The Consequences of Consensus: American Health Policy in the Twentieth Century

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MANY OF THE VEXING PROBLEMS OF THE HEALTH sector in the 1980s are the unanticipated consequences of a policy that, for most of this century, seemed self-evidently the best way to advance science and improve the health of the public. I call this policy hierarchical regionalism, by which I mean a particular logic of organization based upon a theory of how medical knowledge is discovered and disseminated. In this article, I reinterpret the history of health policy in the United States between the early twentieth century and about 1970. I tell this story in more detail in a forthcoming book about the history of health policy and health politics in Britain and the United States (Fox 1986b). I have elsewhere described and criticized standard accounts of the history of health policy and explained why I came to believe that they were conceptually and methodologically flawed (Fox 1983, 1985).

Hierarchical regionalism is a phrase I use to summarize three assumptions that became the basis of policy for organizing health services in every industrial nation. These assumptions are as follows. The causes of and cures for most diseases are usually discovered in the laboratories of teaching hospitals and medical schools. These discoveries are then disseminated down hierarchies of investigators, institutions,

The Milbank Quarterly, Vol. 64, No. 1, 1986

and practitioners, which serve particular geographical areas. A central goal of health policy is stimulating the creation of hierarchies in regions which lack them and making existing ones more efficient.

The phrase "hierarchical regionalism," as I use it, is descriptive, not judgmental. The phrase summarizes ideas I found repeatedly expressed in published and unpublished primary sources beginning in the second decade of this century. The word "hierarchical" describes two concepts that dominate the literature of medicine and health policy since that time. The first concept is that medical care is work performed by people whose relative status and authority are determined by how much they know and by the complexity of the tasks they perform. The second is that these people and their work places should relate to each other in an orderly way that, when diagrammed, resembles a pyramid. "Regionalism," as the word is used in the literature of medicine and health policy, refers to a belief that geographic areas—which may be but usually are not congruent with political jurisdictions—rather than individual practices, clinics, or hospitals, are the proper units for which to plan, administer, and evaluate medical care.

Many definitions of hierarchy and regionalism have been advocated throughout the century. Each definition has expressed the views of particular individuals and groups about how medical services should be organized. Hierarchies have been proposed and created with enormous variations in formality, structure, and patterns of authority. Regions, similarly, have been proposed or created with considerable differences in size, population, and congruence with political boundaries. Thus, hierarchies have been dominated by both university medical centers and free-standing hospitals. Relations within hierarchies have been described by some people as those between academics and community practitioners and by others as those between specialists and generalists. Similarly, regions have sometimes been formally organized, by law or voluntary action, and at other times have been defined by physicians' patterns of referring patients.

This article is about what most Americans have meant when they proposed and implemented policy to organize medical services from about 1914 to sometime in the 1970s. The dates cannot be precise because I am describing continuity and change in what texts say rather than discrete events. The ponderous phrase hierarchical regionalism is the best one I could devise to summarize the dominant themes I found in these texts. Moreover, the phrase summarizes what was new in twentieth-century health policy and calls attention to the events

in the history of medical science and its application that were considered the justification for new policy. Hierarchical regionalism has been the framework, the preferred logic of organization, for trying to achieve important social goals. These goals include preventing and curing illness and removing financial and geographic barriers to access to services: in general, creating more rational and equitable social policies.

Both words, hierarchy and regionalism, have many historical and contemporary associations. Moreover, the words have been given different meanings in different countries. Hierarchical regionalism in Britain, for example, has been interpreted very differently than it has in the United States (Fox 1986b). I ask readers, at least temporarily, to suspend their own historical and contemporary associations with the phrase and use the words, as I do, as a value-neutral summary of important and complicated ideas.

Moreover, I do not claim that hierarchical regionalism is all one need understand to comprehend the history of health policy in the twentieth century. I argue only that it is central to understanding policy for organizing medical services in order to create the possibility of providing them equitably and efficiently. There is much more to health policy than can be comprehended within my thesis or any other, as Marmor (1984), for example, has written.

