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An Exceptional Nation: Why the United States Lacks Universal Health Insurance

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An Exceptional Nation:
Why the United States Lacks Universal Health Insurance

Senior Project submitted to
The Division of Social Studies
of Bard College

by
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Annandale-on-Hudson, New York

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Any project of this magnitude is by necessity somewhat of a communal experience.

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Introduction: The American Health Care System

The narrative of American exceptionalism dates back to the earliest periods of American history, with America viewed as a mythical “city on a hill,” and continues to be a mainstay in American political discourse.¹ Social scientists typically reject the nationalist or normative implications of such views; nevertheless, they have debated the extent to which the development of the United States differs from that of other nations, and the exceptional nature of those national differences.² No consensus on the general question of the United States as a distinctive nation has been reached, but there is agreement regarding particular topics.

Of the various differences between the policy approaches of the United States and other high-income countries, few are more exceptional than the health insurance system in the United States. Even critics of the exceptionalism thesis admit that the health insurance system of the United States contrasts sharply with those of other countries.³ This senior project is an examination of why provision for health insurance in the US has diverged from that of other nations. First, however, it is necessary to explain how health insurance differs in the United States as opposed to other countries.

¹ John Torpey, “American Exceptionalism?” in *The New Blackwell Companion to the Sociology Religion*, ed. Bryan S. Turner, 141–59. (Malden, MA: Wiley-Blackwell, 2010), 141.

² Robin Archer, *Why Is There No Labor Party in the United States*, (Princeton: Princeton University Press, 2007).

Eric Foner, “Why Is There No Socialism in the United States.” *History Workshop* 17 (1984): 57–80.

Michael Kammen, “The Problem of American Exceptionalism: A Reconsideration.” *American Quarterly* 45, no. 1 (1993): 1–43.

Seymour Martin Lipset, and Gary Marks. *It Didn't Happen Here: Why Socialism Failed in the United States*, (New York: W. W. Norton & Company, 2000).

Byron E Shafer, “American Exceptionalism.” *Annual Review of Political Science* 2 (1999): 445–63.

Werner Sombart. *Why Is There No Socialism in the United States?* trans. Patricia M. Hocking and C.T. Husbands, (White Plains, NY: International Arts and Science Press, 1976).

³ Graham K. Wilson, *Only in America? The Politics of the United States in Comparative Perspective*, (Chatham, NJ: Chatham House Publishers, 1998), 73–75.

A common misconception holds that whereas the United States has a purely market based health insurance system, other high-income countries have a government run single payer system. This is simply incorrect, for two reasons. One, it understates the role of government in the provision of health insurance in the United States, and secondly, it overstates the role of government in the provision of health insurance in other countries.

Health insurance in the United States is mostly a private phenomenon, with most insured US citizens receiving that coverage through a private, usually for-profit, insurance company.⁴ Typically, this is done through the workplace, with the employer providing group plans to all full-time employees. Employers of a certain size are required to offer health insurance, and receive tax benefits for doing so.⁵ Although there are minimum requirements plans have to meet, they vary heavily in quality and coverage.⁶ They are not always comprehensive, as insured people frequently have to pay an amount known as a co-pay to access services. The plans are usually not free, and can charge monthly deductibles. Dependents can often be placed in the same plan as an employee, usually at extra cost. For Americans whose employer does not offer insurance, the other private option is to buy insurance on the market, which uninsured people are now required to do as a result of the Affordable Care Act, with failure to do so resulting in a fine. For those with medium-low incomes, the government provides a subsidy to purchase insurance.⁷

⁴ Jessica C. Barnett, and Marina S. Vornovitsky. "Health Insurance Coverage in the United States: 2015." Washington D.C., 2016, 2.

⁵ Most employee contributions to employer-sponsored insurance are also deductible, although not all are, depending on the type of plan. Employer contributions are not subject to the payroll tax, making them more cost effective for the employer and employee than providing the same funds in the form of wages. Jonathan Gruber, "The Tax Exclusion for Employer Sponsored Health Insurance," Working Paper 15766 (National Bureau of Economic Research, 2010), 3-5, 19.

Sara Rosenbaum, "The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice," *Public Health Reports* 126, no. 1 (2011): 130.

⁶ *Ibid.*, 131.

⁷ *Ibid.*

Care itself is provided at private institutions, often the office of practitioners or at privately owned hospitals. This is roughly how private insurance works in the United States, a facially private system with substantial support from the government.

An increasing number of American do not receive their health insurance privately. About 40% now receive health insurance through the government, a number which has grown since the passage of the Affordable Care Act.⁸ The two largest government health insurance programs are Medicare, a program for the elderly, and Medicaid, a program for the poor. Medicare provides hospital insurance to Americans over age 65, with the option of buying supplemental physicians' insurance.⁹ Medicare is a national program, without state involvement. Medicaid, by contrast, is a federally funded program in which requirements and the basic operations are set by the state governments, leading to large state-level differences.¹⁰ Although Medicare and Medicaid were created simultaneously, the two have different political fortunes, with Medicare polling far more favorably.¹¹ Medicare is paid for by the payroll tax, which also covers Social Security, and the popular conception is that an individual worker puts money into the Medicare pool which they then deservedly use in retirement. Medicaid, by contrast, is paid through general funds.

A substantial number of Americans, 13.2%, have no health insurance at all.¹² This number has decreased recently due to the policies of the Affordable Care Act, particularly Medicaid expansion, the individual mandate, and subsidies for private insurance. Still, the

⁸ Barnett and Vornovitsky, "Health Insurance Coverage in the United States: 2015," 2.

⁹ Beatrix Hoffman, *Health Care for Some: Rights and Rationing in the United States Since 1930*, (Chicago: University of Chicago Press, 2012), 123-124.

¹⁰ Barnett and Vornovitsky, "Health Insurance Coverage in the United States: 2015," 14.

¹¹ Martin Gilens, *Why Americans Hate Welfare: Race, Media and the Politics of Antipoverty Policy*, (Chicago: University of Chicago Press, 1999), 44-45.

¹² Barnett and Vornovitsky. "Health Insurance Coverage in the United States: 2015," 4.

passage of the Affordable Care Act has not eliminated the problem of uninsurance, Only further legislation would be able to eliminate the uninsured population.

How does this system compare to that of other countries? It depends which countries one is comparing to. Generally, the most distinctive element of the US health insurance system is the large number of uninsured people. The United States has the highest rate of uninsured people of any OECD country, with the exception of crisis-ridden Greece.¹³ Unlike Greece, the high rate of uninsurance is not the result of factors temporally specific to the current era, but is instead the result of the wider historical development of the health insurance system. The second major distinction is that the US tends to have a larger role for for-profit insurance companies than do other countries. It is important, however, not to exaggerate this distinction. The problem is that other countries' health insurance systems vary widely. The British system, for example, does not have a major role for for-profit insurers. Instead, the national government provides not only health insurance but a government run national health *service* which directly provides care to patients. The only comparable component of the US system is the Veterans' Administration hospital network. In France, by contrast, government provided insurance covers most major illnesses, but there are gaps in the public insurance which are filled by private companies.¹⁴ Japan has a mostly for-profit system.¹⁵ Germany's sickness-funds are private, but are highly regulated and are not for profit.¹⁶ These differences matter in understanding what is and is not distinctive about health insurance in the United States.

¹³ OECD, "Health at a Glance 2015," (Paris, 2016), 121.

¹⁴ Victor G. Rodwin "The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States," *American Journal of Public Health* 93, no. 1 (2003), 31-32.

¹⁵ Thomas Bodenheimer, and Kevin Grumbach. "Health Care in Four Nations." in *The Social Medicine Reader: Health Policy, Markets, and Medicine*, ed, Jonathan Oberlander et. al, (Durham, NC: Duke University Press, 2005), 218-225.

¹⁶ *Ibid.*, 200-205.

Before beginning a discussion of the history of health policy in the United States, it is necessary to define and distinguish several key terms which are commonly used in health insurance debates. “Universal health insurance” is a system in which everyone has insurance, but this insurance could be provided any number of ways, from the use of for-profit companies to government insurance. A single payer system, by contrast, combines universal coverage with the presence of a “single payer”, the government. Thus, one can have a universal health insurance system without a single payer system. National health insurance is single payer done at the national level. This is important when making regional distinctions, as other countries’ provinces have sometimes passed their own single payer system prior to there being national health insurance.¹⁷ During the 1930’s and 40’s, debates centered around the use of the terms “voluntary” and “compulsory” insurance. These terms have changed meanings over time, as “voluntary” insurance in that context referred to private insurance, and “compulsory” insurance referred to public insurance. The concept that private insurance might be compulsory, as is the case under the Affordable Care Act, had not yet been formulated. Finally, “socialized medicine” is a term frequently used in a derogatory manner, and without clear meaning. The constantly changing usage leaves it without analytic precision, and the term is not used in this paper.

There are several methods of paying for medical care. “Fee for service” was the traditional method of paying for medical service, in which a patient pays an individual physician for each service performed, with the fee decided entirely by the individual doctor, usually on a sliding scale. This contrasts with other methods. Insurance can be provided on an indemnity, service benefits, or pre-paid model. With indemnity payments, the patient provides payment and then bills the insurer for reimbursement, while with a service benefits model the provider bills

¹⁷ Antonia Maioni, *Parting at the Crossroads, The Emergence of Health Insurance in the United States and Canada*, (Princeton, NJ: Princeton University Press, 1998), 93.

the insurer directly.¹⁸ Alternatively, in a pre-paid model, physicians receive either a salary or receive automatic payments based on the number of patients they see, without the need to bill for a given service.¹⁹ Service benefits plan are the most common type of insurance, although pre-paid plans have risen in usage in recent years through Health Maintenance Organizations (HMOs). Indemnity, service benefits, and pre-paid care are consistent with either public or private insurance. Medicare, for example, uses a service benefits model, whereas the Veterans Administration system is pre-paid.

A Brief History Health Policy in the United States

Federal government action on health insurance began in the 18th century, with a 1798 act guaranteeing health insurance for sailors.²⁰ Despite this early government intervention, health insurance was not a major issue during the late 18th and 19th centuries. Individuals saw a family doctor who accepted a fee from the patient. Doctors would use a sliding scale to allow individuals with lesser means to be able to afford care. Quality of care was poor, however, and as one analyst put it, at the turn of the 20th century a random physician seeing a random patient with a random disease would only have a fifty percent chance of actually helping the patient.²¹

Changes in the structure of medicine during the late 19th and early 20th century brought about major change in the delivery of medical care. Hospitals were becoming increasingly central to the delivery of medical care.²² This, along with the Flexner Report, which called for increased standards in medical schools, caused an increase in the cost of health care.²³ A small

¹⁸ Hoffman, *Health Care for Some*, 92.

¹⁹ *Ibid.*, 191.

²⁰ *Ibid.*, xxvi.

²¹ Julius B. Richmond and Rashi Fein, *The Health Care Mess: How We Got Into It and What It Will Take To Get Out*, (Cambridge, MA: Harvard University Press, 2005), 9.

²² Paul Starr, *The Social Transformation in American Medicine*, (New York: Basic Books, 1982), 146.

²³ David Dranove, *Code Red: An Economist Explains How to Revive the Healthcare System Without Destroying it*, (Princeton, NJ: Princeton University Press, 2008), 9.

number of people received medical care through their employers, but these occupations were few and far between.²⁴ Most people paid the physician for the service received, with additional procedures costing additional money.

Other countries were beginning to experiment heavily with health insurance, including Germany and the United Kingdom. In the United States, the American Association for Labor Legislation, a group led mostly by college professors, tried to enact compulsory insurance in the 1910's, but the effort failed.²⁵ The national American Federation of Labor, led by Samuel Gompers, refused to support the legislation for ideological reasons, due to his belief that working people should not rely on government benefits for their well-being, but rather through private action.²⁶ The AALL's proposals were not limited to health insurance. They included sick pay insurance, a higher priority for many workers than health insurance, as well as life insurance, the latter of which upset the powerful life insurance industry, contributing to the downfall of the proposal.²⁷ This moment of potential reform ended with the United States' entry into World War 1, as the AALL's link to German policies were no longer politically tenable.²⁸ In a reversal of future health insurance battles, the American Medical Association was ambivalent about these proposals, at times even supportive. By 1920, however, the AMA had decided it was opposed to compulsory health insurance, as the AMA was concerned about the loss of autonomy that would result from state intervention, and the disruption of the fee for service system with a potential

²⁴ In 1928, 11% of firms with fewer than 250 workers, and 15.5% of firms with 150 or more workers, provided health or accident insurance. Frank Dobbin, "The Origins of Private Social Insurance: Public Policy and Fringe Benefits in America, 1920-1950," *American Journal of Sociology* 97, no.5 (1992): 1424.

²⁵ Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*, (Cambridge, MA: Harvard University Press, 1992), 176-204.

²⁶ *Ibid.*, 207-210.

²⁷ Starr, *The Social Transformation of American Medicine*, 252.

²⁸ *Ibid.*, 253.

reduction of income.²⁹ From that point on, the AMA has been opposed to universal health insurance efforts, often constituting the chief resistance to such proposals.

Proponents of universal health insurance were less active in the 1920s, but the 20s nonetheless contained several major developments. The first of these is the 1921 Sheppard-Towner Act, which subsidized clinics pre and post birth care for mothers and newly born infants, creating a potential precedent for government intervention in health care.³⁰ The Act expired in 1929 without renewal.³¹ Second was the creation of the Committee on the Costs of Medical Care, founded in 1927, which conducted research on efforts to solve the growing problem of unaffordable medical care. Its report was released in 1932, and found that hospitalization costs were well beyond the means of the average family, with patients relying on hospital to provide care for free. It criticized fee for service as creating misplaced incentives in which physicians financially benefit from providing unnecessary treatments.³² Thirdly, new alternatives to traditional fee for service care were developed, the first of these being the development of Blue Cross hospital insurance in 1929 at Baylor University Hospital.³³ The medical field was undergoing major changes, trying to find ways to allow people to access the newer, more costly care. It had not yet found a way to do this sustainably when the Great Depression hit, exacerbating the already existing problems.

It is in this context that the Roosevelt administration attempted to provide a universal or near-universal solution to the problem by creating a system of public insurance. Government was not the only actor looking at solutions, however. Private, voluntary insurance grew in usage in

²⁹ Ibid., 247-248.

Hoffman, *Health Care for Some*, xxxiv.

³⁰ Skocpol, *Protecting Soldiers and Mothers*, 10.

³¹ Ibid., 514.

³² Dranove, *Code Red*, 11-14.

³³ Starr, *The Social Transformation of American Medicine*, 295-298.

this time, but the growth was mostly limited to hospital insurance. The American Medical Association opposed insurance, public or private, that included medical care, if it did not follow a strict set of conditions. For example, the AMA required that “the immediate cost should be borne by the patient if able to pay at the time the service is rendered.”³⁴ This hardline position began to soften in the late 1930’s, partially in response to efforts by proponents of public insurance. The AMA began, with much internal tension, to support Blue Shield physicians’ insurance, although enrollment was highly limited at first.³⁵ Despite the limitations on these private insurance efforts, they suggested to opponents of national health insurance that the private sector might be able to provide insurance for the vast majority of Americans, even though this was not yet the case. By 1940, less than 10% of Americans had hospital insurance, with fewer possessing surgical benefits. Health costs continued to rise, however, despite many Americans’ inability to pay. In 1929, health spending was 3.5% of GDP. In 1940, it was 4.0%. Ten years later, it was 4.4%, and by 1960, health spending was equal to 5.3% of GDP.³⁶

Access to health insurance rose precipitously during the Second World War. There is some argument as to what factors were most crucial to this rise. The traditional argument is that during World War 2, the government imposed strict limits on wage increases which did not apply to fringe benefits. Employers thus added benefits, including health insurance, in lieu of pay increases.³⁷ More recent analyses have questioned this causal linkage, arguing that the 1939 revisions to the Social Security Act incentivized employer provision of fringe benefits, leading to

³⁴ The AMA explicitly opposed hospital insurance that included medical care, in contrast to the costs of hospitalization. Quoted in Starr, *The Social Transformation of American Medicine*, 299-300.

³⁵ Starr, *The Social Transformation of American Medicine*, 306-310.

³⁶ Dranove, *Code Red*, 12.

³⁷ Frank Dobbin, “The Origins of Private Social Insurance: Public Policy and Fringe Benefits in America, 1920-1950,” 1436-1437.

the increase in pension coverage as well as health insurance coverage during the war.³⁸ The increase in insurance did not stop at the end of the war. Labor unions, which supported a national health insurance system took on an increasing role in negotiating private insurance plans.³⁹ By 1950, when key supporters of national health insurance lost re-election, 50.7% of Americans had hospital insurance, with 35.8% having surgical benefits, rates which continued to increase up to the creation of Medicare and Medicaid. Figure 1 graphs the increase of insurance rates throughout this period, although there is no solid data from before 1940.

