and a newer expression of concern for the health needs of mothers and children. The tactical retreat of 1949–1951 had finally borne fruit; but there were soon

to be questions about the quality of the produce. The compromise solutions meant renewed commitments for the medical care of categorically delimited groups in our society and through inherently unequal multiple systems of medical care. No one system or all together had any mandate of law or any substantial leverage in practice to effect needed improvements in the medical care system as a whole.

As to *Medicare*: The insurance specifications accepted by the Congressional committees had not come mainly from the proponents of national health legislation or from the specifications they had been developing for *health* legislation. On the contrary, they had been taken mainly from the opponents who, accepting that they could not any longer block action, had persuaded Congressional leaders to substitute the designs and gimmicks of private *indemnity* insurance. The insurance industry — strongly aided and abetted by “organized medicine” and hospital leadership — had won on three fronts: their insurance patterns were preserved and indeed emulated; they had achieved relief from difficult and expensive insurance obligations for the aged; and they now had a statutory privilege of functioning as fiscal intermediaries for the hospital costs (Title XVIII, Part A) and as insurance carriers for the supplementary medical service costs (Title XVIII, Part B) of the public program. The hospitals had won guarantee of full cost reimbursement at whatever levels, and the medical professions had obtained guarantees for the payment of usual and customary prevailing charges, constituting for both the institutional and personal providers signed blank checks on the program’s funds. To the millions of people 65 and over to whom the program would bring much assistance toward receiving and paying for needed care, the assurances were qualified by many arbitrary delimitations and many exclusions among the needed medical care services, and by the requirements to meet deductibles and copayments. Protections of the general public interest — in availability, utilization, control of cost escalations and of quality of care — were of insignificant scope, and even these were soon to be diluted away.

As to *Medicaid*: The open-end assured and enlarged federal grants-in-aid meant substantial fiscal relief for the few relatively wealthy states that could afford their financial shares of large programs for the poor and for the medically indigent near-poor. However, even this generous federal fiscal support also meant minimal

and tight-fisted programs for the intended beneficiaries in states with both meager fiscal resources and large proportions in their populations needing help and in states with indisposition to use their resources for the medical care of the under-privileged.

Through application of great skill in federal program development and in administration on the part of the personnel in the Department of Health, Education, and Welfare, and especially in the Social Security Administration, and of skill and vigor in some of the states and in some portions of the insurance industry, millions of aged persons and millions of poor and near-poor soon began to benefit from these programs. And the states had some needed and welcome fiscal relief.

Otherwise, however, Medicare and Medicaid — severally and together — began to serve the nation badly. Their complexities have led to widespread confusion and misunderstandings in the public and among providers. The insurance-industry-oriented statutory specifications of Medicare and the welfare-oriented design of Medicaid have invited and encouraged extravagances and further distortions and fractionations of medical care within these programs. The practices under these programs have enlarged and intensified the administrative, delivery, and cost problems throughout the medical care activities of the entire private sector. And by supporting three separate mainstreams of medical care, one for the aged, another for the poor and near-poor, and still another for all others, these newer programs have contributed to the strains in our social fabric.

At the Congressional level, the program accomplishments have been sources of pride for the benefits brought to the aged and to the poor and the near-poor. But some of the program consequences have also been sources of grievous disappointments; and the fiscal developments have brought anguished outcries from legislators who believe they had been entrapped into having to support programs that require steeply rising taxes and appropriations at levels far beyond what they had been persuaded to expect.

Nevertheless, perhaps I should say that the enactment of Medicare as national social insurance for the aged — and its supplementation by Medicaid — marked a victory after nearly 15 years of legislative battles which had begun with what I referred to as a “tactical retreat” from proposals for comprehensive national health

insurance. However, having used the word “victory” I have to add that now — after six years of operational experience and with medical care in mounting crisis throughout the nation — we may have to conclude that the enactments in 1965 were but a Pyrrhic victory.