In the United States, hierarchical regionalism became national policy in several stages, which I describe in this article, emphasizing the years between 1945 and 1965 when the coalitions promoting hierarchical regionalism achieved their greatest success. Between 1914 and the mid-1930s, most advocates of hierarchical regionalism as a method of organizing or reorganizing medical services linked it to changes in how medical care was financed and in the purpose of medical education. From the late 1930s until the early 1960s, most of its advocates carefully separated measures to rationalize and increase the supply of health services from proposals to finance them through health insurance. During these years, hierarchical regionalism became the basis of federal policy to subsidize hospital construction and scientific research, of state contributions to the capital and operating budgets of medical schools and teaching hospitals, and of programs of health planning and professional education sponsored by philanthropic foundations. In the 1960s, hierarchical regionalism was the central theme of new federal legislation to train health professionals, plan for building and coordinating hospitals in states and regions, and disseminate science and technology from teaching hospitals. The states continued to increase

their investment in medical education. During this decade and into the 1970s, hierarchical regionalism was, for the first time, politically compatible with public programs to finance medical care for the elderly and the poor. Since the early 1970s, however, the national policy of hierarchical regionalism has been eroded as a result of unexpected consequences of its success.

Hierarchy in Health Policy, 1914–1941

The standard interpretation of what I call the first stage in the history of hierarchical regionalism in the United States separates two issues which were connected in the minds of contemporaries: health insurance and medical education. The first campaign for compulsory health insurance, which was initiated in 1914 by the American Association for Labor Legislation, is usually described as a lost crusade (Numbers 1978). According to this interpretation, an enlightened proposal to reduce the financial burden of medical care on individuals by legislation in the states was thwarted, for a variety of reasons, by the medical profession, the American Federation of Labor, and the life insurance industry. During the same years, in apparent contrast, medical education was reformed as the result of an alliance between philanthropic foundations—notably those endowed by Rockefeller and Carnegie—and the leadership of the American Medical Association. In large measure as a consequence of Abraham Flexner's report and the actions that followed it, the worst medical schools disappeared and those that remained made science central to preclinical and clinical education (Fox 1986a; Ludmerer 1985).

Compulsory insurance and scientific medical education were, however, closely linked policies in the minds of contemporaries. Proponents of compulsory insurance criticized the ignorance of general practitioners and proposed to establish hierarchies of physicians in order to provide the recipients of insurance with high-quality care. The grants to medical schools from the Rockefeller philanthropies were based on a strategy of establishing regional medical centers from which scientific research and medical education would be disseminated (Fox 1980). Many of the most outspoken advocates of compulsory insurance were prominent medical educators. For such physicians—Richard C. Cabot of Harvard and Victor C. Vaughn of the University of Michigan, for example—insurance and scientific medical education were means to

the end of putting medical practice on a properly scientific basis (Rubinow 1916; Cabot 1916).

In the mid-1920s, a cluster of philanthropic foundations sponsored two groups that promoted national policy for hierarchical regionalism. The reports of these groups are convenient summaries of beliefs which were expressed and acted upon, according to other primary sources, by important constituencies in health affairs. The Commission on Medical Education (1932), which has been ignored by most historians, published a book-length final report in 1932 proposing that medical schools and their teaching hospitals lead the reorganization of medical care in their regions. A second report, issued later the same year by the better known Committee on the Costs of Medical Care (1932), recommended that medical care be organized in regional hierarchies based on hospitals and that it be financed by voluntary group payment.

The Commission and the Committee each had physician members representing both academic medicine and private practice. These physicians unanimously supported the recommendations of the Commission on Medical Education. A few months later, however, the representatives of private practice on the Committee on the Costs of Medical Care (CCMC) wrote a minority report attacking, not group payment, but rather what they regarded as an effort to impose a rigid hierarchy on the profession.

The different political consequences of the recommendations of these two groups foreshadowed events in health policy during the next thirty years. The authors of the report on medical education asserted that regional hierarchies should be created in order to investigate, apply, and disseminate medical science. But they did not directly criticize general practitioners. Instead, they assumed that all right-thinking physicians agreed with them about the causes of progress. The CCMC majority, in contrast, attacked the competence of private practitioners of medicine on almost every page of their report. They created the impression—which angered the committee's minority and spokesmen for organized medicine—that proponents of changing how medical care was financed also wanted to restrict the autonomy of most physicians.

Members of the CCMC majority and of its research staff were soon prominent in formulating and advocating proposals for health policy within the New Deal. I. S. Falk and Edgar Sydenstriker, for example, who served as staff members of the Committee on Economic Security

appointed by President Roosevelt in 1934, pressed for health insurance to be included in the Committee's recommendation for a social security program (Hirshfield 1970). A few years later, Falk, as a staff member of the Social Security Administration, helped to formulate proposals for a major health program by an Interdepartmental Committee to Coordinate Health and Welfare Activities (1938a). Michael M. Davis, who defended the CCMC recommendations in articles and as an executive of the Rosenwald Fund, was a featured speaker at a Washington conference in 1938 which promoted the program of the Interdepartmental Committee to Coordinate Health and Welfare Activities (1938b).