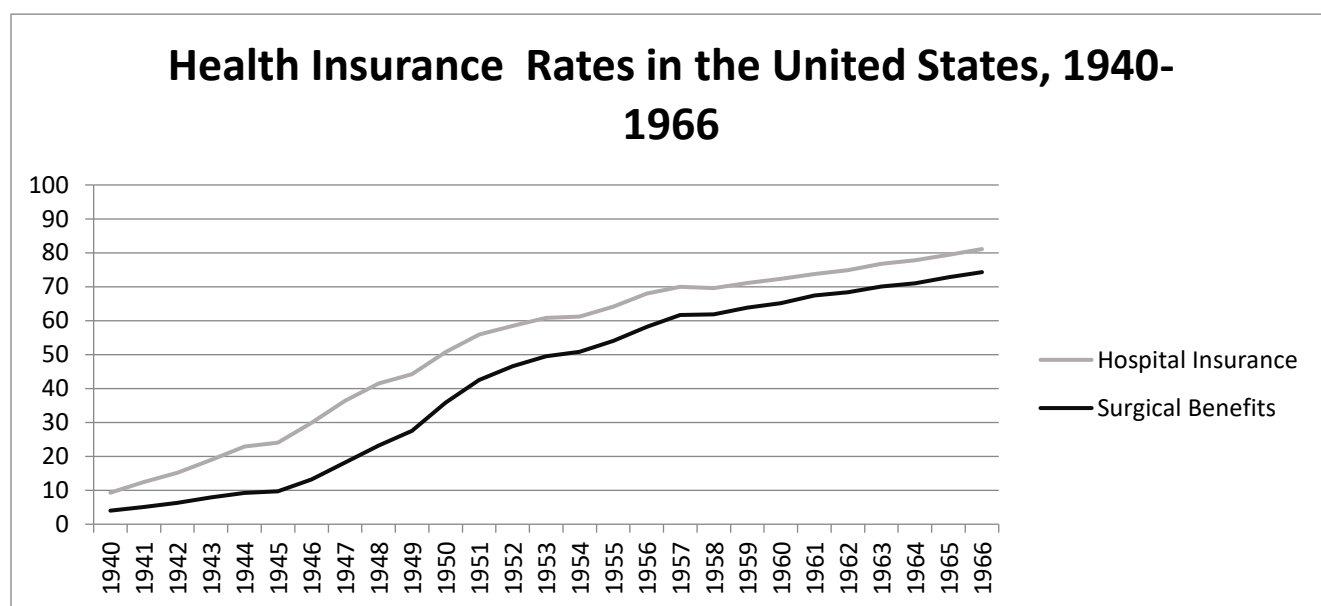


Figure 1. Percentage of Americans covered by health insurance.

Source: Louis Reed, "Private Health Insurance: Coverage and Financial Experience, 1940-1966," *Social Security Bulletin* 30, no. 11 (1967): 12.

This strong role for private insurance has created strong path dependency effects, by reducing popular demand for universal public insurance. Despite the myriad complaints with private health insurance, a citizen covered by private insurance would be significantly less likely to push for government insurance than if they were uninsured entirely. By the early 1950's, there

³⁸ Ibid., 1438-1440.

³⁹ Alan Derickson, "Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958," *The Journal of American History* 60, no. 4 (1994): 1346-1350.

were several groups which were disproportionately uninsured, including African-Americans, the elderly, the poor, farmers, and workers at small businesses, all groups which lacked substantial political power.⁴⁰ Reformers such as Oscar Ewing soon focused on covering some of these gaps with targeted programs, a vision which was later realized with Medicare and Medicaid.⁴¹ Medicare and Medicaid were passed with strong backing by organized labor and lukewarm reaction by hospitals, over the opposition of a declining AMA.⁴²

After 1950, a national, single-payer health care system has been almost entirely off the political agenda. It has received support from some members of Congress, from Ted Kennedy to Bernie Sanders, but it has not received the support of any sitting president since Truman, and has not made legislative headway. The development of high levels of private insurance, along with the role played by Medicare and Medicaid, has made the later passage national health insurance far less likely.

To answer the question of why the United States lacks national health insurance, it is therefore necessary to examine a period prior to these strong path dependency effects, as in many ways the results of the earlier health insurance debates determined the results of later ones. This senior project examines the broader question of why the US lacks universal health insurance through an investigation into two critical moments: the presidencies of Roosevelt and Truman. The battles over health insurance policy during both presidents have been heavily written about by historians and social scientists. This project attempts to evaluate and synthesize the available studies, and it also provides additional insight into this historical moment through the use of original archival research. The primary sources consulted form the basis for the narratives

⁴⁰ Hoffman, *Health Care for Some*, 90-91.

⁴¹ Maioni, *Parting at the Crossroads*, 108-110.

⁴² Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*, (Princeton, NJ: Princeton University Press, 2003), 234-242.

developed in chapters 2 and 3. Documents were consulted from the archives of the Interdepartmental Committee to Coordinate Health and Welfare Activities at the Roosevelt Presidential Library, the archives of Senator Robert Wagner, housed at Georgetown University, the records of Frances Perkins, held at Columbia University, and the records of the Committee for the Nation's Health, held at the New York Academy of Medicine.

Chapter 1 provides a general overview and evaluation of the major explanations that have been offered for the exceptional health insurance system of the United States. I find that some of these deserve more careful consideration than others. Chapters 2 and 3 consider the stronger explanations in more detail within the context of struggles for universal health insurance during the Roosevelt and Truman presidencies, respectively.

Chapter 1: Explaining the American Health Insurance Dilemma

Previous researchers have formulated several explanations for the unique character of the US health insurance system. These explanations are not necessarily mutually exclusive, and should instead be seen as adding to each other. It is important to note that some explanations are temporally specific; the reasons why President Truman's health insurance push failed are not necessarily the reasons why President Clinton's proposal made little headway in Congress. This temporal specificity does not mean we can look at any given policy battle over health insurance completely separately from previous fights. Each major debate on health insurance policy has left a policy legacy with lasting implications. Just as the failure to pass national health insurance under Truman shaped the goals of later reformers, the Democrats under President Obama learned from the mistakes made under President Clinton to successfully pass the Affordable Care Act. Thus, some explanations may only be relevant to a particular moment, whereas others are used across eras. The goal of this chapter is to describe these cross-temporal explanations, and to evaluate the strengths and weaknesses of them.

The Industrialism Approach

Early theorists of the welfare state viewed it as an inevitable consequence of economic growth and industrialization. These changes created the need and capacity for a welfare state.¹ This approach has fallen out of favor compared to other models. It is particularly ill-suited to explain the United States' distinctive health insurance system, given the high levels of industrialization in the United States. There is little question that the United States' possesses the technical and economic capacity to have national health insurance. Yet, as Hacker argues, this does not mean that the industrialism approach lacks any validity in explaining interstate variance

¹ Harold L. Wilensky and Charles N. Lebeaux, *Industrial Society and Social Welfare* (New York: Russell Sage Foundation, 1958), 14-15.

in health policy, for “national health policies are indeed constrained by economic conditions and by the underlying features of the medical sector.”² The industrialism approach may be particularly useful for understanding why health insurance policy became salient, first in the 1910s to a limited extent, and then more so in the 1930s and 1940s. As health technology, quality, and thus cost increased, the provision of health care became increasingly consequential as a political issue.

The Liberal Tradition

One argument for the distinctiveness of the United States in policy and ideology is the strength and character of its liberal tradition. The United States is said by theorists in this tradition to have a particularly laissez-faire political ideology, a consequence of the lack of an American feudal tradition.³ Statist challengers to laissez-faire doctrine in the United States have more difficulty gaining traction than they do in Europe. This results in less class consciousness, as well as less popular and elite support for government programs.⁴ The ultimate effect of this is a generally smaller welfare state, and specifically less government involvement in health insurance.

This emphasis on national values is more common in the older literature, with the clearest example being Daniel Hirshfield’s book on *The Lost Reform*. For Hirshfield, proponents of public health insurance continuously had difficulty gaining substantial support for their proposals. Although by the time of the New Deal there was support for government action in a range of matters, not just health care, that action “had to conform as much as possible to the

² Jacob Hacker, “The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy,” *Studies in American Political Development* 12, no. 1 (1998): 62.

³ Louis Hartz, *The Liberal Tradition in America*, (New York: Harcourt, Brace and Company, 1955), 3-5.

⁴ *Ibid.*, 261-264.

traditional views of individualism, freedom, and responsibility.”⁵ If there was a less intrusive proposal with less government involvement, the proposals for state intervention would receive less support.⁶ This, Hirshfield argues, was the path taken by health insurance proposals in the New Deal, with private insurance winning out over government plans because it was more ideologically consistent with Americans’ views.

The liberalism approach, with its focus on culture and ideology, is initially plausible. Public opinion surveys taken in recent decades show that Americans are less supportive of government action to secure a basic income, reduce income inequality, take care of poor people, provide food and shelter for those in need, and provide health insurance.⁷ Distinctive social conditions in the United States could plausibly lead to a distinctive set of values, which, while changing over time, led to reduced support for a European-style welfare state. Ultimately, however, national values are not able to explain the distinctive path taken by the United States with regards to health policy. Given the weaknesses in this approach, it is dealt with in detail in this literature review rather than in the following two chapters.

There are several problems with this approach. First, it takes American ideology as a constant, as opposed to something which changes with social conditions. Liberal ideology changed over time, such that by the New Deal there was substantial support for the Social Security pension system.⁸ The exclusion of health insurance from Social Security cannot be

⁵ Daniel Hirshfield, *The Lost Reform*, (Cambridge, MA: Harvard University Press, 1970), 43.

⁶ Ibid.

⁷ Graham K. Wilson, *Only in America: The Politics of the United States in Comparative Perspective*, (Chatham, NJ: Chatham House Publishers, 1998), 27-29.

Robert Y. Shapiro and John T. Young, “Public Opinion and the Welfare State: The United States in Comparative Perspective,” *Political Science Quarterly*, 104, no. 1 (1989): 79.

⁸ Polling at the time showed that 89% of the public was “in favor of Government old age pensions for needy persons”. A poll a few months later showed 68% support for the specific Social Security plan. Support increased after Social Security was instituted, with 96% of the public supporting government

chalked up to an ideology ahistorically conceived, but must be explained with reference to the actual historic conditions and the dominant ideology of the time. The path of Social Security, along with other New Deal proposals, does not conform to Hirshfield's generalization that government action took the least intrusive approach possible. It would have been plausible for employers to have expanded private pensions enough that there was no need for a near-universal government pension plan. That this did not take place shows that non-minimally intrusive policies were able to be passed in the 1930's, and that Hirshfield's claim regarding the relationship between liberal ideology and policy outcomes is incorrect. Liberalism in the United States has changed over time, and has at times allowed intensive government interventions not obviously consistent with individualism.

If ideological consensus in the United States changes over time, it is necessary to explain that change. This moves away from the strongest form of the liberalism hypothesis, which wants to locate laissez-faire beliefs at the core of American political thought rather than as arising out of particular temporal circumstances which sometimes dissipate. One might reasonably argue that contemporary Americans' relatively weak support for government involvement in certain economic issues is the result of longstanding trends in American history, but it may well also reflect the product of more temporally specific events, as public opinion is not stagnant.

Americans in the 1990's had attitudes towards the welfare state more similar to European attitudes than they did in the 1980's.⁹ We should not overstate the argument; the proponents of the liberalism approach are aware that political beliefs are not stagnant. However, the temporal

pensions in 1939. George H. Gallup, *The Gallup Poll: Public Opinion 1935-1971*, (New York: Random House, 1972), 9, 40, 142.

⁹ Christopher Howard, *The Welfare State Nobody Knows*, (Princeton, NJ: Princeton University Press, 2007), 195.

instability of public opinion suggests that the dominance of laissez-faire liberalism at a particular moment is not the result of some intrinsic characteristic of American society.

A second major problem with the national values argument is that it takes for granted that the American social state is smaller than in comparable European countries. This has not always been the case. The United States developed a universal public education system earlier than in many comparable countries, contrary to the expectations of the liberal values approach.¹⁰ Additionally, the United States developed a large pension system in the aftermath of the Civil War to cover war veterans, prior to many European states creating their own pension systems. The program ended up covering about a third of Northern men of the appropriate age.¹¹ Again, the liberal values approach would predict the American welfare state to lag behind in all realms, not just in healthcare or income support, a prediction not supported by the historical evidence.

Third, the national values approach lacks a clear mechanism by which national values do or do not result in certain forms of state action. The national values approach assumes that elite and popular attitudes are in sync with each other, using elite writings to make assumptions about the views of ordinary Americans, and then assumes that those values are enacted in public policy. From conflict over labor organizing to the debates over health insurance, there has been no such clear ideological consensus in favor of classical liberalism in US history. Different organizations and individuals have made competing arguments, with some resulting in changes in government policy, and others failing to do so. The national values approach does not explain the relationship between these differing ideas and policy outcomes.

¹⁰ Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*, (Cambridge, MA: Harvard University Press, 1992), 88-92.

¹¹ *Ibid.*, 1.

A more nuanced version of the national values argument is that national values are reflected in public opinion, and that public opinion then shapes public policy. This second claim is a debated topic in the literature. Quadagno and Street, critics of the liberal values argument, find that “changes in U.S. government policy from the 1950s to the 1980s [had] little correspondence between public sentiment for more versus less government and the decisions made by politicians”.¹² More contemporary evidence suggests that government is responsive to public opinion generally, although once income is controlled for only the views of high-income individuals impact policy.¹³ Even if we accept the claim that public opinion has a strong impact on government action, this is still an insufficiently supported argument to explain why the United States’ health system is distinct. To apply the liberal values argument with regards to public opinion would misrepresent public opinion on government health insurance. The public’s answer to questions about health insurance are quite sensitive to the wording of the question, but overall the public has not been strongly opposed to government health insurance.¹⁴ This was particularly not the case in the 1930’s and 1940’s, prior to the AMA’s campaign to delegitimize the Truman plan.

¹² Jill Quadagno and Debra Street, “Ideology in Public Policy: Antistatism in American Welfare State Transformation,” *Journal of Policy History* 17, no. 1 (2005): 53.

¹³ Martin Gilens *Affluence and Influence: Inequality and Political Power in America*, (Princeton, NJ: Princeton University Press, 2012).

¹⁴ There have been moments when the public has been opposed to national health insurance, such as at the height of the AMA campaign. However, the debate usually falls along the lines from a 1992 disagreement between Altman and Navarro. Navarro argued that the public supported national health insurance, while Altman claimed that the public was “highly ambivalent” about national health insurance. Vicente Navarro, “A Response to Conventional Wisdom”, in *Why the United States Does Not Have a National Health Program*, ed. Vicente Navarro (Amityville, NY: Baywood Publishing Company, 1992), 23-25.

Drew E. Altman, “What Do Americans Really Want” in *Why the United States Does Not Have a National Health Program*, 26.

In 1938, a large majority (81%) of Americans thought that the “government should be responsible for providing medical care for people who are unable to pay for it”.¹⁵ This is not the same as universal health insurance, as it instead proposes a means-tested program. It nonetheless shows support for the basic principle that everyone should have access to care, with at least some government involvement. The first poll asking about a universal plan was issued in 1943, which showed 59% of the public in favor of expanding Social Security to include health insurance, hospital bills, doctors’ bills, and sickness pay.¹⁶ 58% supported doing so in a poll taken the following year, with an additional 10% willing to support such a plan if taxes were not raised.¹⁷

After the war, several pollsters asked more open-ended questions about what they would like to see happen with the insurance system. These data suggest a public more cautious about government health insurance than was the case during the war, which could be reflective of sensitivity to the wording or to actual changes in beliefs. A 1946 poll asking what Americans would like to have happen with health coverage found just 12% in support of having Social Security cover health costs, while 17% supported expanding voluntary coverage, 26% supported doing nothing, 11% wanted government insurance for the needy, with the rest supporting a variety of other options.¹⁸ When asked in that same poll whether their health care would improve under a government plan, 32% thought it would improve, 23% said it would stay the same, and 35% thought it would worsen. Just 60% of Americans polled had heard of the Truman health plan, and only 37% had heard of the Wagner-Dingell-Murray legislation, which would have enacted it.¹⁹ Those that had heard of either were supportive of the plans.²⁰

¹⁵ Gallup, *The Gallup Poll*, 102.

¹⁶ *Ibid.*, 400.

¹⁷ Hadley Cantril, *Public Opinion 1935-1946*, (Princeton, NJ: Princeton University Press, 1951), 442.

¹⁸ *Ibid.*, 578.

¹⁹ *Ibid.*, 442-443

²⁰ *Ibid.*

At that point, passage of Wagner-Dingell-Murray would have been consistent with the views of the American public at large. The best way of synthesizing these disparate results is that the American public was not opposed to government provided insurance. The public would have been satisfied had Social Security been expanded to include health insurance, but they were not particularly in support of doing so, as opposed to other means of increasing access to medical care. Lack of public support cannot be the reason the legislation failed. Therefore, even the more specific version of the national values argument with its emphasis on public opinion lacks empirical support.

It is worth noting that these views shifted as the Truman presidency continued. In 1949, after the AMA campaign against the Truman plan was underway, 43% of Americans thought that their quality of care would decrease under a government plan, with 26% thinking it would improve and 19% thinking it would stay the same. When asked directly whether they would prefer the Truman government plan or the AMA's plan of voluntary insurance, 47% preferred the AMA plan, with 33% preferring the Truman plan.²¹

A comparison of public opinion in the United States and Great Britain provides limited support for the liberalism hypothesis. Britain had already developed a limited system of public health insurance, but it after World War 2 that the UK instituted its National Health Services. This was done with strong public support. A clear majority supported national health insurance in addition to a level of government control over medicine that was never seriously proposed in the United States. In 1943, 70% of the British public supported a state medical service, while a 1944 poll found that 55% of Britons were in support. When given the option between the panel system (a limited system of public funding), complete state control, and private doctors, 55% of

²¹ Gallup, *The Gallup Poll*, 802.

Britons in a 1941 poll preferred complete state control.²² In both cases, the public wanted expanded access to health insurance, but the British public preferred a more active role for the government in the provision of care. These differences do provide at least some tentative support for the liberalism hypothesis, given the Americans' hesitance towards state-run care. The differences in public opinion likely explain why there was no serious proposal to have a national health service in the United States, as was enacted in the United Kingdom in the late 1940's. However, the fact remains that a majority of Americans supported including health insurance in Social Security, and that a majority who knew about efforts to do so supported those efforts. Public opinion thus cannot explain why, in Britain created its National Health Service after the war, and the United States did not succeed in passing national health insurance.