I would like to think that we have learned some lessons from the legislative history of Medicare and Medicaid and from their operations.

1. Categorical coverages of limited population groups and of fractioned personal health services reflect compromises which solve some problems but also create others, and the goal should still be to avoid such compromises even if at the price of further delay in enactment of needed provisions.
2. National health insurance requires comprehensiveness of the population and service coverages; as well as built-in provisions for improvement of availability, for assurances of quality of care, and for cost controls at levels acceptable to public policy.
3. Long and exhaustive public discussion and political debate, and operation of compromise programs, reaffirm that there are no currently acceptable or promising alternatives to the comprehensive national social insurance pattern if we would provide for the effective availability and financing of the personal health services for the nation.

## From Medicare to Health Security and the Current Scene: 1965–1972

### *Beyond Medicare*

Within a year or two after Medicare became operational, many of us concerned about the national needs began to consider its consequences and impacts, and its portent for the future. It was clear that, in Medicare, the Congress had pursued and, in some measure, accepted four basic policies of potentially great moment for the future (Falk, 1966):

1. The health benefits to be made available under Medicare would be assured primarily by governmental financing;

2. Government would assume a responsibility, even if initially of limited scope, to safeguard and guarantee the quality of services for which it pays;
3. The services would be provided not by governmental but by private institutions and practitioners; and
4. The services covered by the financial provisions would be as comprehensive as practical.

In 1965–1966, I thought there would be no turning back from these four policies in the further development of national health insurance, whatever political winds might blow. Perhaps I was too optimistic, at least with respect to the first two. Witness that the first — concerned with governmental financing — is being nearly completely avoided in President Nixon’s health program proposals for the self-maintaining population; and that the second — concerned with quality of care — has been honored as much in the breach as in the observance.

For a while some of us hoped that, despite its limitations, Medicare might become a framework for rehabilitation of the medical care system, and we advocated its extension to people under 65 and the introduction of provisions for system improvement. But we abandoned that hope when it became evident that the Medicare system needed drastic revision such as could be effected only if supported by clear statutory authorization, and that extension through lowering the age of eligibility could be merely an expensive exercise in futility because all the major weakness in the medical care system would not only be retained but even further diffused.<sup>4</sup>

Hopes apart, operation of Medicare soon began to make clear that a program undertaken for only a tenth of the population was not enough for dealing with the medical care problems that afflict the whole national scene. The provision of more money for medical care helped availability of the services for the program’s eligibles; but the provision of money alone and of national health insurance for a small fraction of the population alone could not be sufficient.

<sup>4</sup> This year, by enactment of the Social Security Amendments of 1972 (PL 92-603) providing some limited exceptions to the minimum age of eligibility and extension to the disability pensioners, Medicare begins to apply to some who are under 65; but our fears are confirmed by the lack of substantial measures to improve the system itself.

It was rapidly becoming clear that much more had to be undertaken; that there was urgency because the service needs were increasing, costs were escalating at unprecedented rates, and because the remedies might have to be all the more heroic the longer delayed.

### *Birth of the CNHI*

With this perspective, a self-created private and voluntary group came into being in 1968–1969 to undertake a new assessment and, more particularly, to design a newer version of a comprehensive program for the medical care of the nation — not merely to prepare new poultices or bandaids. The group — to become known as the Committee of One Hundred for National Health Insurance — was led by Walter P. Reuther, President of the United Automobile Workers (UAW), Chairman until his tragic death in a plane accident, and since then by Leonard Woodcock, his successor at UAW. Mr. Reuther was joined by Dr. Michael E. DeBakey, President of Baylor College of Medicine; Mary Lasker of the Albert and Mary Lasker Foundation; the late Whitney M. Young, Jr., Executive Director of the National Urban League, who agreed to serve as Vice-Chairmen, and by Max W. Fine as the Executive Director. There were many others, including members of the Senate and House from both sides of the Congressional aisle. Approximately 100 well-known persons from many walks in the nation's life constituted the Committee.