Although the American Medical Association (AMA) and its federated state societies bitterly opposed compulsory health insurance, leaders of organized medicine endorsed much of the New Deal health program. Most state medical societies contracted with state agencies to provide medical care, financed by federal funds, to people on relief (American Medical Association 1934). In several rural states, medical societies encouraged their members to participate in prepayment programs organized by the Farm Security Administration (Reed 1937). In 1938, the AMA endorsed most of the recommendations of the federal Interdepartmental Committee, including subsidies to construct hospitals and to extend preventive health services to mothers and infants. The AMA was opposed only to the committee's recommendation that federal grants be made to states which enacted programs of health insurance (Garceau 1941; Burrow 1963).

The CCMC veterans and their supporters in the administration and Congress refused to bargain with organized medicine to create a national health program. They assumed that the medical profession was fragmented and that many doctors privately supported compulsory insurance. Because the liberals refused to compromise, the Roosevelt White House and most members of Congress decided that the conflict between proponents of a national health program and organized medicine could not be resolved without unacceptable political costs. The administration recommended no program to Congress (Roosevelt 1939) and had little enthusiasm for legislation introduced by liberal congressmen in 1939 and 1940 to subsidize hospital construction and compulsory insurance.

By the late 1930s, however, a small group of physicians, most of them academics, had begun to formulate an alternative political strategy. Calling themselves the Committee of 430, they pressed for policy to subsidize hospital construction, research, and medical education but

were deliberately silent about how medical services should be financed and whether physicians ought to be paid by fees or salaries. Like the members of the Commission on Medical Education earlier in the decade, they claimed that the medical profession would agree to establishing hierarchies of institutions and practitioners in geographic regions provided that the organizing principle was collegiality rather than coercion. Leaders of the Committee made plain in publications and at the National Health Conference of 1938 that they wanted to be disassociated from the adherents of the CCMC majority report who considered themselves to be a vanguard of reform (Committee of 430 1937). A bill to subsidize hospital construction, introduced in Congress in 1940 and 1941, was supported by the Committee and, eventually, by every faction in organized medicine. Liberals in and out of government disparaged it, however, as an insufficient reform. The bill passed the Senate but died in a House distracted by preparations for war (Hirshfield 1970; Hutmacher 1968; Poen 1979).

Hierarchical Regionalism as National Policy, 1941–1952

Events during World War II hastened the success of the political strategy advocated by the Committee of 430. Almost one-half of American physicians entered military service, where their rank and assignments were based almost entirely on how much specialty training they had. This experience created new adherents of hierarchy who were eager for opportunities after the war to train for membership in the upper ranks of the profession (American Medical Association 1943; Lueth 1945). The mass media and leading politicians frequently applauded the achievements of military medicine and urged that it should become the standard for civilian health services after the war. Growing support for hierarchy and regionalism in the medical profession and the hospital industry was exemplified by two reports, one commissioned by the American Hospital Association, the other by the New York Academy of Medicine, that elaborated a postwar strategy derived from the Committee of 430 rather than the Committee on the Costs of Medical Care (New York Academy of Medicine 1947; American Hospital Association 1947). These reports called for policy to subsidize hospital construction, research, and medical education after the war, and insisted that there were a variety of ways to finance

increasing access to medical care. During the war, moreover, philanthropic foundations made grants to medical schools to link physicians and hospitals in regional networks.

Health insurance underwritten by Blue Cross and commercial firms expanded during the war as a result of federal policy to limit the inflation of wages and prices. The War Labor Board permitted collective bargaining for health insurance as a fringe benefit in order to relieve pressure for higher wages. The Internal Revenue Service excluded health insurance provided by employers from personal and corporate income taxes (Steurerle and Hoffman 1979). This tax subsidy of health insurance was sanctioned by court decisions after the war.

A coalition to prepare legislation for a postwar national hospital construction program was organized, beginning in 1943, primarily by staff of the American Hospital Association and the United States Public Health Service. The organizers obtained pledges of support from Democratic and Republican leaders, officers of religious hospital associations and organized medicine, and representatives of business, labor, and farm groups. Public Health Service staff helped state health departments to write enabling legislation and make preliminary assessments of how many beds were needed (Bugbee 1947; Hoge 1947). A report issued by the Public Health Service following broad consultation with interest groups recommended that hospitals be arrayed in hierarchies within regions, which were defined by the flow of patients needing services rather than by political boundaries (U.S. Public Health Service. Federal Security Agency 1945).