At times, there has been strong popular opposition to a large government role in health insurance, the data from 1949 being the most demonstrable example. However, the above section demonstrates that Americans' hesitance towards the Truman plan in 1949 was not the result of deep-seeded American values, but rather the product of historically specific circumstances. As these poll data show, "American values" can be consistent with support for government provided universal health insurance or with opposition to it. It may be the case that a particularly strong emphasis on individualism weakened Americans' support for government health insurance, and particularly government provided care, relative to European countries. It is also the case that individualist, anti-statist ideology was an ideological resource used by opponents of government health insurance.²³ It is not the case that a distinct American ideology precluded support for, or passage of, government provided health insurance.

²² Cantril, *Public Opinion 1935-1946*, 441-443.

²³ Quadagno and Street. "Ideology and Public Policy: Antistatism in American Welfare State Transformation," *Journal of Policy History* 17, no. 1 (2005), 53-54.

The Role of Interest Groups

A third theoretical approach to the welfare state brings attention to the role of interest groups in the shaping of health policy. The relative importance of interest groups varies over time, although some are consistently influential. Organized labor and organized medicine have been crucial players throughout the twentieth and early twenty first centuries, with health insurance companies becoming key in the second half of the twentieth century. The interest group approach views health policy as resulting from the power dynamics between these groups. Labor unions have been the most powerful backers of national health insurance, with organized medicine and the health insurance companies its most powerful and dedicated opponents. Proponents of the interest group approach argue that since organized labor is relatively weak in the United States, it has been unable to fulfill its demands for universal coverage.²⁴

The working class and the labor unions that represent them are typically key players in the formation of welfare states, either through their direct involvement or through the threat of instability.²⁵ It follows that to understand divergences between welfare states, it is necessary to look at differences in working class power. This view is put most succinctly with regards to health insurance by Vicente Navarro, who argues that “the establishment of a national health program in any country is related primarily to the establishment and influence of the labor movement in that country, realized through labor’s economic (unions) and political (parties) instruments”.²⁶ This model would predict a relationship between the strength of unions and

²⁴ Vicente Navarro, “Why Some Countries Have National Health Insurance, Others Have National Health Services, and the United States has Neither,” in *Why the United States Does Not Have a National Health Program*.

²⁵ Gosta Esping-Anderen, *The Three Worlds of Welfare Capitalism*, (Princeton, NJ: Princeton University Press, 1990), 16.

²⁶ Navarro, “Why Some Countries Have National Health Insurance, Others Have National Health Services, and the United States has Neither,” 140.

working class parties, the passage of government health insurance, and the level of decommodification with regards to healthcare. It is important to distinguish between strong and weak versions of this argument. Navarro's claim that variation in national health insurance policies is caused "primarily" by the labor movement is the strong version of the labor movement argument. The weak version of the argument is that labor movement strength has a substantial impact on variation in national health programs, although it is not necessarily the primary factor.

Working class power matters for welfare state formation broadly and health policy specifically, but Navarro's claim that interstate variation in health policy can be explained "primarily" by differences in class power is more a more difficult claim to support. He provides a table which he argues shows that social insurance follows the development of the formation of a socialist party and trade unions. However, the table does not support his argument. In five of the twelve countries, a major social insurance program preceded the formation of *either* a socialist party or a major trade union federation.²⁷ Navarro's own data demonstrate that welfare states do not only form in response to strong unions or socialist parties. Navarro's "social insurance" is not limited to health policy, and it could be the case that health insurance has its own logic distinct from that of other social insurance programs. Nonetheless, the strong labor movement argument proposed by Navarro simply does not have sufficient evidence.

With regards to the United States, the working-class power model has come under criticism by scholars of other traditions. Theda Skocpol, a proponent of institutionalism in a comparison of the different paths taken by welfare states in the US and the UK after World War 2, argues that differences in labor movement strength are insufficient to explain the different

²⁷ Ibid., 140-141.

policy outcomes. She claims that since the density rate in the US was increasing faster than in the UK, and the US had more strikes during and after the war, a labor-centric approach would expect the US to have developed a more extensive welfare state in the post-war period. She interprets the development of a strong welfare state in the UK at that time as evidence against a labor-centric approach.

Skocpol's account of labor movement strength ignores the actual size in membership. British union density was about twice the size of American union density from before World War 2 to immediately afterwards, a fact she leaves to a footnote.²⁸ . Regardless of the frequency of strikes (the higher strike rate in the US during the war is probably a consequence of the lack of direct threat to the American homeland), the larger size of British unions would be expected to contribute to a more expansive welfare state, as was the case. It is unclear why Skocpol uses "the growth of unions or the launching of strikes" is a better measure of the impact of unions than membership figures, particularly because strikes can be launched from a position of weakness, and do not necessarily reflect strength. Contrary to Skocpol's argument, the comparative case of the US and UK after the war provides support for a working-class power approach, particularly if the presence in Britain of a genuine labor party is taken into account. Some version of the weak labor argument is therefore a plausible explanation for the post-war divergences between the two countries' welfare states.

In the United States, unions' political power reached their peak in the years after World War II, their success in negotiating for private insurance and their organizational divisions weakened their ability and resolve to push for a single payer health insurance system at that time. Since then, unions' economic and political influence has declined, with union density dropping

²⁸ Theda Skocpol, *Social Policy in the United States: Future Possibilities in Historical Perspective*, (Princeton, NJ: Princeton University Press, 1995), 200.

from around 33% at the end of World War 2 to 10.7% in 2016.²⁹ Nonetheless, unions have continued to play a major role in health policy in the years since the Truman effort, providing critical support for Medicare and the Affordable Care Act.³⁰ The drop in union density has weakened working class political power and has made the passage of a universal government health insurance program less likely.

The typical counterpart to the role of labor unions is that of major corporations. There is a tradition in welfare state theory which argues that welfare states emerge due to the needs of corporations and other elite forces. Rather than a victory for the working class, the welfare state is viewed as a way of preventing workers from gaining influence. 19th century Germany is the paradigmatic example of this model, as Bismarck created the first modern welfare state as a way of consoling the industrial working class and providing security for the regime.³¹ In the context of the New Deal United States, debate over this model usually focuses on the passage of Social Security, and the role of corporate reformers in its passage.³² The New Deal more broadly can be viewed as an effort by President Roosevelt to save capitalism from radical forces on the right and left by providing relief from the Depression, although this may exaggerate the dangers to capitalism present at the time.³³ However, much of the opposition to the New Deal came from the elite and from big business, suggesting that if Roosevelt was saving capitalism, the capitalists

²⁹ U.S. Library of Congress, Congressional Research Service, Mayer, Gerald. *Union Membership Trends in the United States*, (2012), 23.

United States Department of Labor, Bureau of Labor Statistics, *Union Members – 2016*, (Washington D.C., 2017), 1.

³⁰ Tracy Roof *American Labor, Congress, and the Welfare State, 1935-2010*, (Baltimore: Johns Hopkins University Press, 2011), 2-4. 93.

³¹ Donald Madison, “From Bismarck to Medicare – A Brief History of Medical Care Payment in America” in *The Social Medicine Reader: Health Policy, Markets, and Medicine* ed. Jonathan Oberlander et al. (Durham, NC: Duke University Press, 2005), 34-36.

³² Jacob S. Hacker and Paul Pierson, “Business Power and Social Policy: Employers and the Formation of the American Welfare State,” *Politics & Society* 30, no. 2 (2002).

³³ Theda Skocpol, “Political Response to Capitalist Crisis: Neo-Marxist Theories of the State and the Case of the New Deal,” *Politics & Society* 10, no. 2, (1980): 156.

were not aware of it. Additionally, there were elements of the New Deal, such as the National Labor Relations Act, which clearly went against the long term interests of corporations.

This is a heavily debated paradigm with regards to health insurance as well. Marie Gottschalk argues that internationally, corporations had little role in the passage of government health insurance programs. Gottschalk uses the German case as evidence against the corporate influence argument, since Bismarck was not a representative of the capitalist class.³⁴ Navarro, by contrast, argues that universal health insurance is supported by corporations to legitimize and strengthen the capitalist system in response to working class demands from below.³⁵ This view needs empirical evidence however. Even if we accept the argument, it leaves unanswered the question of how influential corporations actually are. If corporations acquiesce to the development of social programs they otherwise would not support due to working class power, it seems odd to conclude, as Navarro does, that corporate political power is hegemonic.³⁶

The corporate landscape with regards to healthcare was vastly different in the 1930's then it would be just two decades later, as private health insurance was still in its infancy. Corporations took less of an interest in insurance policy. Even those corporations involved in crafting Social Security were more eager for a national pension system than in health insurance.³⁷ For this reason, scholars have not given as much attention to the role of corporations

³⁴ Gottschalk, *The Shadow Welfare State*, 23.

Although Bismarck was not himself a capitalist, he was in charge of a rapidly industrializing capitalist state. Thus, one can question Gottschalk as to whether his specific class origins are less consequential than the class interests he clearly represented.

³⁵ Vicente Navarro, "The Political Economy of Medical Care – An Explanation of the Composition, Nature, and Functions of the Present Health Sector in the United States" in *Health and Medical Care in the US: A Critical Analysis* ed. Vicente Navarro (Farmingdale, NY: Baywood Publishing Company, 1977), 106-109.

³⁶ For a development of this argument with regards to Social Security, see Hacker and Pierson, "Business Power and Social Policy: Employers and the Formation of the American Welfare State," 306-310.

³⁷ Peter Swenson and Scott Greer "Foul Weather Friends: Big Business and Health Care Reform in the 1990s in Historical Perspective," *Journal of Health Politics, Policy, and Law* 27, no. 4 (2002): 616-618.

in shaping health policy in the 1930's and 1940's as they have for later periods. Corporate influence could partially explain the failure of government health insurance proposals, although such an explanation would have to contend with the presence of a far more visible anti-reform lobby: the American Medical Association.

The AMA is frequently credited with defeating Truman's health care policy, but their influence is not limited to that single moment. The threat of the AMA's involvement hung over plans made under Roosevelt to push for government insurance, a threat that was realized in the 1940's when President Truman pushed for national health insurance. After defeating Truman's effort, the AMA has lost political influence. They were unable to stop Medicare, and while still a powerful lobby they lack the power to dictate power they once held. Few scholars would doubt that the AMA has had a crucial role in the shaping of health policy, particularly in the 1930's and 1940's. The questions to ask are with regards to its importance relative to other factors, and to the reasons why the AMA had the influence it did.

Institutionalism

Institutionalist approaches focus on the role of US government institutions in shaping the development of public policy. This includes elements of American politics such as the role of committee chairmen, the Senatorial filibuster, the role of political parties, and federalism. The general argument made is that these institutions impeded the development of universal health insurance. The committee chairman system gave a large amount of power to a small number of legislators. During the Jim Crow era, these were frequently conservative southern Democrats who obtained seniority due to uncompetitive elections.³⁸ Although the chairman system has since

³⁸ Sven Steinmo Jon Watts, "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America," *Journal of Health Politics, Policy and Law* 20, no. 2 (1995), 340.

been reformed, for decades it gave disproportionate power to legislators skeptical of government health insurance programs.³⁹

The filibuster makes any successful legislation require a super-majority in the Senate, as opposed to the simple majority required in most other legislatures. This makes it more difficult to pass major pieces of legislation, particularly those that are ideologically divisive and would be unlikely to attract substantial bi-partisan support. The filibuster has clearly not prevented the passage of all major social legislation, so its influence should not be overstated. It has, however, prevented a small legislative majority from passing such legislation. Either a party needs to have overwhelming control in the Senate, as was the case for the Democrats in 1935 with the passage of Social Security, or it needs to find support in the opposing party, possibly making compromises along the way, as was the case with the passage of Medicare.⁴⁰ The filibuster is thus one institutional feature of the US political process which has worked against the creation of national health insurance.

Particularly significant is the American party system. In countries like Canada with a system of party discipline, members of parliament from a particular party have to vote for legislation supported by that party's leaders.⁴¹ If that party is in the majority, it can thus pass the legislation it wishes without intra-party defections. This streamlines the legislative process and makes passing major pieces of legislation easier. In the United States, individual members of Congress can and frequently do vote against the wishes of their party leaders. Opponents of legislation do not have to pressure party leaders, but can instead convince individual members of Congress. In the case of health insurance, intra-party splits in the Democratic Party were a

³⁹ Ibid., 357-358.

⁴⁰ Hoffman, *Health Care for Some*, 123-124.

⁴¹ Antonia Maioni, *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada*, (Princeton, NJ: Princeton University Press, 1998), 22-25.

critical reason why the Truman plan failed, as southern Democrats refused to get on board with the legislation. Maioni argues that a more centralized party system would have been more likely to result in successful health insurance legislation during that period.⁴² One counterpoint to that argument is that it assumes southern Democrats would have stayed in the Democratic Party if they lacked the flexibility to oppose northern Democrats on key votes that went against white Southern interests on civil rights. Counterfactually, a more centralized party system would likely have resulted in a distinct Southern party that would have likely opposed government health insurance efforts.

Institutionalism need not be in conflict with interest-group approaches. Indeed, institutionalist scholars have noted the interaction between US political institutions and interest groups. The US party system has made it easier to apply pressure to elected representatives, thus augmenting the power of interest groups.⁴³ If we accept the argument that interest groups have played a major role in preventing the passage of national health insurance, it is still necessary to explain why those interest groups are more powerful in the United States than in countries such as Canada or the United Kingdom. Thus, institutionalism can complement the interest groups discussed earlier, particularly with its insights on the impacts of party structure.

A second major component of the US party system is its two-party nature and the lack of a working class political party. In Canada, proponents of national health insurance channeled their efforts into a populist party dedicated to its passage.⁴⁴ Third party efforts in the United States have constantly failed, and instead proponents of universal health insurance have channeled their efforts into working in the Democratic Party. Although northern Democrats

⁴² Ibid.

⁴³ Pamela Behan, *Solving the Health Care Problem: How Other Nations Succeeded and Why the United States Has Not*, (Albany, NY: SUNY Press, 2006), 87.

⁴⁴ Maioni, *Parting at the Crossroads*, 128-130.

supported national health insurance in the 1940's, their support since then has been haphazard at best. The lack of a labor party was not a crucial factor in the 1930's or 1940's, but the right-ward shift in the Democratic Party since then has worked against the passage of national health insurance.⁴⁵

One of the crucial elements in the US constitutional system is the presence of federalism, which gives a large role to state governments in the formation of social policy. The role of federalism in the history of American health insurance reform efforts is complex. Whereas comparative scholars who examine the Canadian case argue that Canada's relatively decentralized federalism aided public health insurance efforts, comparative scholars with a focus on Europe argue that the United States' relative decentralization has resulted in a smaller welfare state overall.⁴⁶ Comparative statistical analyses have found that federal states do tend to have lower levels of social welfare than unitary states.⁴⁷ However, indepth case studies have found that the relationship between federalism and the welfare state is more varied, with federalism at times making it easier to increase the size of the welfare state.⁴⁸ This has been the case with the Canadian healthcare system. In Canada, provinces had a major role in the creation of government health insurance, with Saskatchewan's public insurance serving as a major impetus for the federal government to get involved in creating a minimum standard of insurance by which all

⁴⁵ Ian Budge et al., *Mapping Policy Preferences: Estimates for Parties, Electors, and Governments 1945-1998* (New York: Oxford University Press, 2001).

⁴⁶ Maioni, *Parting at the Crossroads*, 25-28.

Robert T. Kudrle and Theodore R. Marmor, "The Development of Welfare States in North America," in *The Development of Welfare States in Europe and North America*, ed. Peter Flora and Arnold J. Heidenheimer (New Brunswick, NJ: Transaction Books, 1981), 81.

⁴⁷ Herbert Obinger, Francis G. Castles, and Stephan Liebfried, ""Introduction: Federalism and the Welfare State" in *Federalism and the Welfare State*, ed. Herbert Obinger, Francis G. Castles, and Stephan Liebfried (New York: Cambridge University Press, 2005), 3-4.

⁴⁸ *Ibid*, 42-44.

provinces have to abide.⁴⁹ The simplistic argument that federalism itself made it harder to pass national health insurance in the United States is thus not tenable, although it is possible that the particular variety of federalism found in the US impeded national health insurance efforts. It could also be possible that federalism has made it easier to create single-payer, and that the failure of single-payer plans is despite, not because of, federalism.

Federalism has historically offered opportunities for the single-payer advocates. Rather than having to convince a national government with competing regional interests, advocates could start by winning single-payer in a single state first, using that state as a “laboratory of democracy” with the idea that the model would then spread to other states and perhaps then to the national government, as happened in Canada. Reformers have tried this, on several occasions. State level action was attempted in the 1910’s, failing narrowly in the New York legislature.⁵⁰ It was attempted again in the 1940’s in California, reportedly failing by just a single vote.⁵¹ It has been tried again in recent years in Vermont, with the legislature actually having passed a single-payer plan only to decide later that it was not financially feasible.⁵²

Some of the explanations that have been used to explain the failure of single payer nationally are not as applicable at the state level. For example, many of the states where there have been major single payer efforts have particularly strong labor movements. In California, labor union density in the 1950’s was above 40%, similar to the rate in the United Kingdom at

⁴⁹Boychuk, Gerald. “National Health Insurance in the United States and Canada: Race, Territorial Integration and the Roots of Difference.” In Annual Meeting of the Canadian Political Science Association, (Vancouver, British Columbia, 2008), 14-15.

⁵⁰ Starr, *The Social Transformation of American Medicine*, 253-254.

⁵¹ “The American Medical Association: Power, Purpose, and Politics in Organized Medicine,” 1013.