Unlike the CCMC, this self-elected Committee did *not* have to start by making an open-minded, extensive, and time-consuming study of medical care in the national scene. On the contrary, hundreds of studies and many years of public and professional discussions had identified the nature and magnitude of those needs, and also the reasons for their prevalence — reflecting inadequacies in both the financing of medical care and in the organization of the resources for availability and delivery of medical services. The organizing group in the Committee therefore began by preparing a provisional statement of *principles* for an action program. These were presented to the prospective members of the Committee (January 30, 1969); and, after some revisions, these became the Committee's platform. Subscription to these principles became a precondition for membership in the Committee.

## *CNHI Proposals*

The Committee's perspective on *social policy* for "today and for the future" was expressed in a clear and unambiguous declaration:

The American people have a right to good medical care. The Committee for National Health Insurance believes that fulfillment of that right requires the enactment of national health insurance. . . . We [also] believe our health services must now be revitalized to overcome serious deficiencies in organization. Only a program of national health insurance can provide the supports required to bring about the changes that are needed.

And the Committee's principles expressed more specifically its convictions as to the major specifications for a program that would implement that social policy, including commitments to the following:

1. The availability of all needed and practical personal health services to all persons, as a matter of right;
2. Thorough utilization of all useful resources for care within a framework of improved organization;
3. Amplification of resources for care and organizational improvement on an evolutionary course;
4. Fiscal security through the *governmental* social insurance pattern and on a budget basis;
5. Provision of services through the *private* sector;
6. Built-in protections for quality of care and required observance of quality standards as a precondition for receipt of public payment for services; and
7. Public administration, with participation by both consumers and providers, and public accounting of program operations and performances.

These commitments in the aggregate were intended to strike at all the recognized major causes of crisis in the national health care scene: (a) shortages and maldistributions in various categories of health manpower and facilities; (b) steeply rising costs and their financing; (c) inadequacies in the system for assuring availability and delivery of needed services; (d) lack of sufficient and effective

controls for the assurance of quality of care; and (e) interrelations among these specific causes of deficiency.

### *The Health Security Bill*

The Committee then undertook, through a Technical Subcommittee and many consultants, to move from the declaration of general principles and the expression of objectives to the details of design, devising specifications for a program that had promise — initially and over time — of leading to the development and achievement of an adequate system for the medical care of the whole population.

The Committee's specifications were translated into a comprehensive bill. Since it dealt as much with system improvement as with national financing, the proposed program was christened "Health Security" rather than "National Health Insurance."<sup>5</sup>

The legislative introduction of the Health Security bill had been anticipated by a somewhat similar bill developed and sponsored by the AFL-CIO.<sup>6</sup> Soon thereafter, agreement was reached to pool these two efforts. Differences in the two bills were reconciled and a common Health Security bill was prepared for introduction at the beginning of the 92nd Congress.<sup>7</sup>

### *Other Legislative Proposals*

The publicity generated by the meetings of the Committee for National Health Insurance and by the public discussions of its program objectives had aroused much interest throughout 1969 and 1970. A consensus began to emerge not only that national action is needed but also that it impends. Various groups, therefore, undertook to develop or to accelerate the development of alternative proposals.

<sup>5</sup>The Bill (S. 4297, 91st Congress, 2nd Session) was introduced in the Senate on August 27, 1970 by a politically bi-partisan group of 15 Senators (Senators Kennedy, Cooper, Yarborough, Saxbe, with 11 other Senators) and referred to the Committee on finance; and, exclusive of the financing provision, it was also introduced (S. 4323) on September 8, 1970, by four of the Senators so that it was referred to the Committee on Labor and Public Welfare which held hearings on it on September 23-24, 1970.

<sup>6</sup>H.R. 15779 (91st Congress, 2nd Session), introduced by Representative Griffiths of Michigan on February 9, 1970.