The legislative history of the hospital construction program, which was introduced in Congress in 1945 by Senators Lister Hill, a Democrat, and Harold Burton, a Republican, demonstrated the strength and displayed the agenda of a new coalition for health policy. The bill was supported by representatives of groups located everywhere on the political and health professional spectrum. Members of these groups testified about the achievements of medical science and asserted that there was a compelling public interest in encouraging research and disseminating its results. The only critics of the bill were a few liberal senators and congressmen who supported subsidies for hospital construction but wanted them to be combined with national health insurance (U.S. Congress. Senate 1945). Although President Truman had announced a national health program that included insurance, he signed the hospital construction bill into law in the summer of 1946

without holding it hostage for the passage of other health measures (Poen 1979).

The coalition that created the national hospital construction program soon pressed for other legislation. Its most visible success was promoting a federal subsidy for biomedical research. The National Institutes of Health increased in number and funding in the late 1940s and early 1950s. Advocacy of federal aid to medical education by the coalition was less successful. Until 1956 when legislation was passed to assist medical schools to construct facilities for research, and 1963, when direct federal aid for medical education was enacted, creating a national program of aid for medical education was impeded by conflict between public and private medical schools and by the AMA's wariness about increasing the number of physicians (Strickland 1972).

Promoters of new health policy in the 1950s both stimulated and took advantage of rising demand for medical care. Demand was encouraged by the media and financed by voluntary insurance. In 1931, 48 percent of Americans saw a doctor each year; by the early 1950s, 72 percent did (Feldman 1966). The average number of annual visits to doctors for each person almost doubled from the late 1920s to the mid-1950s (Lerner and Anderson 1963). In the fifteen years after 1945, the number of admissions to nonfederal hospitals increased by 58 percent (Joint Committee of the American Hospital Association and the U.S. Public Health Service 1961). In the three decades after 1929, consumer spending for medical care increased from 3.7 to 6 cents of every dollar earned (Reed and Hanft 1966).

To many people concerned with health affairs in the 1950s, like most of their contemporaries who focused on economic policy, growth was a substitute for redistribution. The enormous growth in voluntary health insurance, and especially of Blue Cross and Blue Shield plans, was frequently cited as evidence that prosperity made it possible to expand access to medical care without enacting any other national health insurance laws than amendments to the Internal Revenue Code. Moreover, regional hierarchies seemed to be emerging and becoming more rational throughout the country, even though Blue Cross and other insurance plans did not provide incentives to creating them by, for instance, restricting which hospitals could be reimbursed for particular procedures. A Brookings Institution study in 1952 concluded, for example, that health policy could ignore the problem of how to allocate scarce resources. Proper federal and state policy would simply subsidize an increasing supply of research, facilities, and manpower and, thus,

of available medical care (Bachman 1952). Two sociologists who analyzed the results of a survey of medical care costs and utilization in 1953 concluded that growth through voluntary action was the method of reform which was preferred by most Americans (Anderson and Feldman 1956).

The collaboration of powerful groups pressing for subsidies to increase the supply of medical services was obscured by what most people perceived to be the domination of health politics by the AMA. This contemporary view was enshrined as the standard interpretation of the recent history of health policy in the works of many polemicists, journalists, and even historians and political scientists (Fox 1983). These writers credited the AMA with defeating legislation that was already doomed because of the strength of the conservative coalition in Congress and the inability of the Truman administration to marshall liberal constituencies to support its programs. For instance, after the congressional elections of 1950, the AMA took credit for defeating liberals who were doomed, according to close contemporary observers and recent historians, by factional disputes within state parties or by their support for the Korean War (Hamby 1973; Hartmen 1971; Mayhew 1966; Pemberton 1979; Douglas 1972). When the AMA was challenged by a powerful lobby—veterans' organizations eager to expand their hospital benefits, for example—it was not invincible (Magnuson 1951). More important, leaders of state and local medical societies often allied with academic physicians, labor, and business interests in order to press for increased spending on hospitals and medical schools.