⁵² John E. McDonough, “The Demise of Vermont’s Single-Payer Plan, *New England Journal of Medicine*, 372, no. 17, (2015), 1584.

the time its National Health Service was created.⁵³ New York has historically had some of the highest union densities of any state, although Vermont's union density in recent years has been roughly the national average.⁵⁴ This evidence can be interpreted in two major ways. First, that strong labor unions do make it more likely that single payer insurance will be on the political agenda, and make it more likely to pass. Secondly, that high rates of union membership are not themselves sufficient to pass single payer insurance, given that those states which have had density rates in line with those of countries with single payer have not themselves passed it. This suggests that although the strength of the labor movement matters, the weakness of unions has not been the only or primary feature of American politics preventing the passage of national health insurance.

Institutionalist theorists consistently use the concept of path dependency, which refers to past outcomes constraining future possibilities.⁵⁵ One particularly relevant example in the development of health policy is long term consequences of the rapid expansion of private insurance in the 1940's, discussed in the introduction. There is some disagreement among scholars about the scope of the effects of the high rates of private insurance; Boychuk argues that Canada's rates of private insurance were also high when it passed government health insurance.⁵⁶ Steinmo and Watts argue that the main factors stopping universal insurance in the 1970's was the

⁵³ Fred Glass, *From Mission to Microchip: A History of the California Labor Movement*, (Berkeley: University of California Press, 2016).

Skocpol, *Social Policy in the United States*, 200.

⁵⁴ Schmitt, John, Janelle Jones, and Milla Sanes. "State Union Membership, 2012." Washington D.C.: Center for Economic Policy Research, (2013), 3.

Vermont's union density was slightly above the national average in 2011 and below the national average in 2012.

⁵⁵ Hacker, "The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy," 75-76.

⁵⁶ Boychuk, "National Health Insurance in the United States and Canada: Race, Territorial Integration and the Roots of Difference", 17-19.

impact of political institutions, rather than a lack of demand for it.⁵⁷ Overall, however, the literature on the conglomeration of private benefits regulated and at times subsidized via tax policy, which has been labeled the “private welfare state”, suggests that it leads to less demand for public programs, such as government health insurance.⁵⁸ Any explanation for the failure of universal public health insurance must come to grips with the fact that private insurance has accomplished much of what early reformers hoped public insurance would do. Or, as Madison argues, “the most effective argument against the Truman plan was that social health insurance wasn’t needed, because soon everyone would be covered by voluntary, private health insurance.”⁵⁹ In actuality, “everyone” would not be covered, but those without coverage tended to have less political influence and lacked the ability to enact national health insurance.

The Role of Contingent Explanations

Whereas sociologists and political scientists have tended to focus on larger structural and cultural explanations for the United States’ distinctive healthcare system, the explanation of any historical event also has immediate causes. For example, it has been argued that part of the reason health insurance did not pass under FDR was that the president lacked an interest in the issue equal to his interest in pensions.⁶⁰ The American Association for Labor Legislation’s health insurance campaign ran into bad timing, as it emerged as progressivism was declining, as well

⁵⁷ Steinmo and Watts, “It’s the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America,” 355.

However, Steinmo and Watts’ argument ignores that the proposals on the political agenda in the 1970’s would have kept a major role for private insurance, suggesting that there were path dependency effects limiting the scope of options.

⁵⁸ Stevens, “Blurring the Boundaries: How the Federal Government Has Influenced Welfare Benefits in the Private Sector,” 145-148.

⁵⁹ Donald L. Madison “From Bismarck to Medicare – A Brief History of Medical Care Payment in America,” 54.

⁶⁰ David Blumenthal and James A. Morone, *The Heart of Power: Health and Politics in the Oval Office*, (Berkeley, University of California Press, 2009), 56.

as the American entry into World War I.⁶¹ The particular character and ideology of Samuel Gompers had a major impact on the position of the AFL towards health insurance.

These contingent explanations have a crucial role in understanding the dynamics of a particular reform effort. As we have discussed with the impact of rising insurance rates, any contingent events that led to initial failure would have made subsequent reform less likely. It is plausible that these contingent events did shape the long-term development of health policy in the United States. However, it would be a mistake to view the outcome of a century of policy debates on health insurance as merely the result of chance and contingent events. There are deep-seeded aspects to the American political system, from the institution of the Senate, the committee system to the relative power of the working class, that have on balance made the passage of universal health insurance less likely. No one factor on its own is determinative. Together, however, they have raised the bar so that only in the presence of multiple favorable contingent factors would the passage of national health insurance be possible. Notwithstanding the increase in the number of insured people following the passage of the Affordable Care Act, such a moment has not yet occurred. The two following chapters explore two periods where the passage of national health insurance seemed plausible, the Roosevelt and Truman presidencies.

⁶¹ Starr, *The Social Transformation of American Medicine*, 243, 253.

Chapter 2: The Roosevelt Presidency and Health Insurance

President Franklin Roosevelt's term in office offered two major opportunities to pass universal health insurance. The first of these was during the run-up to the passage of the Social Security Act of 1935, with high level officials considering including health insurance in the Act. The second major moment was in the late 30's, which saw the National Health Conference and the introduction of the first Wagner health bill in 1939. The Roosevelt era is of particular significance in the history of health insurance policy; Roosevelt's was the first administration to back universal health insurance, and 1939 saw the first national universal health insurance bill.

The New Deal provided opportunities for substantial changes in social policy. The New Deal did not create the US welfare state, as the US government had already engaged in large welfare programs, such as the national pension for Civil War veterans. Nonetheless, the policy legacy of the New Deal is substantial, having brought about Social Security, unemployment insurance, and a Keynesian state far more willing to intervene in the economy. Even in the realm of health care itself, the New Deal saw an expanded government role, with the Farm Security Administration providing healthcare to 600,000 people, mostly in rural states.¹ Why then was health insurance “the lost reform” of the New Deal?

If prior to the New Deal health care was difficult for many Americans to procure, the Depression greatly worsened the problem. Tens of millions of people simply lacked the funds to pay physicians.² Although doctors had traditionally allowed poor people to receive care for free or at a reduced rate, the lower levels of national income meant that physicians were not able to do this for sufficient numbers of people.³ Public hospitals were over capacity, while private

¹ Paul Starr, *The Social Transformation of American Medicine*, (New York: Basic Books, 1982), 304.

² Beatrix Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930*, (Chicago: University of Chicago Press, 2012), 15.

³ *Ibid.*, 8.

hospitals were unable to find patients able to pay.⁴ It was a public health disaster.⁵ Medicine was not the only societal institution under severe stress during the Depression. President Roosevelt had to prioritize certain issues at the expense of others. During the most formative years of the New Deal, health insurance never rose to the top of the agenda.

The Committee For Economic Security

To design a national pension system, President Roosevelt had Secretary of Labor Francis Perkins lead the Committee on Economic Security, which was to issue a report proposing policy to strengthen economic security, defined as “protection of the individual against the many hazards which often result in destitution,” and viewed by the Committee as the “fundamental objective of the New Deal.”⁶ The work of the CES was shaped by the Great Depression, and the Committee was most interested in aspects that would address economic conditions directly, such as unemployment insurance. The CES did have a mandate to include health issues, including insurance, as sickness was said to contribute to economic insecurity. The CES initial report contained several suggestions related to public health, including additional federal funds for local public health programs, and adding personnel to the Public Health Service.⁷ The CES report not only covered public health, however, but also included a discussion on the need for health insurance. At the time, private insurance was itself a controversial matter, as it disrupted the traditional fee-for-service method of collecting payments. The CES report defended the principle of private health insurance, noting that it was “neither new nor novel,” but argued that voluntary

⁴ Ibid.

⁵ Hoffman mentions a government study which “found that 30 percent of cases of serious, disabling illness among families on relief received no medical attention.” Ibid., 15.

⁶ Committee on Economic Security. “First Tentative Draft: Report of the Committee on Economic Security.” Washington D.C., (1934), 1.

⁷ Ibid., 43.

insurance was too expensive for a large percentage of the population.⁸ Thus, as a method of securing health access to the general population, “voluntary insurance holds no promise of being much more effective in the near future than it has been in the past.”⁹ Only a system of compulsory insurance, the CES argued, would be sufficient to provide health insurance for the general public. The CES report failed to include any specifics as to how compulsory insurance might work, instead noting that it had been tried in other countries. Alternatively, the CES was to continue collaborating with the AMA and other professional groups to come up with an acceptable plan, which the CES said was not yet finished.¹⁰ Absent a proposal from the CES, health insurance was not included in the Social Security Act.

The absence of health insurance from the CES report should not be understood as a consequence of the technical necessity in needing more time to draft a proposal. President Roosevelt’s actions suggest that it was strategic considerations which determined the course of health insurance in the CES. In November of 1934, the father-in-law of Roosevelt’s son James, Dr. Harvey Cushing, wrote to Roosevelt asking him to delay any health proposals, noting the position taken by the AMA.¹¹ Instead, Cushing asked “Could the organization of such a department or bureau be taken under consideration at this time, the discussion of this difficult project regarding sickness insurance might well be postponed until a department was in existence which could properly and permanently administer it.”¹² This was a subtle move by Cushing, an opponent of national health insurance, to weaken the efforts of proponents. Roosevelt listened to

⁸ Ibid., 47.

⁹ Ibid.

¹⁰ Ibid., 48.

¹¹ David Blumenthal and James A. Morone, *The Heart of Power: Health and Politics in the Oval Office*, (Berkeley, CA: University of California Press, 2009), 33.

Harvey Cushing to Franklin Delano Roosevelt, November 10, 1934.

¹² Ibid.

his advice, forwarding the Cushing letter to Perkins, and asking her to begin to set up an interdepartmental committee on health and welfare.¹³ Roosevelt said in a cabinet meeting, when asked to include sick pay insurance in the Social Security bill, that he did not want any additional items to be added to it.¹⁴ A March 1935 letter to the President from the sub-committee on responsibility for health insurance asked him to reconsider this position.¹⁵ The justification given in the report for health insurance's absence is therefore not the most likely explanation. Health insurance's exclusion from Social Security was a political decision, not the consequence of needing more time to formulate a proposal.

The most plausible alternative rationale for health insurance's exclusion from the CES report is an interest group explanation which focuses on the role of the AMA. When word spread that the CES was considering including health insurance in Social Security, the AMA responded with strong outcry at the thought of such a policy.¹⁶ Passing a Social Security bill with a health insurance provision over the opposition of the AMA may have been possible, but it would have been more difficult than passing the bill without such a provision. Members of the CES were cognizant of the difficulties a Social Security bill with health insurance would have had in passing Congress.¹⁷ Health insurance had never been the priority of Roosevelt, whose main goals from Social Security were unemployment insurance and a pension plan.¹⁸ Given that including health insurance would imperil the passage of the provisions deemed more important, it made strategic sense for health insurance to be excluded from the bill. Other provisions of the Social

¹³ Franklin Delano Roosevelt to Frances Perkins, November 13, 1934.

¹⁴ Unknown to Franklin Delano Roosevelt, March 18, 1935.

¹⁵ Ibid.

¹⁶ George Martin, *Madam Secretary: Frances Perkins*, (Boston: Houghton Mifflin, 1976), 347.

¹⁷ Daniel Beland and Jacob Hacker, "Ideas, Private Institutions and American Welfare State 'Exceptionalism': The Case of Health and Old Age Insurance, 1915-1965," *International Journal of Social Welfare* 13, no. 1 (2004): 50.

¹⁸ Ibid., 344.

Security Act elicited opposition, but there was no organized, respected profession whose traditional practice was encumbered by those provisions in the way that national health insurance would have changed the medical profession. This made Social Security far easier to pass than would have been the case had it included health insurance. The political power of the AMA, along with the direct link that it had to FDR through Dr. Cushing, is thus crucial to understanding why health insurance was excluded from Social Security legislation.

Interest group theory by itself cannot explain why Roosevelt gave a higher priority to unemployment insurance and pensions than to health insurance. There are a range of plausible factors. The lack of prioritization of health insurance could reasonably be the consequence of President Roosevelt's personal priorities, shaped by his own experiences with the medical profession.¹⁹ A second plausible type of explanation would focus on the economic conditions of the time. The veritable crisis of employment in the midst of the Depression likely contributed to unemployment insurance's prioritization. Although there was a need for action on health insurance, solving unemployment was the more pressing problem. Finally, Beland and Hacker argue that part of the reason why health insurance was lower on reformers' agenda was that it had already failed in the 1910's, creating the sense that it would be politically difficult to pass. This moves beyond simple interest group politics to add that the perception of interest group power has policy consequences. Additionally, they argue that there was a lack of popular mobilization for health insurance to the extent that there was with old-age pensions, thus creating fewer political incentives to prioritize health insurance.²⁰

Several of these explanations need to be combined to understand the Roosevelt's administration's priorities. Roosevelt himself had backed government health programs as

¹⁹ Blumenthal and Morone, *The Heart of Power*, 24-28.

²⁰ Beland and Hacker, "Ideas, Private Institutions and American Welfare State Exceptionalism," 50.

governor of New York, comparing the state's responsibilities in health to its responsibilities in education, so this was not an unfamiliar issue to him.²¹ He had not been at the forefront of universal health insurance proposals, but he had enough familiarity with the topic to understand its importance. This suggests that Roosevelt's hesitance in including health insurance had more to do with the political ramifications than with an individual lack of interest, even if he hypothetically could have given it a higher level of prioritization.

The lack of mass mobilization pointed to by Beland and Hacker is a far more crucial explanation. A social movement in favor of universal health insurance would have changed the White House's political calculations, and thus may well have led to health insurance's inclusion in Social Security. The lack of popular mobilization is related to the relatively weak level of institutionalization of the labor movement at the time, as the Social Security Act was formulated prior to the passage of the pro-union Wagner Act. Unions were actively organizing throughout 1934 and early 1935, after being weakened severely by the Great Depression, but they were not in a position to push heavily for legislation not directly related to their well-being.²² However, the importance of the lack of mass mobilization should not be overstated, as national health insurance was passed in Great Britain and Canada without it.

Beland and Hacker's argument regarding the impact of previous policy proposals is intriguing, but the case is overstated, as it ignores efforts to expand health access in the 1920's, such as the 1921 Sheppard-Towner Act, and the Committee on the Costs of Medical Care. It also avoids discussing the earlier efforts in the 1910's to pass workers' pensions. Indeed, it was the

²¹ As governor of New York, Roosevelt supported expanded government health programs, arguing that "public health... is a responsibility of the state.... The state educates its children. Why not also keep them well?" Quoted in Blumenthal and Morone, *The Heart of Power*, 27.

²² Robert H. Zieger, Timothy J. Minchin, Gilbert J. Gall, *American Workers American Unions: The 20th & Early 21st Centuries*, 4th ed. (Baltimore: Johns Hopkins University Press, 2014), 66-103.

same organization, the American Association for Labor Legislation, which led both the health insurance and pension efforts of that time.²³ Beland and Hacker do not address the possible consequences of the earlier failures of pension plans, significantly weakening their argument.

The Interdepartmental Committee and the Wagner Bill

The 1934 letter from Cushing asked Roosevelt not just to delay any health insurance program, but to set up a proper department or agency to run the federal government's health efforts. Roosevelt's letter to Perkins later that year started a process of setting up a committee to begin that coordination. Roosevelt followed up with a 1936 executive order, issued days before Roosevelt's reelection, which created the Interdepartmental Committee to Coordinate Health and Welfare Activities.²⁴ Josephine Roche, an official in the Treasury Department, was chosen to lead the Committee. The initial stated goal of the IC was to coordinate work already done, and to issue proposals leading towards departmental reorganization for better coordination.²⁵ The Interdepartmental Committee soon went beyond that mandate, and instead, with Roosevelt's approval, issued a proposal for significantly expanding government's role in health care.

Unlike the Committee on Economic Security's ultimate decision to exclude any concrete policy ideas on health insurance, the Interdepartmental Committee issued a set of five proposals on health policy. These proposals, in order, were an expansion public health programs, hospital construction, health care for the indigent, a general health program, and insurance for sick pay.²⁶ Of these, only the indigent health care and the general health program directly concern the

²³ Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*, (Cambridge, Harvard University Press, 1992), 176-203.

²⁴ Executive Order of October 27, 1936, Interdepartmental Committee to Coordinate Health and Welfare Activities.

²⁵ *Ibid.*

²⁶ "National Health Program: A Summary." In *Proceedings of the National Health Conference*, Washington D.C.: Interdepartmental Committee to Coordinate Health and Welfare Activities, (1938): i–vii.

provision of care, although the fact that the proposal was part of a broader rethinking of health care in the United States is consequential.

The Interdepartmental Committee's report found that 40 million Americans had low incomes and were in obvious need of financial assistance in paying for medical care. To address this program, the IC called for "federal grants-in-aid to the states toward the costs of a medical care program for recipients of public assistance and other medically needy persons."²⁷ This program would include both those on public assistance, and those not on assistance but unable to afford care.²⁸ Medical care provided would include "minimum essential needs," including "medical and surgical care... hospitalization, exclusive of the period of maternity, and of care of the tuberculous and mentally diseased; bedside nursing care; and emergency dental care."²⁹ States would have significant flexibility in shaping programs to their liking, with the federal government setting minimum standards that needed to be met if a state was to receive federal funds. A state could, presumably, decide to not set up a program at all if it wished.

The general program of medical care was formulated separately from medical care for the indigent. This probably related to FDR's general dislike for programs that put people on the dole, as opposed to programs, like Social Security, in which people become eligible for benefits by putting money into the system.³⁰ The conceptual difference was that poor people were simply unable to afford care, whereas the working and middle class could afford care, but "the costs must be spread among groups of people and over periods of time," through the insurance

²⁷ Oscar Chapman, "Report of the Technical Committee on Medical Care to the National Health Conference." In *Proceedings of the National Health Conference*, 51.