<sup>7</sup>S. 3, January 25, 1971, sponsored by 25 Senators and H.R. 22 introduced by Representatives Griffiths, Corman, and many others on January 22, 1971.



President Nixon expressed his administration's views in a Message to Congress on February 18, 1971, and DHEW increased its activities in support of his promised program. "Organized medicine," the hospital associations, the insurance industry, and others in and out of Congress presented their own programs, and legislative submittals multiplied. Soon, the legislative stage became crowded with many actors, each advocating his own remedy or nonremedy for the medical care aches and pains.

As an example of the nonremedy, I would refer to the "Medi-credit" bills sponsored by the American Medical Association — nonremedy because they are patently designed primarily to preserve the status quo and to prescribe unfunded drafts on the U.S. Treasury for the augmented purchase of contracts from the private health insurance industry. Among bills that are mixtures of placebos and remedies are the proposals from the commercial insurance companies ("Healthcare"), from the American Hospital Association (its Perloff Commission report on "Ameriplan" and, subsequently, the somewhat revised proposals in H.R. 14140 introduced by Representative Ullman of Oregon on March 28, 1972), and from the Administration ("National Health Insurance Partnership," "Family Health Insurance Plan," and "Health Maintenance Organization Act"). These bills differ from the Health Security proposal in many respects, but principally by applying to less than the total population, by preserving multiple medical care systems, by narrower scope of benefits, by slower pace of development, by reliance on multiple sources of funding, by greater reliance on private administration, by lesser stimuli to systems improvement, by more casual protections of quality of care, by greater dependence on state-by-state action or even by delegation of implementation to employers, private insurance, and the marketplace, etc.; and it would take us far afield to become involved at this time in their details and intricacies (see Falk, 1970).

The numerous proposals and their aggregate involvement of large proportions of the members of both the Senate and the House demanded attention from the Congressional apparatus. Extensive hearings on the Health Security and other bills and on other aspects of the "Health Crisis in America, 1971" were held by a Subcommittee on Health of the Senate Committee on Labor and Public Welfare (February 22, 1971 and ff), on "National Health Insurance" by the

Senate Committee on Finance (April 26–28, 1971), and on “National Health Insurance Proposals” by the House Committee on Ways and Means (October 19, 1971–March 10, 1972). It was gratifying that the APHA took an active part in the hearings, recommending comprehensive overhaul and improvement of the medical care system.

### *Health Maintenance Organizations (HMO's)*

While the actors were playing out their parts on this legislative stage, one of the parts in the play began to assume an augmented role through previously staged entrances from the wings. As remarked earlier, the Health Security program had undertaken not merely fiscal solutions but also system improvements. A principal element toward a better system, in the view of the CNHI, is the encouragement of organized availability of comprehensive personal health services through prepaid multi-specialty and multi-discipline group practice. The CNHI regarded this as the only pattern yet devised with promise for the medical care system to become able to meet modern and currently prospective needs.<sup>8</sup> Many others besides the CNHI had been coming to this conclusion; but, convinced that an evolutionary development course required allowance for intermediate levels between “solo” and “group” practice, they had found an answer in some of the medical society sponsored “foundation” patterns. These would organize availability of (more or less) comprehensive services on a capitation payment basis, but would permit performance through solo practice and would not require group practice. A combination of group practice and foundation plans, named “Health Maintenance Organizations” (“HMO's”) by Dr. Paul M. Ellwood of Minneapolis and his associates, rapidly became a popular proposal — sponsored by President Nixon, the Department of Health, Education, and Welfare and by many others. This created no conflict for the Health Security program, since its specifications included supports for both group practice “comprehensive health service organizations” and non-group practice “professional foundations,” and both are included in its bills (S. 3 and H.R. 22).

<sup>8</sup>In large measure, the proposal spells out the logistics of much that the CCMC Final Report had envisaged in 1932 as “The Essentials of a Satisfactory Medical Program” and “An Ultimate Objective in the Organization of Medicine.”

