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# Of a Healthy Constitution: Socialized Medicine Between the Triumphs of Social Security and Medicare

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Of a Healthy Constitution: Socialized Medicine Between the Triumphs of Social Security and  
Medicare

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“The phrase ‘socialized medicine’ means little or much. It has many different implications for those who use it and to those who hear it. It would be only by chance that I could guess what it means to you.”

-Isidore Falk to the National Medical Association, New York, 1939

## Introduction

In January 1937, Thomas Thacher, a former solicitor general of the United States under President Hoover, gave a talk at the annual meeting of the American Academy of Medicine. He attacked socialized medicine as a “fallacy” that would “blanket the country without regard to local conditions and individuals.” He also expressed doubts about the constitutionality of socialized medicine under the proposed system of compulsory health insurance, adding that states had no power to enforce funding for it. (Funding for such insurance would entail a sliding scale of costs between those in the upper and middle-income brackets, or to take money from the rich and give it to the poor.) Speaking directly to the physicians present, he said, “Generosity in relieving distress is characteristic of our people, and particularly of your profession. But we prefer to do our own giving.”<sup>1</sup>

Speeches of this sort were not rare in the 1930s or in the following years. The key players in the debate surrounding national health insurance all make an appearance – physicians and government officials discussed the implication of what a compulsory system would mean in America. Physicians were of the opinion that charity should not be linked to a compulsory infrastructure – but they found their strongest allies in those who made constitutional arguments against the idea. Thus the narrative of socialized medicine as distinctly *un-American* came to dominate the national conversation.

### *Before Social Security*

The elusive prospect of universal health insurance has perplexed and challenged American reformers ever since the concept first entered the American political discourse. Yet the idea of a

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<sup>1</sup> “Socialization of Medicine Hit as Fallacy,” *Springfield Republican*, January 9, 1937, America’s Historical Newspapers.

government being partly responsible for the health of its citizens was hardly new. As early as the yellow fever epidemic in Philadelphia in the 1790s, the question of whether quarantine was a federal or a state responsibility confronted Congress. The blueprint of the new republic, the Constitution, “made no mention of health”<sup>2</sup> and left the interpretation of the Declaration of Independence’s inalienable rights of “life” for later generations to link to the right to health or healthcare.<sup>3</sup>

As medicine changed, so did the question of the provision of healthcare within an interpretation of the Constitution that was both politically palatable and feasible. Various policies in the 18th and 19th centuries marked the federal government’s foray into the administration of healthcare; the 1798 “Act for the Relief of Sick and Disabled Seamen” or the Civil War merchant marine federal hospitals are but two of these examples.<sup>4</sup> In the twentieth century, however, the prevalence of Americans visiting hospitals increased dramatically, medical treatment became more efficacious, and paying physicians for their services grew to a scale large enough for questions about a patient’s right to care, or a physician’s to reimbursement, emerged as ones of political economy.<sup>5</sup> With the Great Depression of the 1930s, the issue of health became inextricably linked to a question of security. Economic security meant health security and vice versa; after all, illness or injury meant lost wages from an inability to work in tandem with unpredictable expenses for treatment itself. Within the conceptual paradigm of social

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<sup>2</sup> Beatrix Hoffman, *Healthcare for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2012), xxv.

<sup>3</sup> According to the historian Beatrix Hoffmann, “there is no evidence that Thomas Jefferson, in an age when medicine was not equated with lifesaving powers, had such an idea in mind.”

<sup>4</sup> Hoffman, *Healthcare for Some: Rights and Rationing in the United States since 1930*, xxvi.

<sup>5</sup> It is interesting to note that physicians seemed to have no problem with the idea of calling upon the federal government to intervene to secure their right to reimbursement for their services. They preferred to give charity care as they saw fit, but also expected federal participation in this charity – after all, they had to also make a livelihood. Professionals insisted that the government had a role in providing indigent care by retroactively reimbursing physicians after the latter had provided care. This growing call for government action arose out of the Depression era, when providers became frustrated with the number of patients they had to turn away, and the very little reimbursement they received for patients they did treat. See Beatrix Hoffmann’s *Healthcare for Some: Rights and Rationing in the United States since 1930*, 15.

insurance, prevalent in Europe and the U.S. at the time, the notion of a *right* to health was translated into protection against risk, which paved the way for the success of the Economic Security Act of 1935, otherwise known as the Social Security Act.