A national Commission on the Health Needs of the Nation, which reported to Harry Truman a month before Dwight Eisenhower became president, declared in a widely publicized report that the priority of health policy ought to be increasing the supply of medical services. This report, like most such documents, is important less for its direct influence on events, than because its analysis and conclusions, and the mass of unpublished evidence gathered in support of them, reveal a great deal about the beliefs, aspirations, and strengths of particular constituencies. The authors of the report proclaimed that health had become possible only a few decades previously, when medicine had entered its golden age. Health could be attained and improved if people had access to more medical care. More access would result from a policy to train more physicians and other professionals, build hospitals, and, the Commission insisted, "support any worthwhile

research idea." Most of the problems in the organization of medical care would be remedied by economic growth, which would stimulate voluntary action. Physician and hospital services, except for the elderly and the poor whose care should be subsidized by the federal government, could be financed by voluntary purchases of insurance. Physicians should eventually practice in groups, linked to each other and to other institutions in hierarchies. Such arrangements would, however, grow naturally, "as an extension of the influence of the hospital" (President's Commission on the Health Needs of the Nation 1952). The hospital was the center of community care, the authors and most of their contemporaries believed. The fundamental assumptions of hierarchical regionalism were now regarded as self-evident, although there were competing strategies for acting on them.

Because of the consensus that hierarchical regionalism was the proper basis of health policy, the recommendations of the Commission were widely endorsed. They were supported by editorials in the general and professional press. The report was cited as authoritative throughout the decade because it was the single best statement of the agenda of coalitions which operated in the states in the 1950s and as promoters of national policy in the 1960s and 1970s.

Promoting Hierarchy in States and Regions, 1952–1960

By 1952 coalitions in the states were working to increase public support for medical education. Ten states had appointed committees to plan new medical schools. A quarter of a billion dollars, most of it in appropriations and capital from the sale of revenue bonds, was committed to new medical school construction (Fine 1952). Support for medical school budgets from state and city governments increased more than 400 percent between 1948 and 1958. Federal research funds augmented medical school and teaching hospital budgets. Nine new state university teaching hospitals opened during the 1950s. Four new schools were established. Planning, begun in the 1950s, led to the creation of 15 new schools in the next decade. Between 1948 and 1962 funds from local appropriations or philanthropy matched federal grants to construct 126 projects in hospitals owned or controlled by medical schools (Surgeon General's Consulting Group on Medical Education 1959; Lippard 1974).

The members of the coalitions advocating increased public spending for medical education shared an interest in providing more care and more sophisticated services. The most prominent members of these groups were leaders of state and county medical societies, trustees of large hospitals, businessmen, bankers, labor leaders, and elected public officials (Lippard and Purcell 1972).

This community interest in linking services and education was symbolized by the name inflation that occurred at many hospitals and medical schools. Hospital trustees frequently renamed their institutions "medical centers" in order to demonstrate an identification with education, research, and advancing technology. A few years later, university medical schools and hospitals began calling attention to their higher status by using the name "health sciences center" to distinguish themselves from these ubiquitous medical centers.

Physicians were the most influential advocates of converting hospitals into medical centers and of establishing or expanding medical schools. An increasingly powerful group within the medical profession aspired to higher prestige and personal satisfaction through association with medical schools. Specialists were now routinely elected to offices in state and county medical societies. These new leaders' education, training, and experience in war, as well as their thriving practices, made them expansive about the future.

The AMA gradually accommodated to the growing strength of academic physicians and their allies. In 1956, for example, its Council on Medical Service, rejecting a complaint from physicians in Mississippi, ruled that academic physicians who received salaries and a proportion of the fees charged on their behalf were not in unfair competition with community colleagues (Turner, Wiggins, and Shepherd 1956). Moreover, the AMA retreated from its complacent belief that there was an adequate supply of physicians. In 1954, despite a decline in applicants to medical schools and published studies suggesting that claims of a doctor shortage were exaggerated, the AMA Council on Medical Education and Hospitals insisted that demand for more physicians would continue to grow (U.S. Congress. House. Committee on Interstate and Foreign Commerce 1957; Ciocco, Altman, and Truan 1952; Fein 1954).

Physicians' new enthusiasm for expanding medical education with state and increasingly with federal subsidies was welcomed by leaders of hospital associations and of organizations promoting research on

particular diseases and by the Association of American Medical Colleges. With increasing support from the medical profession, these groups pressed the case for federal subsidy of medical schools' operating budgets with new vigor, beginning in the late 1950s.