²⁸ *Ibid.*

²⁹ *Ibid.*, 52.

³⁰ Martin, *Madam Secretary*, 345-346.

principle.³¹ It also might have been thought to be politically easier to pass a proposal for medical care for poor people than for a general medical program.³² Like the program for the poor, the general medical program was to in actuality be a set of forty-eight different state systems, with substantial financial contributions from the federal government. States could set up programs as they pleased, including a program of universal insurance, or a system in which medical care is provided directly by the government, and could set up an income limit beyond which an individual would not be eligible for the program.³³ Similar to the CES report, the IC proposal argued that voluntary insurance would be unable to cover a substantial enough portion of wage-earners.³⁴ Despite separating the proposals for a general medical program from the indigent care proposal, the IC report argues in favor of having a general medical program for all regardless of indigent status, comparing it to public education accessible to all.³⁵

Upon receiving the IC's report and its health policy proposals in March 1938, President Roosevelt wrote to Roche to suggest "that your Committee give consideration to the desirability of inviting at some appropriate time representatives of the interested public and of the medical and other professions" to discuss health care problems and solutions.³⁶ Roche acted on Roosevelt's proposal, initiating the National Health Conference held in July of that year. The Interdepartmental Committee invited key stakeholders from across the medical and lay worlds.

³¹ Arthur Altmeyer, "Report of the Technical Committee on Medical Care to the National Health Conference." In *Proceedings of the National Health Conference*, 61.

³² Indeed, the idea to have the government provide insurance to poor people was ultimately realized nearly thirty years later, with the passage of Medicaid.

³³ Interdepartmental Committee on Health and Welfare Activities. "Report and Recommendations on National Health." Washington D.C., 1939, 65-66.

³⁴ Altmeyer, "Report of the Technical Committee on Medical Care to the National Health Conference," 62.

³⁵ The analogy is limited in that education is controlled mostly by local governments, whereas the health programs were to be state plans.

³⁶ Franklin Roosevelt to Josephine Roche, March 8, 1938.

Representatives of the major medical organizations, such as the American Pharmaceutical Association, the American Hospital Association, and the American Medical Association, were present, as were representatives from organized labor, religious organizations, rural organizations, consumer groups, women's groups, black groups, and even the National Congress of Parents and Teachers.³⁷ Business representatives were also present but were not particularly active in the discussions. Roche told attendees that the goal of the conference was to determine the country's health needs, and to formulate policies that would lead to better cooperation to meet those needs.³⁸ In actuality, Roche hoped to reach a consensus for the Interdepartmental Committee's plan.

The response to the Conference was mostly positive. Groups from across the country wrote to the Interdepartmental Committee, giving their thoughts on the IC's proposal. The most frequent supporters of the plan were labor unions. Not a single union which wrote to the Interdepartmental Committee opposed the plan, and support came not only from national unions but from many locals as well. This is notable because of the divisions within the labor movement at the time. Both the CIO, which had strong social democratic roots, and the AFL, with its traditional attitude of not relying on the state, supported a national health insurance program by the time of the Conference. Support came from other organizations amenable to government intervention, like the National Lawyers Guild.

Sensing the need to support some changes, the key players in the medical industry supported parts of the plan, but not the entirety of the program. Groups like the AMA needed to balance their institutional interests with the growing popular and elite support for expanded government intervention in the health sector. This led AMA president Irvin Abell to argue at the

³⁷ "Participants of the National Health Conference." In *Proceedings of the National Health Conference*0.

³⁸ Josephine Roche to Nathan Sinai, June 23, 1938.

Conference that “there can be no acceptance by the medical profession of any system of medical care which is based on the idea that the well-to-do shall receive one quality of medical care while the farmer, the laborer, and the white-collar worker are to be placated with a wider distribution of an inferior medical service.”³⁹ Egalitarian rhetoric was necessary to stave off popular discontent, even though the fee-for-service preferred by the AMA allowed for the wealthy to receive higher quality care than others. The AMA’s stated sympathy for the goals of reformers was not just rhetorical, as the AMA endorsed the principles of all parts of the Interdepartmental Committee’s plan, with the exception of the proposal for the general medical program. On the question of a general medical program, the AMA’s opposition was unequivocal. The committee tasked with responding to the proposal found that compulsory insurance would lead to a “complicated, bureaucratic system... which has no place in a democratic state,” to increased taxes and government spending, and would lend itself to political control and manipulation.⁴⁰ The AMA was prepared to give ground on other health related matters, but not on compulsory insurance.

The National Medical Association, the professional association for black doctors with a typically more progressive attitude than the AMA, endorsed the other proposals except for a general medical program. Its stated reason was that it did not want to jeopardize the other components of the plan by including a national health program, suggesting that in a more favorable political environment it might have endorsed the entire proposal.⁴¹ The NMA’s hesitation was also related to the unclear racial implications of the proposal. Although the report discusses racial disparities in health outcomes, it was unknown whether the federal government

³⁹ Abell, Irvin. “No Title.” in *Proceedings of the National Health Conference*, 8.

⁴⁰ Walter Donaldson, “Report of Reference Committee on Consideration of the National Health Program.” American Medical Association, (1938), 3.

⁴¹ George Bowles, “Recommendations of a Special Committee of the National Medical Association to the Technical Committee on Medical Care.” Washington D.C.: National Medical Association, (1938), 1.

would fund states which restricted blacks' ability to access care under the program. The editor of the NMA journal reported that although many black doctors were skeptical of the AMA and its racial biases, they trusted state governments even less.⁴²

This issue also concerned the NAACP, whose chairman wrote to Roche after the Conference asking that she ensure that there be no Jim Crow elements in the health program.⁴³

The Committee of Physicians for the Improvement of Medical Care, a group of dissident doctors, were critical of the AMA's position, particularly their disregard for the health needs of the middle-class and their assumption that "defects in the present health service can not be attributed to the methods by which medical care is provided by physicians."⁴⁴ Like the NMA, the Committee of Physicians did not endorse recommendation four. Although the Committee of Physicians supported the recommendation's principles, it did not think that the use of compulsory insurance at the present moment was appropriate, leaving the possibility open that it would support compulsory insurance at a later moment. Both the NMA and the Committee of Physicians expressed a greater potential willingness to support national insurance than the AMA, but neither was willing to endorse the specific proposal of the Interdepartmental Committee. Thus, the two doctors' groups which were in a position to challenge the AMA's claim to speak for all US doctors did not do so with regards to the IC's national health program proposal.

The American Hospital Association was sympathetic to the goals of the conference plan, although their support for increased hospital construction was tentative and applicable only in locations with truly demonstrable need. The AHA did not take a position on the general medical

⁴² John A. Kenney to Robert F. Wagner, June 8, 1939.

⁴³ Louis T. Wright to Josephine Roche, July 30, 1938.

⁴⁴ John Peters, "The National Health Conference." New Haven, CT: Committee of Physicians for the Improvement of Medical Care, (1938), 3.

program.⁴⁵ The other two major hospital organizations, representing Protestant and Catholic hospitals, respectively, opposed any plan for compulsory insurance.⁴⁶ A joint statement by the three hospital associations stated that they did not have a consensus on compulsory insurance, but that they thought voluntary insurance would be able to cover people with a range of incomes.⁴⁷ Similarly, the American Dental Association pushed its own interests in terms of supporting the inclusion of dental programs in all components of the plan, but did not take a position on the comprehensive national health program.⁴⁸ Some groups were less concerned about the details of the proposal. The American Pharmaceutical Association, for example, expressed its desire that everyone should be able to get care and that patients keep their choice of doctor.⁴⁹ The American Nurses Association and the American Public Health Association took similar positions, stating support for the conference's proposals without specifically taking a position on compulsory health insurance.⁵⁰

There was some criticism from the political left. The American League for Public Medicine, formally known as the Medical League for Socialized Medicine, refused to support the Interdepartmental Committee's proposal because of its inclusion of compulsory health insurance.⁵¹ The American League would only support a truly public medical program in which

⁴⁵ Interdepartmental Committee to Coordinate Health and Welfare Activities to Franklin Delano Roosevelt, "Memorandum Concerning the National Health Program," December 12, 1938.

⁴⁶ "Report of the Resolutions Committee," Dallas, TX: American Protestant Hospital Association, 1938. Alphonse Schwitalle, "Pronouncement of the Catholic Hospital Association on the National Health Program," 1938.

⁴⁷ Fred Carter, Bryce Twitty, and Alphonse Schwitalle. "Attitude of the Hospital Associations to the National Health Program," 1938.

⁴⁸ Interdepartmental Committee to Coordinate Health and Welfare Activities to Franklin Delano Roosevelt, "Memorandum Concerning the National Health Program," December 12, 1938.

⁴⁹ Ibid.

⁵⁰ "Statement by American Nurses' Association, National League for Nursing Education, National Organization for Public Health Nursing," 1939.

"Resolution Adopted by the American Public Health Association." Kansas City, 1938.

⁵¹ States had the option to enact compulsory insurance or to provide services directly.

care would be provided directly by government institutions, as with education.⁵² This position was not expressed by other organizations, although a few individuals expressed criticism of the plan for having insufficient government intervention.⁵³

In the aftermath of the conference, administration officials wished to have legislative action on the Interdepartmental Committee's proposal. President Roosevelt sent the IC's report to Congress in January of 1939 with his own message on health security, which emphasized the leeway given to state governments in the plan.⁵⁴ Senator Robert Wagner of New York was at that point working on a legislative version of the proposal, which was introduced in February.⁵⁵ As the chief sponsor of the legislation, Wagner took on an increasingly prominent role in serving as a spokesman for the national health program.

The bill did not make progress legislatively. There were hearings, but the bill did not advance out of committee, with a committee report released in September calling for action on the bill after further study.⁵⁶ Although Wagner did not give up on the bill after the start of war in Europe in September, the war did distract from his efforts as political attention shifted to events abroad. President Roosevelt continued to push for some form of health legislation, writing to Frances Perkins in November of 1940 to reformulate the Committee on Economic Security's

⁵² Joseph Slavitt to Fred E. Hoehler, January 19, 1939.

⁵³ A doctor of public health, J. Rosslyn Earp, criticized the Wagner bill for giving too much flexibility to state governments. Peter Kleid, a physician, wrote to FDR criticizing the Wagner bill for not having a system of national compulsory insurance.

J. Rosslyn Earp to Dr. C. E. Waller, March 8, 1939.

Peter Kleid to Franklin Delano Roosevelt, March 9, 1939.

⁵⁴ Franklin Delano Roosevelt, "Message from the President of the United States Transmitting the Annual Message on Health Security." Washington D.C., 1939.

⁵⁵ Wagner, Robert F. "Robert F Wagner's Summary of National Health Bill." Washington D.C., 1939.

⁵⁶ Antonia Maioni, *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada*, (Princeton, NJ: Princeton University Press, 1998), 47.

recommendations and to send them to him by January.⁵⁷ This was simply not a moment when national health insurance could be enacted, however, due to the focus on the war. Although Wagner introduced a second version of the bill in 1943, the original moment of possible legislative action had already passed. Health insurance was going to have to wait until at least the end of war.

The failure of the 1939 Wagner bill had immediate causes, particularly the onset of war, along with the poor showing of liberal Democrats' in the 1938 mid-terms.⁵⁸ The ideological composition of Congress was more skeptical of large New Deal programs in 1939 than it had been two years earlier. Additionally, President Roosevelt's relationships with many Democrats, particularly those from the South, had soured.⁵⁹ Congress was now a less hospitable environment for a national health program.

The opposition to the Wagner bill frequently couched its language in traditional laissez-faire liberalism. Concerns were brought up about the tyrannical nature of government bureaucracies, and the increase in governmental debt. This was the most common opposition framing in correspondence to Wagner and the Interdepartmental Committee. An example of this is the statement by Congressman Frederick Smith, a physician, in a radio discussion with Wagner. Smith argued that the advances of American medicine can be explained by its great

⁵⁷ Franklin Delano Roosevelt to Frances Perkins, November 19, 1940.

This could be interpreted as Roosevelt distancing himself from the IC plan due to the lack of sufficient support.

⁵⁸ The Democrats lost 7 seats in the Senate, and 72 seats in the House, along with 9 favorable third-party members. Democrats still possessed large majorities in both chambers, but now were more centered in the South.

United States Senate, "Party Division," *Art and History*, <https://www.senate.gov/history/partydiv.htm> (Accessed 30 Apr. 2017).

United States House of Representatives, "Party Divisions of the House of Representatives," *History, Art, & Archives*, <http://history.house.gov/Institution/Party-Divisions/Party-Divisions/> (Accessed 30 Apr. 2017).

⁵⁹ Jamie Carson, "Electoral and Partisan Forces in the Roosevelt Era: The Congressional Elections of 1938," *Congress & the Presidency* 28, no. 2 (2001): 161-162.

“human liberty and freedom from political restraint.”⁶⁰ The Wagner bill, Smith claimed, would set up a massive bureaucracy, and would be doomed to fail, like any plan for “socialized medicine” because of human nature.⁶¹ It would be harder to find a more quintessentially liberal argument against national health insurance, one which has reverberated in later debates.

There were other arguments as well, including one viscerally anti-Semitic letter sent to Wagner, opposing his support for the “Jew-Screw-Blue Deal.”⁶² The more traditional, conservative notion that private individual medical practice must be defended was not frequently used. This could be taken as evidence that the power of American liberalism had a causal role leading to the defeat of the Wagner bill, but to do so would be a mistake. Ideological configurations likely shaped the content of the debate over the bill, but they did not have a role in shaping policy outcomes. As described in chapter 1, the general public approved of proposals similar to the Wagner plan. The argument that American liberalism was a major contributor to the defeat of universal health insurance also ignores the extent to which proponents of expanded government action reframed liberal ideology to allow for their programs. Senator Wagner would frequently point to ways in which his proposal was in step with previous policies and American tradition, mentioning the 1798 bill giving health insurance to sailors.⁶³ Supporters would argue that they were simply extending the principle of voluntary insurance, which had become increasingly accepted. Opponents would dispute this claim, such as writer George Morris’ comment “I am not entirely in accord with Senator Wagner’s statement that this proposal does not break with American tradition. I have never known the government to produce a doctor.”⁶⁴

⁶⁰ Frederick Smith, “The National Health Bill,” *The American Forum of the Air*, NBC, Washington D.C., 1939, 6.

⁶¹ *Ibid.*

⁶² Walter H. Adams to Robert F. Wagner, March 6, 1939.

⁶³ Robert F. Wagner, “Speech of Robert F. Wagner,” NBC, Washington D.C., January 30, 1939.

⁶⁴ George Morris, “The National Health Bill,” 11.

The liberalism thesis argues that principles of American liberalism would lead to rejection of a national health insurance program. The actual arguments used by supporters suggests that this cannot assumed to be the case, and that the meanings and implications of American liberalism were contested.

Labor unions were the most frequent supporters of the Wagner bill. This was a moment of upsurge in labor, with the unions heavily invested in organizing basic industries like steel and automobiles.⁶⁵ The unions, particularly those in the newly formed Congress of Industrial Organizations had not yet developed the dedicated political machinery they would use later to great success, although they were still politically active.⁶⁶ The labor movement played a larger role in pushing for health insurance legislation than it had in the 1910's, when AFL president Samuel Gompers refused to support national efforts, but it was still weak politically, compared to the post-war era. Unions sent their wishes of support, but they lacked the capacity to muscle a controversial health bill through Congress. Even if they had been able to, unions had some concerns over the specifics of the Wagner bill, especially the heavy role given to state governments. Unions were concerned that states less favorable to unions would create lower quality programs, but that those states would have better environments for business, leading to worse economic outcomes in the pro-union states.⁶⁷ Derickson argues that organized labor was thus less active in pushing for the Wagner bill than they would have been with a more favorable piece of legislation.⁶⁸

⁶⁵ Zieger, Minchin, and Gall, *American Workers American Unions*, 105-111.

⁶⁶ *Ibid.*, 159-161.

The CIO PAC was formed in the lead up to the 1944 election. The AFL followed with the Labor League for Political Education.

⁶⁷ Alan Derickson, "Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958," *The Journal of American History* 80, no. 4 (1994): 1339.

⁶⁸ *Ibid.*

Business might have been expected to be strongly opposed to the Wagner bill, but instead they were largely indifferent. A representative from the American Molasses Company was present at the National Health Conference, and argued that “progressive business will regard an adequate health service as a subsidy to industry, not a burden.”⁶⁹ The National Association of Broadcasters similarly supported the proposal, and offered to help in publicizing it.⁷⁰ Both business statements are significant in that they lacked any attention to policy detail, issuing vague generalities of support rather than praise for particular aspects of the program. The Philadelphia Board of Trade wrote to Wagner in opposition to his bill, but there is not evidence that other business groups got involved. This could partially be the result of a selection bias in the records, as I did not examine the archives of leading opponents to the legislation. Businesses may well have corresponded with those more likely to be receptive to their views. However, even if this possibility is granted, the positions taken by the leading medical organizations are referred to constantly in the documents, both with their own statements and by others discussing their positions. Those medical groups which were concerned about elements of the Interdepartmental Committee’s proposal at least met with the IC, and sent resolutions to the IC in efforts to influence them.⁷¹ There is no comparable evidence of substantial interaction between business groups and the Interdepartmental Committee. This is consistent with Paul Starr’s account, which found that businesses rose in importance in health care debates during the second half of the twentieth century.⁷² There is little evidence to suggest that business groups played anything more than a marginal role in the health insurance debates of the late 1930’s.