Indeed, encouragement for the development of HMO's is also included in several of the competing national proposals.

Since the creation of HMO's involves time lags, shorter for "foundations" and longer for "group practice" plans, separate legislative proposals were prepared and introduced to stimulate and support their development at once. DHEW did not wait on specific enabling legislative authorization or appropriations, but — in conjunction with the then ongoing program for neighborhood health centers which had been initiated by the Office of Economic Opportunity (OEO) — proceeded to invite, approve and fund newer planning projects for the production of new HMO's of both types. (DHEW had already entered this field through support grants under Section 314(e) of the PHS Act.) Continuing funding of HMO planning was halted, however, when Congressional committees objected to this activity in advance of specific legislative authorization and applicable appropriations.

Two HMO bills then began to move through the legislative course, with active and constructive support from the APHA and the Group Health Association of America.

In the House, the bills developed by Representatives Roy, Rogers and others<sup>9,10</sup> had extensive study and hearings in the Committee on Interstate and Foreign Commerce; but, reportedly confronted by opposition from the American Medical Association, they failed to be reported out from the Committee and died with the adjournment of the 92nd Congress.

In the Senate, a much more comprehensive bill from Senators Kennedy, Javits, and others<sup>11</sup> received public hearings; was favorably

<sup>9</sup>H.R. 11728: It provided supports for the planning, development and initial operating costs of both group practice and foundation type plans, and also for management and clinical training for HMO's and for program evaluations. It provided for a National Advisory Council on HMO's; it prescribed the federal supersession of various obstructive state laws; and it authorized appropriations (without time limit) of so much as may be necessary to carry out the provisions.

<sup>10</sup>H.R. 16782 of September 21, 1972, with many revisions and with the authorizations for appropriations limited in most respects for only two or three years.

<sup>11</sup>S. 3327 of March 13, 1972: It provided supports for the planning, development and initial operating costs of HMO's (group practice plans) and HSO's (health service organizations of the nongroup-practice types, especially for

reported out by the Committee on Labor and Public Welfare; and, with some amendments, was passed in the Senate on September 20, 1972, by a vote of 60:14, but died when the Congress adjourned without further action on this legislation.

Thus, no final enactment came of these proposals in the 92nd Congress. They are likely to receive attention in the 93rd.

Since there is near-agreement on the need to improve the organization of medical care services and to make the services more readily and more sensibly available, HMO development is obviously commendable. It invites movement in the right direction, and I believe it is to be strongly encouraged in the next Congress. It should not, however, be mistaken for other than a major but still fractional part of the much more comprehensive action that is needed.

In its closing days, the 92nd Congress passed portions of the massive H.R. 1, concerned with revisions in social security, public welfare, Medicare, Medicaid, etc., and President Nixon signed it into law (P.L. 92-603). However, while making many important new provisions, it effected no major changes in the course of the history with which we are concerned here.

## What's Ahead for Medical Care?

Many people in many walks of life are now convinced that the enactment of a national health insurance is imminent — that it is “an idea whose time has come.” Perhaps the next year or two will show that this is a sound judgment. We should be clear, however, that it matters much whether action, soon or later on, is dictated by firm and affirmative commitment to a national health insurance that will undertake to deal with the nation’s needs comprehensively, or by an ill-defined and negative dissatisfaction with the status quo. If by affirmative commitment, there is justified hope for the beginning of a new chap-

rural populations lacking medical care services), and for area health education and service centers. It specified the federal supersession of various obstructive state laws, and proposed the establishment of a National Advisory Council on Health Care Delivery. It also included extensive provisions for quality protections and improvements through activities of a Commission on Quality Health Care Assurance, proposed establishment of a National Health Institute of Health Care Delivery, and a medical malpractice reinsurance program. Specific appropriations were authorized for the three fiscal years 1973-1975, aggregating \$4.895 billion.

ter in the evolution of medical care, to be guided by new social policy and toward new national goals over the horizon. If by dissatisfaction alone, we have to be prepared for disappointments from a tinkering with the system and — under whatever guise — continuing frustrations from compromises that will be designed as much to preserve the vested interests of those who exploit medicine and medical care as to serve the general welfare.