Yet the Act itself did not include a health insurance component.<sup>6</sup> Consequently, debate continued over the next three decades, culminating with the passage of Medicare and Medicaid. While monumental achievements for elderly and poor Americans, this legislation fell short of the broader of ambitions of proponents of universal health insurance. With the passage of Social Security, its architects certainly intended to continue expanding both the demographic reach of its coverage as well as the types of social welfare benefits provided. Excluded groups did win inclusion gradually after World War II, but the broader agenda stalled in the 1940s and early 50s, despite the overall institutionalization of the New Deal. Until President Lyndon Johnson's Great Society and War on Poverty, defining access to medical care and health insurance as a right was a volatile discussion that required examining the role of Congress in upholding "the general welfare" (an ambiguous Constitutional mandate) and the role of the president in pursuing an agenda for national health insurance while avoiding the censure of the powerful American Medical Association, which had established a strong hold on the American ideals of the physician's roles, medical ethics, and access to health. The ability to manipulate the label of "socialized medicine" and its valences significantly shaped the discourse around the constitutionality of a health insurance agenda, and whether or not such an agenda would have a detrimental effect on a distinctly "American" way of life or set of ideals.

There has been extensive scholarship on the question of national, public health insurance in the United States. Historians have looked at factors such as the absence of a labor party and

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<sup>6</sup> See Beatrix Hoffman, *Healthcare for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2012). Koppelman writes that Franklin Roosevelt considered health insurance along with other New Deal reforms, but feared it would "sink" Social Security and unemployment insurance.

the emergence of collective bargaining over private health insurance benefits from employers. Others have argued that the Red Scare of the late 1940s and early 1950s fundamentally derailed the possibility of a broader welfare state. Historians who write about race assert that racial politics in the South were divisive enough to prevent any sort of implementation on a federal level.<sup>7</sup> There is also an extensive social science literature. Political scientists have argued that structurally American federalism stymies the potential of a social democratic welfare state; that Americans are ideologically anti-statist; or that the U.S. traditionally has a weak central state.<sup>8</sup>

But invoking the Constitution's allowance or disavowal of national health reform has not been at the forefront of the discussion – this, despite the idea that the constitutionality argument might have been the strongest at the disposal of 'socialized medicine's' opponents, since loyalty to the Constitution is a bipartisan given. Stoking paranoia against a social system that threatened the fabric of American democracy turned out to be easier than legally attacking the premises upon which reformers built congressional proposals for socialized medicine. The latter tactic led to a politics of fear that, in a departure from the economic arguments that helped shape Social Security, perfectly set the stage for McCarthyism. Opponents of socialized medicine presented political and ideological arguments instead of constitutional or legal arguments against proposed reform. In doing so, they conflated Americanism with constitutionalism, thereby making opposition to socialized medicine *patriotic*. Americanism did not necessarily hold the same meaning for conservative politicians and physicians, but they united where they found common ground in order to oppose an importation of 'un-American' ideals from abroad. Meanwhile, proponents of national health insurance immediately after World War II were faced with the task

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<sup>7</sup> See Jill Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance* (Oxford University Press, 2006). Hospitals were racially segregated for patients, and even integrated staff had distinct roles for black and white physicians and nurses. Southern politicians opposed federal "intrusion" into local health policies and demanded that administration of social programs be left to the states and local governments.

<sup>8</sup> Ibid.

of defending their own patriotism while finding ways to advocate reform that built on the Social Security success of the New Deal era.

By examining the contributions of some of the architects of Social Security and the efforts for national health reform in the late 1930s and 1940s, this study explores the intersection of intellectual, policy, and legal history. Edwin Witte, Isidore Falk, and Franz Goldmann were some of these scholars and researchers who advocated some form of national health insurance; each of them found their efforts stymied by *ad hominem* arguments and suspicion (courtesy of conservative Congressmen and their associates, such as James Kem and Marjorie Shearon). The reluctance of these health insurance advocates to associate with the label of “socialized medicine,” as well as their opponents’ enthusiasm to make that connection, illustrates the political balancing act that advocates thought they could strike and control. Their objective to design a federal health insurance program to socially distribute risk required assessing the drawbacks of the alternative: private insurance, based on medical underwriting and cash indemnity, which the medical profession backed by the 1950s. The role of the courts in interpreting the Constitution for health and healthcare, and the role of the American Medical Association in doing the same, became crucial elements in this contestation.

### **The New Deal Security Project: Edwin Witte, Isidore Falk, and the Need for Insurance**

In his January 1935 address to Congress on Social Security, Franklin D. Roosevelt recommended different types of legislation to bolster economic security. One of them was “additional federal aid to State and local public health agencies and the strengthening of the Federal Public Health service.”<sup>9</sup> He took note to distinguish that he was not “at this time

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<sup>9</sup> Franking D. Roosevelt, “Message to Congress on Social Security, January 17, 1935,” in



recommending the adoption of so-called ‘health insurance,’ though groups representing the medical profession are cooperating with the Federal Government in the further study of the subject and definite progress is being made.”<sup>10</sup> While cautious, President Roosevelt’s announcement signaled that he supported increasing federal funds to the states in order to strengthen the infrastructure of healthcare. His insistence that the Committee on Economic Security was consulting with physicians suggests that the medical profession was perhaps not incontrovertibly against universal health insurance.