⁶⁹ Oscar Chapman, “The National Health Conference,” Evening Star Radio Forum, NBC, Washington D.C., August 8, 1938.

⁷⁰ Neville Miller to Josephine Roche, July 22, 1938.

⁷¹ “List of Committees from Professional Groups with Which the Interdepartmental Committee and the Technical Committee Have Met,” 1938.

⁷² Starr, *The Social Transformation of American Medicine*, 25-27.

The health insurance debate thus seems to poorly fit the model of a standoff between the forces of labor and capital. Organized labor was one of the major forces in support of the IC and Wagner proposals, simultaneous with several major organizing drives. Big business, by contrast, was nearly absent from the discussion. A class struggle model thus is inadequate to understand the health insurance policy outcomes of the time.

American political institutions contributed to the defeat of the bill. The disproportionate power of Southern Democrats, and the inability of the president to corral his party members to support the bill, had a role in the failure of health insurance proposals under Roosevelt. The problem with focusing on them too heavily, however, is that these institutional parameters were able to be overcome throughout this period. The question thus becomes why was the path of health insurance different than the rest of the New Deal. The answer most easily supported by the evidence is that to have created universal insurance would have violated the core interests of a powerful lobbying group with professional legitimacy. President Roosevelt was not willing to risk the rest of his program on such a difficult fight.

Conclusion

The defeat for universal health insurance under Roosevelt happened in a particular historical context which, while better suited for the development of national health insurance than in the aftermath of the rise of private insurance, resulted in a limited window of opportunity. World War 2 cut short the growing momentum for national health insurance at the end of the 1930's, as the United States was not going to experiment with a new health insurance system with its impending entrance into war. During the Social Security debate, President Roosevelt did not want to jeopardize the entire bill by including a health insurance provision. By the time health insurance was back on the agenda, the Democrats had a slimmer majority in Congress,

and would have faced a more organized, well-funded opposition than had been the case with Social Security. The American Medical Association was so feared that it did not have to fully exert its political power through electoral campaigning during the Roosevelt era. Only with the ascension of President Truman, who prioritized the development of a national health insurance system, did the AMA have to fully exert its considerable financial and political resources.

Chapter 3: The Committee for the Nation's Health and the Failure of Health Insurance Reform in the Post-War Era

In many respects, the period following World War 2 was the most conducive to the passage of national health insurance. Labor unions were at their historic peak in density.¹ The sitting president, Harry Truman, had spoken publicly and unequivocally about the need for national health insurance. Democrats controlled the Congress until the 1946 elections, and then again after 1948. Congress enacted other pieces of health reformers' agenda, including funding for hospital construction, medical research, and medical education, but the goal of national health insurance continued to elude reformers.² Yet the effort in the late 40's to enact national health insurance failed. This chapter examines the history of that period in an effort to explain why the campaign failed, through a particular focus on the major advocacy group dedicated to supporting national health insurance, the Committee for the Nation's Health (CNH). As the most influential organization of its type, the history and ultimate failure of the CNH provides insight into why national health insurance was not enacted during this period.

The CNH coordinated the escalating campaign for national health insurance of the late 1940's. Founded in 1946, the CNH closed formally in 1958, although it had all but ceased to exist after 1956. Led by Michael Davis, a sociologist by training who had played a critical role in the Committee on the Costs of Medical Care in the 1920's, the CNH partook in lobbying, public relations activities, and efforts to coordinate groups in favor of national health insurance.³

¹ U.S. Library of Congress, Congressional Research Service, Mayer, Gerald. *Union Membership Trends in the United States*, (2012), 11.

² Paul Starr, *The Social Transformation in American Medicine*, (New York: Basic Books, 1982), 338-352.

³ George Rosen, "Michael M. Davis: Pioneer in Medical Care," *American Journal of Public Health* 62, no. 3 (1972), 321.

The CNH originated in a 1944 meeting called by Senator Robert Wager, the major congressional sponsor of national health insurance legislation. This group, called the Social Security Charter Committee, would turn into the Committee for the Nation's Health two years later, in the aftermath of a speech President Truman gave on national health insurance.⁴ After that speech, 200 public figures signed a letter supporting Truman's plan, which later ran as an advertisement.⁵ In January of 1946, those individuals began to form an organization, with the help of \$40,000 in donations.⁶ The CNH incorporated on March 1 of that year, with the express purpose "to encourage, stimulate interest in, promote understanding of and generally to support the national health program proposed by the President of the United States... and to enlighten and direct public opinion to that end."⁷ By November of 1946, the CNH had received 2,400 donations.⁸

The CNH began with leadership diverse in institutional affiliation. Several physicians were on its Board of Directors, with Dr. Channing Frothingham of Massachusetts the chairman of the organization.⁹ Two religious leaders were vice-chairs of the CNH, as were the presidents of the CIO and the AFL. There were several people heavily linked to the previous administration involved in the group, such as Jonathan Daniels, FDR's press secretary, as well as Eleanor Roosevelt herself, a vice-chair. Business was represented by David Sarnoff, head of the Radio

⁴ Monte Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicine*, (Columbia, MO: University of Missouri Press, 1979), 42-43.

⁵ Davis, Michael. "Report of the President to the Annual Meeting," 1947.

⁶ All monetary figures are given without adjustment for inflation. Throughout the period, the dollar was worth slightly more than ten times as much as it is today, so \$40,000 is a bit more than \$400,000 in today's term.

"CPI Inflation Calculator." Bureau of Labor Statistics, 2017.

https://www.bls.gov/data/inflation_calculator.htm.

⁷ "Bylaws and Incorporation of Committee for the Nation's Health, Inc." New York, 1946, 1-2.

⁸ "Minutes of Executive Committee Held on November 17, 1946." Washington D.C., 1946, 1.

⁹ "Organization of the Committee for the Nation's Health," 1946, 1.

Corporation of America, and Gerald Swope, leader of General Electric.¹⁰ There were several prominent lawyers as well, including the future Supreme Court Justice Abe Fortas.¹¹ The CNH brought together prominent individuals from key sectors of the society, from labor unions to medicine to business. The difficulty would be in coordinating these different forces.

This coalition was more paper-based than a real alliance. Big business, even as represented by Sarnoff and Swope, was never heavily involved in the CNH. Both the AFL and the CIO placed key figures inside the CNH's leadership to help direct it, but there were no equivalent representatives from the major employers. Doctors, particularly Frothingham, were involved with the CNH, but the group never developed a substantial base of support among physicians. At one point, a speech by the CNH Executive Committee member and physician Theodore Sanders cited a poll showing that 25% of NY physicians supported national health insurance.¹² This was taken as a sign that there was significant opposition to the AMA among physicians, reflecting the sorry state of the support among physicians for the CNH and national health insurance. The fact that only 25% of doctors in one of the most liberal states in the country supported national health insurance, and that this was seen as a promising statistic by the CNH, shows the extent to which the CNH lacked mass support from physicians.

The Committee for the Nation's Health engaged in a variety of political activities in an attempt to garner support for national health insurance, many of which were oriented towards gaining elite support. Davis and donor Albert Lasker testified to Congress in 1947 in support of the Wagner-Murray-Dingell legislation.¹³ The CNH lobbied both parties to include support for

¹⁰ Ibid.

¹¹ Ibid.

¹² Sanders, Theodore. "Address By Theodore M. Sanders at Panel Discussion on 'Welfare Legislation - A Progressive Program For Every American.'" Washington D.C.: Democratic National Committee, 1948, 1.

¹³ John Gunther, *Taken at the Flood: The Story of Albert D. Lasker*, (New York: Harper & Brothers, 1960), 320.

national health insurance in their 1948 party platforms, which was ultimately unsuccessful in both cases.¹⁴ The CNH also tried to increase popular support for national health insurance. This was done through a mass media campaign, and through responding in press to attacks by the AMA or other groups. The CNH would coordinate responses to criticisms of national health insurance and its proponents, getting multiple individuals to issue responses in particularly crucial circumstances.¹⁵ The CNH worked heavily with the press to get favorable stories published, and hired a public relations firm to cover press activities, although after unsatisfactory results the CNH shifted to using paid staff and focused on using the specialized press, which was generally more favorable. They also distributed literature directly, printing thousands of pamphlets and propaganda pieces annually.¹⁶ The CNH's most heavy coordination was with organized labor, which provided the largest base of organizations fully committed to national health insurance.

The legislation the CNH supported was quite similar to the proposals of the National Health Conference of 1938, and to the Wagner bill of 1939. The CNH backed national health insurance, as proposed by President Truman and as detailed in the Wagner-Murray-Dingell legislation. This legislation had components other than national health insurance. The bill also included additional federal funding for states' public health programs, funding for medical education and research, funding for "community-wide maternal and child health services," and

Davis, Michael M. "Statement by Michael M. Davis in Behalf of the Committee for the Nation's Health before the Senate Education and Labor Committee." Washington D.C., 1946.

¹⁴ Sanders, "Address by Theodore M. Sanders at Panel Discussion on 'Welfare Legislation- A Progressive Program For Every American'".

Gardner Cowles. "Statement on National Health." Committee for the Nation's Health, 1948.

"1948 Democratic Party Platform." The American Presidency Project, 1948.

<http://www.presidency.ucsb.edu/ws/?pid=29599>.

¹⁵ Channing Frothingham to William Green, March 5, 1951.

Michael Davis to Gerald Swope, March 5, 1951.

¹⁶ Michael Davis to Executive Committee, September 30, 1948.

additional aid to help poor people access care.¹⁷ The CNH backed all of these provisions but focused most heavily on national health insurance.

The Wagner-Murray-Dingell bill of 1945 had several critical components of its insurance plan. Similar to the 1939 bill, it kept the institution of private practice, and, unlike the British plan, did not create government run medical establishments. Rather, the system of private hospitals and facilities was maintained, with the difference being that the vast majority of individuals would now be insured by the government. The major distinction between the 1939 bill and the 1945 bill was that the latter set up a truly national insurance system, based on Social Security. The plan was nearly universal, and included groups not covered under Social Security, such as farmers, domestic workers, and the self-employed.¹⁸ The major groups of excluded workers were ministers and government workers.¹⁹ Senator Wagner estimated that about 110 million people would be covered, out of a population of around 140 million.²⁰ Like Social Security, the plan maintained a strong relationship with employment, and the plan was to be financed via a payroll tax.²¹ Unemployed individuals would not be automatically covered,

¹⁷ Wagner, Robert. "Statement of Senator Robert F. Wagner of New York on Introduction of the National Health Act of 1945." Washington D.C., 1945, 19.

¹⁸ This had important racial implications, as agricultural workers and domestic workers were disproportionately black. It is for this reason that they were originally excluded from Social Security. Ira Katznelson, *When Affirmative Action was White: An Untold History of Racial Inequality in Twentieth-Century America*, (New York: W.W. Norton & Company, 2005), 22.

¹⁹ Wagner, "Statement of Senator Robert F. Wagner of New York on Introduction of the National Health Act of 1945," 19.

²⁰ Wagner, Robert. "Health Insurance For The American People," 1946, 9.

Hobbs, Frank, and Nicole Stoops. "Demographic Trends in the 20th Century." Washington D.C., 2002, 11.

The 1940 Census recorded a population of 132.2 million, while the 1950 census found a population of 151.3 million, leaving a little more than 140 million in 1945.

²¹ American Federation of Labor. "National Health Insurance Program (Draft)," 1951. 8.

although local governments could decide to include welfare recipients.²² This was not a fully universal health insurance scheme, but it was a significant step in that direction.

The arguments and rhetoric used by the CNH and by Wagner followed a fairly set pattern, one similar to the arguments made during the Roosevelt era. National health insurance proponents argued that too many people lacked access to adequate medical care. Although voluntary insurance was growing, it was thought insufficient to ever cover a substantial enough percentage of the population. There was thus a need for the government to step in, applying the insurance principle to as broad a population as possible.²³ Proponents were careful to rebut certain phrasings they were concerned would weaken support. In particular, the term “socialized medicine” was heavily disavowed. Both Wagner and the CNH rebuked the term and denied that the proposal qualified.²⁴ Their argument was that “socialized medicine” refers to “medical care furnished by Government doctors free of charge,” and that the Wagner-Murray-Dingell legislation did not use government physicians.²⁵ Additionally, proponents refuted certain false accusations against the bill, noting that patients would maintain their choice of doctor, a fact frequently pointed to by proponents.²⁶

The Donors Versus Organized Labor

²² Davis, Michael. “Health Care for All.” Survey Graphic. New York, December 1945.
http://www.archive.org/stream/surveygraphic34survrch/surveygraphic34survrch_djvu.txt.

²³ Ibid.

²⁴ Wagner, Robert. “Questions and Answers About the Prepaid Health Care Provisions of the National Health Act of 1945.” Congressional Record, 1946.

Paterson, Chat. “Proposed Program for Committee for the Nation’s Health,” 1949.

²⁵ Wagner, “Questions and Answers About the Prepaid Health Care Provisions of the National Health Act of 1945.”

²⁶ Ibid.

Davis, “Statement by Michael M. Davis in Behalf of the Committee for the Nation’s Health before the Senate Education and Labor Committee”, 2.

In 1946, the CNH's budget was \$50,000 for the nine months it was active.²⁷ The substantial funding for the CNH initially came from a handful of sources,²⁸ particularly the Lasker and Rosenwald families. In 1949, for example, the Laskers and Rosenwalds gave the CNH \$50,000 for the first half of the year, more than half the annual budget.²⁹ This led them to have significant influence over the CNH, with Albert Lasker having a seat on the Board of Directors.³⁰ A life-long Republican, Albert Lasker, who earned tens millions of dollars in the advertising industry, became liberal towards the end of his life, voting for Roosevelt in 1944 and for Truman in 1948.³¹ His wife, Mary Lasker, herself active in the debates regarding the CNH, would continue as a medical philanthropist for decades after Albert Laskers' death in 1952.³² Lessing Rosenwald, the chief interlocutor from the Rosenwald family, inherited his fortune from Julius Rosenwald, who had become affluent through Sears.³³ Anna Rosenberg, a member of the Board of Directors and a public relations executive who had been close with FDR, was allied with the Laskers and Rosenwalds.³⁴

It is not entirely clear why conflict emerged in the CNH between the Rosenwalds, Laskers, Rosenberg, and the rest of the organization, including organized labor, Frothingham,

²⁷ Michael Davis. "Financial Estimates for 1949." Washington D.C., 1948.

²⁸ Loucheim, Joseph. "Meeting of the Board of Directors," 1947.

²⁹ Michael Davis to Channing Frothingham, Nelson Cruikshank, and John Edelman, December 30, 1948. Michael Davis to Executive Committee, November 22, 1949. It is not clear if they gave for the second half of the year.

³⁰ Michael Davis to Channing Frothingham, January 10, 1949.

³¹ Gunther, *Taken at the Flood*, 4, 294.

³² Pace, Eric. "Mary W. Lasker, Philanthropist For Medical Research, Dies at 93." New York Times. February 23, 1994. <http://www.nytimes.com/1994/02/23/obituaries/mary-w-lasker-philanthropist-for-medical-research-dies-at-93.html?pagewanted=all>.

³³ Smith, J. Y. "Lessing Rosenwald Dies, Donated Art, Rare Books." Washington Post. June 26, 1979. https://www.washingtonpost.com/archive/local/1979/06/26/lessing-rosenwald-dies-donated-art-rare-books/3eebe53e-0a3a-4e0e-991e-d49fae1b7217/?utm_term=.a33e150634c9.

³⁴ Pace, Eric. "Anna Rosenberg Hoffman Dead; Consultant and 50's Defense Aid." New York Times. May 10, 1983. <http://www.nytimes.com/1983/05/10/obituaries/anna-rosenberg-hoffman-dead-consultant-and-50-s-defense-aide.html>.

and Davis. This senior project examines only the documents in the Committee for the Nation's Health's archive, compiled by Michael Davis. There are more documents containing correspondence from Davis' side, and it is not as clear what the Rosenwalds, Laskers, and Rosenberg were saying in their internal conversations. Thus, the conclusions have to be tentative given the partial nature of the available material.

As early as 1947, executive director Joseph Loucheim called for adding additional sources of revenue, decreasing the CNH's "dependence on a small number of large givers."³⁵ The CNH failed in broadening its donor base, however. Its expenditures dropped to just \$33,000 in 1947, following the \$50,000 budget for 1946.³⁶ Organized labor was not yet a significant financial backer of the CNH, although labor was able to voice its concerns through John Edelman, President of the Textile Workers Union (CIO), and Nelson Cruikshank, a high-ranking AFL staff member. Open conflict only broke out the following year. An immediate cause of the clash was the failure of the CNH to pass national health insurance legislation in the first half of 1948. The donors expected such legislation to pass, although given the Republican control of Congress this does not seem to have been a reasonable expectation. Later in the year, Rosenwald confronted Davis over the failure, saying that he had "promised passage of a health insurance bill in 1948," a charge Davis denied.³⁷ Davis suggested that it was the Laskers who had promised the Rosenwalds passage of legislation.³⁸ Regardless of what Davis may or may not have suggested to the donors about the likelihood of quick success, the lack of demonstrable progress left the donors feeling the need to change the direction of the organization.

³⁵ Loucheim, Joseph. "Meeting of the Board of Directors," 1947.

³⁶ Davis, "Financial Estimates for 1949."

³⁷ Michael Davis to Channing Frothingham, Nelson Cruikshank, John Edelman, Abe Fortas. December 3, 1948

³⁸ Ibid.