During the 1950s, moreover, organized medicine and the labor movement began, somewhat uneasily, to work together in state and local affairs. Their mutual accommodation was evident initially in physicians' diminishing antagonism toward prepaid group practice. However, the involvement of the unions in medical affairs was mainly a consequence of the growth of voluntary health insurance. Most health insurance was purchased by employers from Blue Cross/Blue Shield or commercial companies, either as a result of collective bargaining or as a way to deter unionization. By 1959, 4 percent of the total compensation of working Americans was paid by employers for health programs (Galenson and Smith 1978). Hospital trustees and administrators were eager to maximize the costs they recovered; physicians wanted high and stable earnings; and most union officials' careers depended on their members' satisfaction with what they obtained for them through collective bargaining. Labor leaders, an economist concluded in 1959, were using the "union's bargaining position to win benefits for the medical profession and the hospitals" (Munts 1967).

Staff members of unions and of organized medicine began to work together to solve practical problems. In 1951, for instance, the AMA invited doctors employed by unions to join a new Committee on Medical Care for Industrial Workers in order to establish standards for group practices sponsored by unions. In the mid-1950s, the *Journal* of the AMA urged organized medicine and the United Mine Workers to cooperate in the Appalachian region, even though the United Mine Workers had built regional hospitals staffed by groups of full-time physicians. A growing number of local medical societies—in Michigan, California, and New York City, for example—endorsed or tolerated prepaid group practice as a result of pressure on them from physicians whose income came mostly from union benefit plans and from fear of federal antitrust action. In 1957 the president of the AMA was, for the first time, an employee of a prepaid group practice. Two years later, the AMA House of Delegates redefined the principle that patients be permitted a free choice of physician to include their right to select a group practice. Nevertheless, strong factions in organized medicine

remained violently opposed to prepaid group practice, and many physicians who worked in them continued to suffer discrimination.

The political goals of organized medicine were, however, changing. From the 1920s to the 1950s, the AMA and the state societies had used the techniques of symbolic politics—slogans, posters, letter-writing campaigns, for example—to unite the majority of physicians against what they regarded as efforts by government to force them to be accountable to the leaders of academic medicine. The politics of service had supported the politics of symbolism for most of that time. In return for physicians' dues and occasional political chores, organized medicine guaranteed them that they would not be disturbed by state and local governments and by academics eager to organize regional hierarchies.

Beginning in World War II, however, physicians increasingly wanted positive action from government at all levels. They wanted subsidized specialty training, new and enlarged hospitals and clinics, and more and larger medical schools. Medical societies' service to their members became the hard work of providing benefits, of obtaining subsidies, and of negotiating for regulations that would enable physicians to increase their control of medical care and their share of its price. Symbolic politics can be—sometimes must be—conducted alone. The politics of public subsidy requires coalition with other claimants of scarce resources.

The goals of groups pressing for medical care programs at the national level also changed during the 1950s. To some extent this change was a result of the failure to enact national health insurance. But it was also a response to the growing strength of local coalitions of physicians, hospital leaders, and politicians eager for state and federal subsidy for hospital growth and expanding medical education. Whatever the balance of causation, the liberal lobbies adopted the agenda of local coalitions. Union leaders, officials of voluntary associations, and many experts on medical care abandoned the campaign for national health insurance in order to press for medical care for the elderly under Social Security. To some of its advocates, what would be called Medicare was an expedient, a first step toward a comprehensive program. But many proponents of medical care for the elderly did not regard it as a temporary measure. The elderly, they declared, were unique because, although they needed more medical care than

any other group, they could not negotiate for medical benefits through collective bargaining (Marmor 1970).

The national agendas of other pressure groups had also changed by 1960. The leaders of the American Hospital Association, no longer terrified of disapproval by the AMA, announced their eagerness to support a variety of national programs to reduce hospital deficits (American Hospital Association 1955). The Association of American Medical Colleges and specialty societies spoke for an increasing number of physicians, many of whom were active in local coalitions. Although it is impossible to know how many physicians identified their interests with those of the local coalitions, it is likely that their numbers included many of the 25 percent of AMA members who ceased paying dues in the 1950s and many younger specialists on the faculties of academic medical centers who never joined organized medicine. In addition, Blue Cross plans and insurance companies were eager to have their most expensive risks, elderly and disabled patients, subsidized by public funds.

By 1960 a new national coalition had formed, uniting supporters of hierarchical regionalism with advocates of entitlement programs to pay for medical care for some individuals. The manifesto for the new coalition was a study by Herman and Anne Somers, *Doctors, Patients and Health Insurance,* published in 1961 by the Brookings Institution. Physicians, the Somers argued, were gaining power to sustain life at a rapidly accelerating rate. The benefits of this power could be extended to more people as a result of public investment in manpower, facilities and research, public subsidy to provide care for the poor and the elderly, and more extensive voluntary insurance for workers and their dependents. The coalition pressing these policies, the Somers said, should take advantage of the fragmentation of the medical profession and ignore doctrinaire advocates of national health insurance (Somers and Somers 1961).