We should, of course, continue our efforts with optimism; but we should not be unaware of the diverse groups, whether comfortable or not with the current system, that will be concerned about change that could threaten their interests or that invites their fear of the new and the unknown. Change in medical care presents challenge to many, and to many kinds of, reluctant dragons. And some among them will continue to resist major change.

If change is proposed on a comprehensive scale, it demands confrontation with the persistent, near-total dominance of the medical care system by the medical professions and with the fiscal sovereignties of the hospitals and other institutional providers. It challenges the place in society and in the economy of the commercial and quasicommercial providers of medical care goods. It appears to threaten the security of some of the people who function within the quasiprofessional and commercial insurance industry and the fiscal returns of the industry. It arouses perplexities among employers troubled about the prospective impacts of medical care costs. It invites reexamination of vested interests among labor unions with hard-won medical care benefits under collective bargaining agreements. It raises new questions about the roles of consumer spokesmen hopeful of a substantial place in the medical care system of the future. It will expose the proposal to the resistances of people generally troubled about taxes or with misgivings about change in their personal relations to providers of care. The resistances will have to be overcome as far as possible by the reasonableness of the proposals and the persuasiveness of the explanations, and, beyond that, by confrontations in the legislative arena.

At the moment, there appear to be three main obstacles to the enactment of a Health Security program: the reluctance of “organized medicine” to accept need for an overhauling of the medical care system; the opposition of the insurance industry to being displaced from its role in managing the financing of medical care; and the

concern of political leaders about the impacts of public financing for the medical care of the nation. Each of these, as well as many others, will have to be surmounted if we are to move toward the clear-purposed goal.

We are involved in the task of improving a major and pervasive part of the social and economic system, especially if what is developed for the improvement of medical care is capable of being well integrated into a more comprehensive health program for the nation. We should not, I believe, underestimate or understate the potential for good. But we also should not underestimate the difficulties ahead in designing the needed changes or in resolving the conflicts of perspective or interests as we try to release Aesculapius from the marketplace.

Surely, we should not repeat the mistakes of the past and again achieve only compromises that nullify good intentions. The opportunities for progress are large and important, and they deserve the concerted efforts of all who have high hopes for the beneficent potentials of good medical care.

I would emphasize concert of efforts. It is not enough toward the achievement of constructive action to be critical of the status quo, to be articulate by voice or pen about what is wrong or bad or not good enough, or for the disaffected to talk only to one another or even only to the general public. This would be an accustomed ignoring of the lessons of history. We are free enough to reject the past; but it is not wise to ignore its lessons.

Those who are content with the status quo or who profit from it have been foresighted. Long ago they devised protective mechanisms against changes they do not want; and they have been — and they are — alert to exploit professional and societal resistances to change. They have vast and diverse resources at their disposal, and they are skilled in the tactics of utilizing their means for inaction or delay, whether by obstructing new proposals or by supporting measures that only seem to promise progress.

If those who are disaffected with the current scene, and those who are not sanguine about progress through the forces of the marketplace—if they would be effective for constructive action—I would urge that they sacrifice so much of their independence of action as is the price of joining in support of the most promising proposal that appears on the national legislative scene. I can see no

hope for substantial progress in the near-time future on any other course. Support need not be uncritical; but neither can it be altogether helpful if uncompromising as to ways, means, or timing for constructive action.

In the contending that is ahead within and between the legislative and the executive branches of our government, the medical care program involves large and influential political stakes. Surely we should be able to join in supporting what is based on promising guidelines for one national system of medical care for everyone, and in resisting further commercialization and fractionation of medical care and reliance on the same leadership and the same mechanisms that have brought us to the current crisis stage.

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