The proposal to revamp the CNH was an unsubtle attack on Davis' authority. Davis was not only the chairman of the executive committee of the Committee for the Nation's Health, but also held a leadership position with the Committee on Research in Medical Economics (CRME), which had existed prior to the CNH and provided research services for it. The CNH shared office space originally with the CRME, but they soon split off, as the CRME needed to protect its tax-exempt status.³⁹ In the second half of 1948, the Rosenwalds and Laskers called for splitting off more fully research (CRME) and political activities (CNH). This meant that one individual, Davis, could not be in charge of both organizations. The Rosenwalds and Laskers instead wanted Davis to serve merely as a "consultant" to the political arm.⁴⁰ They threatened to cut off all funding to the political arm if Davis did not abdicate his position in the CNH.

Davis was happy to give up some of his authority in the Committee for the Nation's Health. He was at the time fulfilling many administrative tasks he found undesirable.⁴¹ He even offered, in a letter to his ally, Channing Frothingham, to step down as chairman of the Executive Committee, or to leave the CNH entirely "if in the opinion of yourself [Frothingham] and other friends, it is best for the cause."⁴² But the downgrading of his role in the CNH to merely a "consultant" was too much an indignity for him to accept. He argued to Frothingham that serving as a consultant "would not yield satisfactory results, for so-called technical considerations are inseparable from objectives and policies."⁴³ There is some validity to Davis' claim regarding consultant work, but a more likely explanation is that Davis would rather have left the organization entirely than be so thoroughly downgraded in rank and prestige.

³⁹ Davis, "Report of the President to the Annual Meeting."

⁴⁰ Michael Davis to Channing Frothingham. November 5, 1948.

⁴¹ Ibid.

⁴² Ibid.

⁴³ Ibid.

This specific focus on limiting Davis' role suggests that there was some personal tension between him and the donors. The Rosenwalds had long funded his CRME, so they were at least somewhat comfortable with his leadership in the research realm.⁴⁴ The donors' proposal was to have him continue leading CRME, so it likely that they were unhappy with his leadership of the CNH rather than being fully against Davis.

The exact direction the donors wanted to take the CNH is not clear from the documents, partially due to the limitations discussed earlier. In an Executive Committee meeting from November of 1938, Davis suggested that the donors wanted increased support from major corporations.⁴⁵ Davis reports that "Mr. Lasker's fixed policy of one-year commitments means they want to make annual decisions, want a PR program for mass media, a new CNH free from New Deal stigma, and a legislative program acceptable to big business."⁴⁶

It is worth explaining each of these policy suggestions, with the caveat that this was Davis' summary of what Lasker had said, rather than a quote from Lasker directly. Given the presence of labor representatives in the room, the mention of "big business" may have been an effort by Davis to get additional support against Lasker's program. The mention of a "PR program for mass media" may seem like a fairly innocuous idea, but this was the subject of consistent debate within the CNH. The problem was that mass media buys were far more expensive than working through more specialized press, such as the labor, the black press, and the women's press. The Committee for the Nation's Health had hired a public relations firm in 1948 to conduct a general press campaign. This effort was thought to have been unsuccessful, and their contract was not renewed. In April of 1948, the Executive Committee decided to focus

⁴⁴ Michael Davis to Lessing Rosenwald, Albert Lasker, Anna Rosenberg. June 23, 1948

⁴⁵ "Office Memorandum of the Executive Committee Meeting." Washington D.C., 1948, 1.

⁴⁶ Ibid., 3.

on the specialized press while continuing outreach to the general press.⁴⁷ It was Davis specifically who had made the case for doing so to Lessing Rosenwald, Albert Lasker, and Anna Rosenberg in June 1948.⁴⁸ Davis' reasoning was that a general press approach would only be successful with more resources, and that an insufficient effort at the general press would leave the CNH open to counter-attacks. The suggestion to return to a general press strategy was thus a rebuke of not only existing CNH policy but specifically of Davis, although it was also a return to Lasker's professional specialty as an advertising executive.

The desire for a CNH "free of New Deal stigma" and for a "legislative program acceptable to big business" went together logically. Davis had stated in 1947 that part of the problem the CNH was having in the general press was because of the association between national health insurance and the New Deal.⁴⁹ Eliminating that stigma through a shift of program towards one friendlier to big business would thus likely lead to more favorable media coverage. As discussed, big business support for the CNH was lacking, besides nominal support from a few key figures. Davis' summary of Lasker's comments does not tell us what changes in policy he had in mind in order to gain additional support from the affluent. Thankfully, Monte Poen's *Harry Truman Versus the Medical Lobby* provides additional insight through an interview Poen conducted with Mary Lasker in 1967. Lasker said that Davis was too ambitious in his policy goals, and that she and the Rosenwalds wanted to redirect the focus of the CNH from national health insurance to other, more achievable health related items.⁵⁰ Doing so would have fundamentally changed the nature of the CNH.

⁴⁷ "Minutes of Executive Committee Meeting Held on April 20, 1948," 1948, 2.

⁴⁸ Michael Davis to Lessing Rosenwald, Albert Lasker, Anna Rosenberg. June 23, 1948.

⁴⁹ Davis, "Report of the President to the Annual Meeting."

⁵⁰ Poen, *Harry Truman Versus the Medical Lobby*, 177.

The donors' turn away from pushing national health insurance should not be understood as a disagreement with that aim. Albert Lasker had testified to Congress in 1947 in favor of national health insurance, and we have little reason to doubt the sincerity of those beliefs. Rather, conflict broke out due to a difference in priority. The Laskers and Rosenwalds were willing to donate large amounts of money to support a national health insurance campaign, but this was far from their only interest and they were not willing to give tens of thousands of dollars year after year to support it. The CNH as an advocate for national health insurance would demand more from them than they were willing to give, and the uncertainty over national health insurance's passage led them to call for a change of direction in the CNH.

A committee led by Frothingham, Cruikshank, Edelman, and Morris Cooke, an engineer, were able to negotiate with the donors for additional contributions for the year 1949. They were aided by Harry Truman's surprise victory in the presidential election, which raised hopes that national health insurance had a realistic chance of passing in the next Congress.

A nearly identical fight emerged in the fall of 1949, with the battle lines similar to the previous year's. This time, however, there was increased animosity towards the donors. In a letter to Davis from November 1949, Cooke wrote that "it ought not to be too difficult to get it over to Mr. Money Bags [presumably Albert Lasker] that if he wants to be the whole works, he had better get up a new organization."⁵¹ Although no one else used language quite as colorful, others had similar sentiments. Particularly noteworthy is the stance taken by organized labor. Poen argues that labor's support for Davis became clear in January 1950, which precipitated Rosenwald leaving the CNH.⁵² In fact, organized labor had been on Davis' side earlier. Cruikshank, the AFL representative, stated in a letter from November of 1949 to Frothingham

⁵¹ Morris Cooke to Michael Davis, November 25, 1949.

⁵² Poen, *Harry Truman Versus the Medical Lobby*, 177-178

that “we have not yet found the way to prevent a concentration of control arising from the concentration of financial support,” a clear rebuke of the donors’ effort to control the organization.⁵³ The AFL thus did not wait until January to support Davis, as Poen alleges.

The position of Edelman, is less clear in the 1949 fight, and perhaps there was a decisive shift in January of 1950. During 1948, however, Edelman was clearly on Davis’ side. After the election of that year, Edelman argued in an Executive Committee meeting that it was not time to compromise but to pursue fully the legislation the CNH desired.⁵⁴ Cruikshank and Edelman both argued “that Dr. Davis’ continued presence on the Executive Committee and his active participation in shaping legislative policy and action would be necessary for CNH’s future soundness”, rebuking the donors’ suggestion that Davis become a consultant.⁵⁵ There is less evidence regarding Edelman’s role in 1949, but the 1948 documents show that Edelman was inclined to back Davis against the influence of the donors.

The Rosenwalds, Laskers, and Anna Rosenberg were isolated within the CNH. If for them national health insurance was just one component of several changes to the health system they would like to have seen, to Davis and other members of the CNH, national health insurance was the crucial component of any health care reform. This was particularly the case for organized labor, which while not opposed to expanding government support for research or medical education, understood that it was health insurance which most directly impacted their membership. In his November 21, 1949 letter to Frothingham, Cruikshank noted the rising support for national health insurance in the AFL, and that the head of Labor’s League for Political Education (the political arm of the AFL) wanted to “make national health insurance one

⁵³ Nelson Cruikshank to Channing Frothingham, November 21, 1949.

⁵⁴ “Office Memorandum of the Executive Committee Meeting.” Washington D.C., 1948, 1.

⁵⁵ “Minutes of Executive Committee Meeting Held on November 3, 1948,” Washington D.C., 1948, 1.

of the major objectives of the political campaign of 1950.”⁵⁶ In such a context, organized labor was not going to allow the CNH to be anything other than a conduit for the campaign for national health insurance. Hence, the proposal by the Rosenwalds and Laskers were simply unacceptable to the unions.

After another year of inadequate progress in 1949, the Rosenwald and Lasker families ceased donations to the CNH.⁵⁷ The immediate reason was Rosenwald’s discovery of the letter from Cruikshank quoted above.⁵⁸ With the withdrawal of support from the Rosenwalds and Laskers, the Committee for the Nation’s Health was on the verge of collapse. At several points, it had funds on hand for just a few weeks.⁵⁹ The only reason the CNH was able to continue operating was the financial support given by labor unions. Unions had not previously been major donors to the CNH, hence the financial domination of the group by a few individuals. In 1950, facing the CNH’s collapse, organized labor came to the CNH’s aid in an unprecedented manner. The largest donation from a union was from the Lady Garment Workers, who gave \$3500, followed by \$2000 donations by the Autoworkers and Steelworkers, and \$1000 from the Machinists.⁶⁰ Among the federations, the AFL gave \$5000 and the CIO gave \$500 for 1950, although the CIO also made an additional \$5000 donation earmarked for 1951. The subsequent year, the Steelworkers gave \$5000, which was matched by the Autoworkers.⁶¹ These figures do not contain the full lengths of labor’s support, since it does not include smaller donations, including from union locals. In total, 80% of funds given in 1950 came from organized labor.⁶²

⁵⁶ Nelson Cruikshank to Channing Frothingham, November 21, 1949.

⁵⁷ Davis, Michael. “Annual Report of the Chairman,” 1950.

⁵⁸ Albert Lasker to Michael Davis, January 23, 1950.

⁵⁹ Channing Frothingham to William Green, March 20, 1950.

⁶⁰ Michael Davis to the Legislative Policy Committee and Mr. Paterson, January 24, 1949

⁶¹ Frederick Robin to Frank Furstenberg, July 16, 1951.

⁶² Michael Davis to the Executive Committee, October 5, 1950.

This reliance on unions continued until the CNH closed, itself a reaction to the merger of the AFL and CIO, which eliminated the need for a separate organization to coordinate their health efforts.

Prior to the merger, labor unions had undergone major changes with regards to their relationship to healthcare in the years following World War 2, which impacted their actions relating to national health insurance proposals. Several unions, including the Steelworkers, the Autoworkers, and the Mineworkers, negotiated private health insurance plans in the years after World War 2.⁶³ This was aided by a 1949 NLRB ruling requiring employers to negotiate over health and other fringe benefits.⁶⁴ Unions spent a considerable amount of their energy and resources securing private insurance, with 55% of strikes in 1949 and 70% of strikes in the beginning of 1950 called for health related issues.⁶⁵ With the exception of the Mineworkers, those unions which won benefits did not end entirely their support for government health insurance, but it has been argued that the issue lost its high level of salience.⁶⁶

Not all unions were able to win health insurance for their members. AFL unions in particular found it more difficult to negotiate for health insurance, due to the local and more competitive nature of the industries with high AFL membership.⁶⁷ Whereas 95% percent of CIO members had privately negotiated health insurance in 1950, only 20% percent of AFL members did.⁶⁸ Other scholars have argued that this led to a reversal of the traditional pattern of the CIO

⁶³ Ibid., 1346-1350.

⁶⁴ Ibid., 1347.

⁶⁵ Beth Stevens, "Blurring the Boundaries: How the Federal Government Has Influenced Welfare Benefits in the Private Sector", in *The Politics of Social Policy in the United States*, ed. Margaret Weir, Ann Sola Orloff, Theda Skocpol (Princeton, NJ: Princeton University Press, 1988), 141.

⁶⁶ Alan Derickson, "Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958," *The Journal of American History* 60, no. 4 (1994): 1346.

⁶⁷ Ibid., 1352.

⁶⁸ Ibid.

Marie Gottschalk, *The Shadow Welfare State*, 44.

more strongly supporting social democratic programs, with the AFL now more concerned about passing a universal health insurance program than the CIO.⁶⁹

The list of donors is at least somewhat contrary to the arguments made regarding the decreased support for national health insurance in the CIO due to the CIO's better success in negotiating private plans. With the exception of the donation from the ILGWU, an AFL affiliate, the major union donations were from CIO unions. The large donations from the Steelworkers and Autoworkers is particularly noteworthy, as these unions had by this point already negotiated private health plans.⁷⁰ To be clear, these unions also happened to be some of the wealthiest, so it would not be surprising that they would top the donations list of an organization financially supported by unions. Additionally, as a federation the AFL had more money than the CIO due to its larger size, perhaps explaining the more sizeable 1950 contribution. The financial figures also do not show the extent of the coordination with the CNH and the grassroots effort the unions put in to fighting for national health insurance. Nonetheless, this singular data point does suggest that the argument regarding the AFL unions' greater eagerness to put resources into the national health insurance fight is overstated, as unions of both federations provided similar amounts of money to the CNH.

Why did the CNH fail?

Michael Davis had a single explanation for the failure to pass national health insurance while the CNH was active: the split between Northern and Southern Democrats. On multiple occasions, Davis argued that the division between Truman and Southern elected officials, brought on by Truman's advocacy for civil rights, made Southern Democrats unwilling to

⁶⁹ Derickson, "Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958," 1336.

⁷⁰ Ibid., 1346-1350.

support Truman's health care agenda.⁷¹ Given that Northern Democrats on their own lacked the votes to pass national health insurance, and the opposition in the Republican Party, this made the legislation politically untenable.

We should take Davis' position seriously. It is reflected in the vote to make a cabinet position for health related activities, seen as a proxy for a national health insurance vote.⁷² Southern Democrats voted overwhelmingly against adding the cabinet position. It also makes sense in the historical context of the Democratic Party. President Franklin Roosevelt's New Deal incorporated black voters in the north, and took a more liberal attitude towards blacks than previous Democratic presidents. Adding black voters to the Democratic coalition, even if they were Northerners, worried white Southerners that this would disrupt Northern Democrats' acceptance of Southern racial practices.⁷³ Nonetheless, white Southerners continued to support the Democratic Party, and the New Deal, with Southern Congressmen only voting against Northern Democrats on race-related issues.⁷⁴

Starting arguably in the late 30's, and definitely by World War 2, Southern Democrats began to move to the right politically, although this may have been limited solely to labor related issues.⁷⁵ The Southern Democrats' less friendly attitude to organized labor during and after the war was a response to the spread of unions, some of which were integrated, to the South, a

⁷¹ Michael Davis to Executive Committee, April 15, 1948.

⁷² Doherty, Kathleen, and Jeffery Jenkins. "Examining a Failed Moment: National Health Care, the AMA, and the U.S. Congress, 1948-1950." In Annual Meeting of the Southern Political Science Association, New Orleans, LA, 2009, 13.

⁷³ Howard Reiter, "The Building of a Bifactional Structure: The Democrats in the 1940s," *Political Science Quarterly* 116, no. 1 (2001).

⁷⁴ Ira Katznelson, Kim Geiger, and Daniel Kryder, "Limiting Liberalism: The Southern Veto in Congress, 1933-1950," *Political Science Quarterly* 108, no. 2 (1993): 296.

⁷⁵ Ibid.

development which fundamentally threatened the Southern racial order.⁷⁶ This led to a shift in Southern Democrats' voting behavior away from support for labor, leading to the 1947 Taft-Hartley Act, passed with support from Republicans and a majority of Southern Democrats, with opposition from Northern Democrats and a border state Democratic President.⁷⁷

Davis suggested that the Southern antipathy to national health insurance legislation was because of their ongoing fight with Truman over civil rights. This may be true, but it also ignores the racial implications of the Wagner-Murray-Dingell legislation, which would have rapidly expanded health access for Southern blacks, challenging Jim Crow. Each year's version of the Wagner-Murray-Dingell bill had different components, with the 1943 and 1945 pieces of legislation having significantly lower levels of local control than the earlier Wagner bill and the later 1947 and 1948 bills.⁷⁸ The conflict between Truman and Southern Democrats may have made the racial implications of the health bill more salient, but in the absence of the feud the racial interests of Southern Democrats still would have led them to either oppose the legislation or seek modifications consistent with Jim Crow, as happened with Social Security.⁷⁹ The major health legislation which did pass in this era, the 1946 Hill-Burton Act, which funded hospital construction, allowed for the funding of segregated facilities, much to the ire of civil rights activists.⁸⁰ Southern Democrats were willing to support health legislation, but only if left Jim Crow entirely unchallenged.

⁷⁶ Sean Farhang and Ira Katznelson, "The Southern Imposition: Congress and Labor in the New Deal and Fair Deal," *Studies in American Political Development* 19, (2005).

⁷⁷ Katznelson, Geiger, and Kryder, "Limiting Liberalism: The Southern Veto in Congress, 1933-1950," 297.

⁷⁸ Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*, (Princeton, NJ: Princeton University Press, 2003), 187.

⁷⁹ Ira Katznelson, *When Affirmative Action was White*, 22.

⁸⁰ Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*, 193.