A National Health Policy, 1960–1968

The health program of the Kennedy administration responded to the growing cohesion of a coalition advocating a new federal policy for medical care. But the Kennedy program of hospital construction, community mental health centers, medical school subsidy, and medical

care for the elderly under Social Security stalled in Congress in 1961, in large measure because it did not become a major administration priority until after the midterm elections of 1962.

The campaign in 1963 to enact what became the Health Professions Educational Assistance Act demonstrated the potential strength of the coalition advocating new health policy. The bill was endorsed by medical, dental, hospital, public health, and group practice associations—though not by the AMA, by farm and labor organizations, and by voluntary associations concerned with particular diseases. The Student American Medical Association, disagreeing with its parent organization, advocated federal financial aid to students. When the bill was delayed by conservatives in Congress, the Secretary of Health, Education, and Welfare reminded members of the coalition supporting it that the measure was part of their larger program to increase the supply of services (U.S. Congress. House. Committee on Interstate and Foreign Commerce. 1963).

Between 1964 and 1966 Lyndon Johnson and the 89th Congress implemented the consensus about health policy that had emerged since the late 1930s. An unprecedented number of measures were passed to increase the supply of services, organize them into loosely structured hierarchies based on geographic regions, and subsidize the cost of care for people who were outside the labor market. The rapid enactment of so much new legislation was the result of events outside health politics. When John Kennedy was assassinated, the Health Professions Educational Assistance Act and a program to create community mental health centers were the only practical achievements of the health program of his administration. Lyndon Johnson's political skills, his popularity, and the election of an unusual number of liberal congressmen in the Democratic landslide of November 1964 persuaded the chairmen of powerful committees in the House and Senate that there was enormous support for the administration's domestic program, and for its health legislation in particular.

The extraordinary political situation following the assassination of John Kennedy explains the rapid enactment but not the substance of the Johnson administration's health program. In the political climate of 1965 and 1966, shared beliefs and the practical experience of coalition in state and local affairs in the recent past made possible unprecedented political alliances in support of new health policy. When Lyndon Johnson sent his health program to Congress in 1965,

however, he spoke for a coalition that had been created over a generation. In his message to Congress announcing his health program, Johnson proclaimed goals similar to those stated for a generation by presidents, leaders of interest groups, and the media. For some participants in health politics, these words were articles of faith; for others, they were self-evident platitudes that justified aggrandizing the interests they represented. For the first time, however, the assumption that properly organized and distributed medical care linked to entitlement programs that paid for services for the elderly and the poor would lead to social progress was embodied in a program that was supported by an effective national coalition.

Only the AMA was outside the consensus, and then only on the issue of medical care for the aged under Social Security. Moreover, the AMA, without significant allies, capitulated and rejoined the national consensus when Medicare became law. In mid-1965, the AMA agreed to negotiate about regulations to implement the program (Marmor 1970; Skidmore 1970). The Johnson administration, welcoming the AMA into the national coalition, signalled its pleasure by taking its advice in amending the bill to create regional medical programs—a measure to diffuse knowledge by voluntary action from medical schools and teaching hospitals—just a few months later (Price 1972; Feder 1977).

By the late 1960s a consensus about how to organize and pay for medical care was supported by a larger and more powerful coalition than at any time in the past. Most of the people who followed the politics of the health sector congratulated themselves. They assumed that, in the near future, regional hierarchies of institutions and practitioners—called, with more optimism than accuracy, health service delivery systems—would become more rational and efficient. Third-party payments for physicians' and hospitals' services would probably become more comprehensive. To some liberals, compulsory national health insurance was—the word was not yet ironic—imminent. Moreover, the achievement and the promise of these policies seemed to represent a splendid balance among competing groups whose members had, in recent memory, been bitter antagonists. As the Surgeon General of the United States Public Health Service said approvingly in the summer of 1965, "No single element, neither private nor academic medicine nor government can write the prescription and impose it on the rest of the partnership" (Stewart 1966).

The Unexpected Consequences of Hierarchical Regionalism

The consensus of the late 1960s became, gradually, the acrimony and uncertainty about health policy of the 1980s. I will not narrate in detail the events of the past decade and a half, which are beyond the scope of this article. But a brief, tentative summary of some of the consequences of the policies that implemented hierarchical regionalism may be of use to readers who are drawn to history because of their interest in contemporary affairs.