One of the few Southern Democrats to support national health insurance was Senator Claude Pepper of Florida. Pepper was by no means a racial liberal, having previously supported the filibuster of anti-lynching legislation sponsored by Robert Wagner.⁸¹ Yet compared to many other Southern Democrats, Pepper's views on race were moderate.⁸² On non-racial matters, Pepper was far to the left, particularly on foreign policy, where he defended Britain's labor government as "socialist" and opposing the Cold War on pro-Soviet grounds.⁸³ His opponent in the 1950 Senate primary used Pepper's alleged closeness to blacks successfully defeat him.⁸⁴ Florida's racial politics had complexities not present in other Southern states, given the substantial number of liberals from New York in the southern tip of the state.⁸⁵ The case of Pepper demonstrates that although it was possible for a Southern Democrat to back Wagner-Murray-Dingell, such support was unlikely. A Democrat with a strong commitment to the New Deal and a lower level of commitment to upholding Jim Crow, like Pepper may have been willing to back national health insurance, but there were few Southern Democratic members of Congress with views similar to him. Hence, the near absence of Southern support for national health insurance.

Michael Davis' explanation for the failure of national health insurance is thus pertinent, but it also conveniently ignores the role of the CNH as a social movement organization. After all, there is little the CNH could have done even hypothetically to minimize the impact of the north-south split, minus compromising the inclusive nature of the legislation. The CNH was heavily

⁸¹ Ortiz, Robert. "Claude Pepper the New South Rebel: Ideology in Action 1936-1952." Florida State University, 2014, 15-16.

⁸² Katznelson, *When Affirmative Action was White*, 18.

⁸³ Jonathan Bell, "Conceptualizing Southern Liberalism: Ideology and the Pepper-Smathers 1950 Primary in Florida," *Journal of American Studies* 37, no. 1 (2003): 17-26.

⁸⁴ *Ibid.*, 38-39.

⁸⁵ *Ibid.*, 20-21.

involved in other facets of the campaign for national health insurance, however, as the leading organization of its type, and it therefore makes sense to examine the operations of the CNH in determining why its goals were not achieved.

The most intuitive explanation is that the CNH lacked the funding of the AMA. The AMA was spending ten times the amount of the CNH, if not more, and these added resources made the efforts of the CNH significantly more difficult. As members of the CNH alluded to, running an underfunded national media campaign can actually hurt the cause, leaving the organization open to counterattacks.⁸⁶ The CNH's inability to compete with the AMA financially most surely contributed to the drop in popular support for national health insurance from 1946 to 1949, and thus made national health insurance less likely to pass. The financial disadvantage possessed by the CNH was the result of several factors. First, doctors tended to have high incomes, and their opposition to national health insurance led to the AMA having a base of wealthy contributors. The structure of the AMA also mattered though. Through its power over licensing, the AMA had the ability to censure doctors who were not members of the organization, so that "defiance of AMA authority means professional suicide for the majority [of physicians]."⁸⁷ Thus, even doctors who were not particularly supportive of the AMA's political agenda had no choice but to pay the yearly assessments.

By contrast, the CNH had no comparable way of securing a stream of donations from those doctors who were in support of national health insurance. Additional revenue need not have come from physicians. Had the CNH had greater support from wealthy donors, it also

⁸⁶ Michael Davis to Lessing Rosenwald, Albert Lasker, Anna Rosenberg. June 23, 1948

⁸⁷ "The American Medical Association: Power, Purpose, and Politics in Organized Medicine," *The Yale Law Journal* 63, no. 7 (1954): 953.

would have been able to compete with the AMA more readily. This support was not forthcoming, however, even from sympathetic figures like Gerald Swope.

The lack of substantial support from the wealthy, with the exception of the major donors already discussed, is a consequence of the balance of powers in the health care debate. As discussed in Chapter 1, industrialists in other countries have on occasion endorsed expanded health insurance. The key is that there needs to be a greater threat that would compel them to compromise. In the case of Social Security, the Townsend movement created pressure from below for an unreasonable program which needed to be avoided.⁸⁸ In the case of Bismarck's health program, the goal was to stave off the threat of socialism.⁸⁹ This elite support for national health insurance therefore is a defensive responsive and an attempt to compromise and weaken the strength of radicals. The Committee for the Nation's Health represented the left-flank of the movement for expanded health insurance. Backed by organized labor, there was no more invasive threat to capitalists via health insurance than the CNH's proposals, particularly in the era of McCarthyism. In such a context, it would have made little sense for capitalists to support the CNH plan en masse. Alternatively, they would have been expected to support expanded access to health insurance via alternative means, especially those that would allow for large profits. This is what happened.

Forces across the political spectrum supported proposals which would have been anathema in the 1930's, such as Senator Taft's plan to provide health insurance to poor people.

⁸⁸ Hacker and Pierson criticize scholars who put too much emphasis on business' role in crafting Social Security, but still accept the argument that "business support... of the SSA (Social Security Act) was itself strategic accommodation, driven by fear of less attractive alternatives"

Jacob S. Hacker and Paul Pierson, "Business Power and Social Policy: Employers and the Formation of the American Welfare State," *Politics and Society* 30, no. 2 (2002): 298, 308.

⁸⁹ Donald Madison, "From Bismarck to Medicare – A Brief History of Medical Care Payment in America" in *The Social Medicine Reader: Health Policy, Markets, and Medicine* ed. Jonathan Oberlander et al. (Durham, NC: Duke University Press, 2005), 34-36.

The wealthy capitalist Bernard Baruch proposed a system of national health insurance for people below a certain income, with the affluent using private insurance. A proposal by two Republicans in Congress, Jacob Javits and Richard Nixon, called for a “locally controlled, government subsidized, private nonprofit insurance system, with premiums scaled to subscribers’ incomes”.⁹⁰ Business supported these more moderate proposals, rather than the large expansion of the welfare state that would have accompanied the Wagner-Murray-Dingell legislation.⁹¹ It is for these reasons that the CNH, short of compromising itself as Lasker proposed, was unable to accrue significant support from big business.

Without healthy support from physicians or big business, the CNH was necessarily going to be heavily out-funded by the AMA. Had organized labor provided substantial contributions prior to 1950, the gap would have been smaller, since as it happened there was no point where the Laskers, Rosenwalds, and unions were making large contributions simultaneously. Nonetheless, even added financial support from the unions would not have done much to close the funding gap.

The AMA’s advantage was not just material. The prestige given to doctors gave the AMA legitimacy in discussing health issues. The AMA had doctors put messages from the AMA in their offices, providing the AMA’s positions with the authority of the doctor’s office.⁹² Starr

⁹⁰ Starr, *The Social Transformation in American Medicine*, 285.

The Javits-Nixon proposal should be understood as a serious effort, rather than merely an attempt to weaken support for single payer. As President, Nixon called for a rapid expansion of non-profit HMOs, coupled with an employer mandate to provide care. Although the Javits-Nixon plan differs from the plan Nixon supported as president, they have enough similarities to suggest that the former was a genuine proposal.

Ibid, 394-397.

⁹¹ Starr argues that the Baruch proposal failed due to the split between Truman and Southern Democrats, while the Javits-Nixon plan did not receive Democratic support.

Ibid.

⁹² Ibid., 288.

adds that the social capital of doctors, including their connections to other wealthy individuals, aided the AMA campaign.⁹³

Differences in the mobilization of financial resources clearly mattered, but there are other resources social movement organizations can use. In particular, some scholars have criticized the CNH and its labor partners for using an elite strategy rather than one of mass mobilization, which Derickson calls “a crucial flaw in the campaign for health security.”⁹⁴ There is no documentary evidence in the CNH’s archives that they held a single rally or protest in favor of national health insurance. This was a result of the advocacy model deployed by the CNH, which relied on using elite backroom deals, in distinction to a mobilizing or organizing approach.⁹⁵ Labor’s hesitance to engage its membership is particularly noteworthy given the otherwise high level of membership involvement in union activities at this time.⁹⁶ However, the importance of the lack of membership mobilization is questionable. Would a mobilized membership been able to convince the same Republicans and Southern Democrats who in 1947 voted for the anti-union Taft-Hartley Act? This is unlikely. Unions, of course, were not powerful enough to stop Taft-Hartley, or to repeal it, despite their mobilization of membership and heavy involvement in Congressional elections. Even if unions had been able to use this level of resources on the nearly simultaneous fight on health insurance, the case of Taft-Hartley demonstrates that national health insurance still likely would have failed. The lack of grassroots mobilization cannot explain the failure of the CNH. This is not to say that the emergence of a massive movement for national health insurance would not have shifted the political balance on the question, but rather that the

⁹³ Ibid.

⁹⁴ Derickson, “Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958,” 1343.

⁹⁵ Jane McAlevey, *No Shortcuts: Organizing for Power in a New Gilded Age*, (New York: Oxford University Press, 2016), 9-12.

⁹⁶ Ibid., 53-56.

level of mobilization which realistically could have been achieved by the CNH and the unions would have been insufficient without changes in the parameters of the health insurance fight.

This leads us to return to the question of labor union strength. The late 1940's were in many ways the heyday of the labor movement, and is when union density reached its apex. This peak was higher than the density achieved by Canadian unions when Canada enacted its single payer legislation in the 1960's.⁹⁷ We should not overestimate the strength of unions in this period, as it was at this moment that the anti-union Taft-Hartley legislation was passed. Nonetheless, the weak labor union hypothesis is less applicable in the late 1940's than at any other time in US history, due to the economic and political power unions possessed. Given that other countries have enacted national health insurance with a labor movement as powerful as the American labor movement of the late 1940's, union weakness cannot be the main factor contributing to the failure of national health insurance in the CNH era. This is not to ignore that when compared internationally, the US labor movement was still relatively weak, and lacked a true labor party to ally with. Nonetheless, the unions were strong enough that, if there had been enough other favorable conditions, national health insurance could plausibly have been enacted.

Contingent events shaped the direction of the push for national health insurance under Truman. First of these was the 1945-1946 strike wave launched after the end of the war, the largest in US history, which resulted in a decrease in popular support for unions, as they were seen as being disruptive and pushing too far.⁹⁸ This weakened unions' political legitimacy, and led the way for the Republican takeover of Congress in the 1946 mid-term elections, after which

⁹⁷ Riddell, W. Craig. "Unionization in Canada and the United States: A Tale of Two Countries." In *Small Differences That Matter: Labor Markets and Income Maintenance in Canada and the United States*, ed. by David Card and Richard B. Freeman, (Chicago: University of Chicago Press, 1993), 110.

⁹⁸ Robert H. Zieger, Timothy J. Minchin and Gilbert J. Gall, *American Workers American Unions*, (Baltimore: Johns Hopkins University, 2014), 148, 153.

national health insurance was foreclosed for two years. By the time Democrats regained power after the 1948 election, rising McCarthyism made policies that could be associated with the Soviet Union anathema. Opponents of national health insurance were aware of this, spreading a fabricated quote from Vladimir Lenin about the importance of government health care to socialism.⁹⁹ These contingencies created an environment less friendly to national health insurance than would otherwise have been the case.

Conclusion

The late 40's were the only era in US history when a sitting president had unequivocally stated his public support for national health insurance. Yet despite the potentially favorable conditions, national health insurance legislation failed to make substantial progress under Truman. This chapter has examined that failure through the lens of the major advocacy organization, the Committee for the Nation's Health. Outfunded by its chief rival, the AMA, the CNH failed to increase public support for the legislation. Yet it was not only a question of resources which led to the defeat of national health insurance legislation. The divide between Northern and Southern Democrats, which had been festering for at least a decade, prevented supporters from gaining majority support in Congress. The CNH's initial failures led to a split within the organization, causing the CNH to serve as merely an appendage of a labor movement not able to commit the resources necessary to single-handedly pass the legislation. The Committee for the Nation's Health continued on for several years after the decisive defeat in the 1950 midterms, but the opportunity had already been missed.

⁹⁹ Gordon, *Dead on Arrival*, 144.

Conclusion

This Senior Project has examined conflict over health insurance policy during a crucial two-decade period, from the beginning of the New Deal to the end of Truman's presidency. The defeat of universal health insurance during this period shaped the subsequent history of health care provision, as the gains made in private health insurance limited the potential for single-payer insurance as well as for a national health system.

Empirically, the best explanation as to why universal health insurance efforts failed in the 1930s and 40s is the lobbying power of the American Medical Association. Not only did the AMA possess ample economic resources, but it fully prioritized medical issues as the representative of America's doctors. Labor unions, the most organized and well-funded supporters of universal health insurance, did not prioritize health policy in this way. Big business was for the most part absent from the debates of the time. The AMA was able to not only overcome public opinion, which was originally in support of adding a health insurance component to the Social Security Act, but to change it. Support for universal health insurance plans dropped precipitously in the late 1940's as the AMA was conducting a major public relations campaign. The AMA was aided by the divide between Northern and Southern Democrats, which was present in the Roosevelt era, and became a crucial impediment to national health insurance during Truman's presidency. Compared to other high-income countries, physicians in the United States have a high level of professional unity and a greater tradition of autonomy from the state, which have both aided the AMA.¹

Interest groups continue to play a major role in the formation of health policy, even as the specific groups themselves have changed in importance. Business groups have gained influence

¹ David Wilsford, *Doctors and the State: The Politics of Health Care in France and the United States*, (Durham, NC: Duke University Press, 1991), 274.

on health policy since the end of the 1940's, and the American Association for Retired People, founded in 1958, is now one of the most influential lobbying groups. Meanwhile, labor unions and the AMA have seen their strength reduced.

The two most recent major health insurance policy initiatives suggest that interest group positions continue to be the key factor determining health policy outcomes. President Trump's on-going efforts to repeal the Affordable Care Act is an illustration of this. The Trump/Ryan plan failed to gain the support of any of the major interest groups. Not only were labor unions opposed, as expected, but the AMA, AHA, ANA, and newer groups, including the AARP, and the conglomeration of health insurance companies were on record against Trump's proposed legislation.² It should be of little surprise then that the effort has failed to date, although the bill's seemingly rushed and ill-thought out nature could not have helped matters. The failure of the Trump plan, along with the 1993 Clinton plan, makes the success of the Affordable Care Act even more noteworthy. Like the creation of Medicare, the ACA is not a fully universal plan, and Supreme Court rulings have given significantly more leeway to state governments than was originally intended. The ACA is just seven years old, and the fully story of its creation has yet to be told. Future researchers will no doubt look at the ACA as an illustration of what factors need to be present for major health insurance reform to succeed in Congress. One easily observable

² Eli Watkins. "Groups Lining Up in Opposition to Health Care Plan." CNN, 2017. <http://www.cnn.com/2017/03/08/politics/interest-groups-politicians-american-health-care-act/>. Abby Goodnough, Robert Pear, and Thomas Kaplan. "Health Groups Unite to Oppose Republican Bill." New York Times, March 9, 2017. https://www.nytimes.com/2017/03/08/us/politics/affordable-care-act-obama-care-health.html?_r=0. AFL-CIO Staff. "9 Ways the Republican Health Care Bill Makes Health Coverage in America Unaffordable and Out of Reach." AFL-CIO, 2017. <https://aflcio.org/2017/3/15/9-ways-republican-health-care-bill-makes-health-coverage-america-unaffordable-and-out>.

metric is the support for interest groups garnered by the ACA; labor unions, the AMA, and insurance companies supported the legislation.³

The actual content of health insurance debates has remained remarkably similar throughout the intervening time between the Truman period and today. The fears of conservatives of a tyrannical government taking away one's choice of doctor remains a trope used in contemporary debates, as is the call by some liberals that only government action can solve the nation's insurance woes. The role played by state governments continues to be an unsolved issue. States' rights concerns were a major concern during the Roosevelt and Truman eras, as particularly mediated through the racism of Jim Crow states. These debates reverberate in the contemporary period. A section of the Affordable Care Act was ruled unconstitutional by the Supreme Court for unjustly coercing states to expand Medicaid. Many states, and all Southern states except Arkansas have subsequently decided not to expand it, thus weakening the national character of the ACA.⁴ This interplay between state governments and the federal government is one which has consistently dogged the formation of any national health policy. The Supreme Court's ruling on Medicaid expansion is unlikely to be the last word on the matter.

What has changed most dramatically since the period examined in this senior project is the scope of liberals' proposals. Although the Affordable Care Act rapidly expanded coverage, it did so in such a way that would have had made conservatives of the 1940's proud, through its continued reliance on for-profit insurers. The Javits-Nixon plan, by contrast, would have

³ Jill Quadagno, "Interest-Group Influence on the Patient Protection and Affordability Act of 2010: Winners and Losers in the Health Care Reform Debate," *Journal of Health Politics, Policy, and Law* 36, no. 3 (2011): 449-453.

Jonathan Oberlander, "Long Time Coming: Why Health Reform Finally Passed," *Health Affairs* 29, no. 6 (2010): 1112-1116.

⁴ Jessica C. Barnett, and Marina S. Vornovitsky. "Health Insurance Coverage in the United States: 2015." Washington D.C., 2016, 19.

provided near-universal coverage through non-profit insurers, and is arguable to the political left of the ACA. Prior to Bernie Sanders' 2016 presidential campaign, single-payer insurance, the policy goal of Harry Truman, had been off the table for decades.

Future research will incorporate the insights that can be gained from the recent successful and unsuccessful efforts to reform the health insurance system. It will also need to examine state-level health insurance policy debates as a way of confirming the conclusions reached here, with attention to the differences of state-level policy formation. States provide fifty different case studies to be examined, which allows for more specific understandings of the interaction between different variables. Most studies of health insurance policy have focused on the national level, even though the federal system allows states great, although not unlimited, leeway in choosing health insurance policies.

The last major theme that needs to be examined is the question of convergence between health insurance systems. As neo-liberal policies are implemented throughout Europe, and with the recent expansion of public health insurance through the Affordable Care Act, the differences between the US model and other countries may be reducing. If true, this convergence would have major implications for how we are to understand the historically exceptional nature of the US health insurance system. It would suggest that health insurance in the United States has had a unique trajectory not because of the country's intrinsic nature, but because of specific historical circumstances which are no longer operative.

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