Hierarchical regionalism remains fundamental to health policy in the United States. The assumption that knowledge that will lead to better health is usually discovered in university and hospital laboratories continues to guide investment in facilities, equipment, and personnel for medical research and education. The assumption that the results of medical research are disseminated most efficiently down hierarchies dominated by hospitals, and especially by large teaching hospitals, is still the basis of policy to plan, build, and equip hospitals and health centers and to link physicians to them. The assumption that consumers are entitled to receive services of increasing sophistication and cost continues to drive policy to finance medical care.

However, the success of hierarchical regionalism as a policy stimulated the erosion of regional hierarchies beginning in the 1970s. Public subsidies for biomedical research, professional education, and improved access to services unintentionally tore apart fragile regional hierarchies—fragile because they were alliances of groups and institutions that could also compete with each other. Public sponsorship of biomedical research and its applications caused an unprecedented increase in the number of new drugs, devices, and medical procedures. Subsidies to train more medical specialists increased the number of physicians on the staffs of community hospitals who were able and eager to perform sophisticated procedures. Third-party payers, moreover, reimbursed physicians without regard to their sophistication, and hospitals for any procedures performed in them as long as they were accredited. Public programs to plan health systems and subsidize the construction of new facilities were administered by state officials who assumed that efficient regionalization would continue to result from mutual accommodation among institutions each of which would benefit from the growing resources of the health sector. Public subsidy of the care of

elderly and poor patients and tax subsidies for voluntary insurance made most of the people in every community sources of potential income to physicians and hospitals (Fox 1985).

The most important of the unexpected consequences of health policy has been the increasing financial cost of medical care. The hope that economic growth would absorb the increasing cost of medical services has proven profoundly wrong. As a result, controlling costs became a central goal of health policy in the 1970s. At first, policy makers tried to use the strategies of hierarchical regionalism, which had been so effective in the years of growth, to restrain the rate at which costs increased. These efforts included mandated peer review of the inpatient services physicians ordered for Medicare patients, incentives to create health maintenance organizations, certificate-of-need programs to inhibit new hospital construction and regulate the diffusion of expensive new technology, and the establishment of new state and regional planning organizations. Yet costs continued to escalate. As a result, the cost crisis assisted the political ascendancy of ideological opponents of risk-pooling, collective provision, and regulation as fundamental principles of social policy. The effects of this new ideological climate on the consensus supporting hierarchical regionalism, and thus on the policies and institutions that had emerged by the 1960s, remain far from clear.

The regional hierarchies established since the 1940s are, however, changing rapidly in the 1980s. Diagnostic and therapeutic procedures that were once available only in the most sophisticated hospitals can now be performed at lower levels in a hierarchy, often at a lower cost than in teaching hospitals. Moreover, regions have become more self-contained. Not only are fewer patients being referred up hierarchies to teaching hospitals but fewer of them are being referred outside their regions to specialized institutions in metropolitan centers (Health Systems Agency of New York City 1983). Perhaps most important, hospitals within particular geographic regions more frequently compete with each other. Large teaching hospitals compete with smaller ones and with community hospitals for patients whose conditions they would not have treated just a few years ago. In some areas, investor-owned firms manage or own hospitals at several levels of a hierarchy and refer patients within their own system (Gray 1983).

Rising expenditures for medical care and increasing competition among physicians and hospitals are results of the success of hierarchical

regionalism. The assumptions on which health policy was based in the past created the problems and opportunities of the present. These assumptions were derived from an interpretation of history—the belief that hierarchical regionalism, a particular method of organizing scientific research and medical care based on it, would promote progress in the future because it had done so in the past.

New health policy is emerging because it always does. New arrangements which are stimulated by the consequences of older policy should not be condemned simply because they are unfamiliar. Neither should these new organizational arrangements be accepted as justified by history. The history of health policy should not be, as it has too often been, used for ideological warfare. Health policy is at once connected to its past and becoming something new as a result of the convergence of past and present.

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Acknowledgments: The research reported here was supported in part by a grant from the Commonwealth Fund Book Program. An earlier version of this

article was presented at a colloquium sponsored by the Davis Center at Princeton University in March 1985. I am grateful to many colleagues for their comments on aspects of this work in progress. I want particularly to acknowledge assistance from Lawrence D. Brown, John C. Burnham, Rudolf Klein, Theodore R. Marmor, Barbara G. Rosenkrantz, and Rosemary Stevens.

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