In 1934, Isidore Falk, a member of the Committee on Economic Security (CES) appointed by FDR, identified the populations affected<sup>11</sup> by his research. He also identified the need for large groups to avoid adverse selection and the inconsistency between public complaints about medical costs (that they are high) and the “real” problem of medical costs (that they are variable and uncertain).<sup>12</sup> Adverse selection, an infamous sort of market failure in insurance markets, was serious enough to hinder otherwise well-designed programs for health insurance – it was also serious enough to, in Falk’s view, call for the construction “state wide compulsory programs”<sup>13</sup> that could draw from sophisticated means of drawing revenue, such as a sliding scale for taxing different income groups and contributions from industry.

Falk and Edwin Witte, an economist who led the CES, viewed social risk pooling as an important mechanism that would provide the basis for a successful national welfare blueprint. Unlike unemployment insurance or old age insurance, however, health insurance was something

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Wilbur Cohen and Robert Ball, *The Report of the Committee on Economic Security of 1935 and Other Basic Documents Relating to the Development of the Social Security Act*, 50th Anniversary Edition (The National Conference on Social Welfare, 1985).

<sup>10</sup> Ibid.

<sup>11</sup> Isidore Falk, “Outline of a Talk before the Committee on Medical Economics (Stamford Medical Society)” February 27, 1934, Box 161, Folder 2339, Yale University Manuscripts and Archives, Isidore Falk Papers. These populations were the indigent, the semi- or “medical” indigent (those who were too poor to pay for healthcare, but did not qualify for insurance), and the lower wage and salary classes.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

that all members of society could consume throughout their lifetimes. Market failures like adverse selection could be alleviated by effective pooling of many people in an insurance scheme in order to drive down the average cost of each beneficiary. Instead of having a few costly beneficiaries (the ones who most need health insurance), under a pooling mechanism, risk could be diluted – regardless of the economic climate.

As New Dealers embarked on the process of creating a national social welfare structure, its unprecedented nature compelled them to consider constitutional questions. What indeed would be the constitutional underpinning for social insurance? During the meetings of the Committee on Economic Security (CES) and the congressional hearings on the bill, New Dealers, as “advocates of social security played on the murky distinction between insurance and welfare, were less concerned about the confusion they were arousing between private insurance and social insurance than they were about the constitutional tests that the Social Security Act faced.”<sup>14</sup> New Dealers capitalized on the federal government’s right to use its taxing and spending powers to underwrite a compulsory national “insurance” program.”<sup>15</sup> But the U.S. Supreme Court had begun in 1935 to strike down key pieces of New Deal legislation. Thus, even as they got the program underway, the fate of social security remained legally uncertain for the next two years.

### *The Supreme Court Speaks*

After 1937, the Supreme Court transformed from an entity that blocked some key New Deal policies to one that backed liberalism for decades. According to political scientist Andrew Koppelman, the Court had originally resisted Roosevelt’s unprecedented push towards national

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<sup>14</sup> W. Andrew Achenbaum, *Social Security: Visions and Revisions* (Cambridge University Press, 1986), 28.

<sup>15</sup> *Ibid.*

legislation in the time of crisis. However, it eventually “capitulated”<sup>16</sup> and after Roosevelt appointed a majority of the justices, the Court did not attempt to place limits on congressional and executive power for the next half-century. Federalism persisted, but the Supreme Court was in a position to back liberalism for decades. Two Supreme Court cases eventually dealt with the constitutionality of the Social Security Act, working with the clause of the Constitution that granted Congress the power “to spend money in aid of the ‘general welfare.’”<sup>17</sup> This general welfare clause, which appears in Article I, Section 8 of the Constitution, gives Congress the power to “lay and collect Taxes, Duties, Imposts, and Excises, to pay the Debts and provide for the common defense and general Welfare of the United States.” In 1937, *Steward Machine Co. v. Davis* upheld Title IX of the act, which imposed an excise tax upon employers of at least eight people.<sup>18</sup> In *Helvering v. Davis* (1937), a shareholder of the Edison Electric Illuminating Company brought the case to court to restrain his company from making payments he viewed as unconstitutional. The Supreme Court “was asked to determine (1) whether the tax imposed upon employers by section 804 of the Social Security Act is within the power of Congress under the Constitution, and (2) whether the validity of the tax imposed upon employees by Section 801 of the SSA is properly in issue in this case, and if it is, whether that tax is within the power of

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<sup>16</sup> Andrew Koppelman, *The Tough Luck Constitution and the Assault on Health Care Reform*, 3. This capitulation came after FDR’s 1937 Judicial Procedures Reform Bill, a failed venture to “pack the court” with justices that would find his New Deal proposals constitutional. Since the Constitution does not define how many justices should be on the Supreme Court, Roosevelt pointed out that Congress could change it as it saw fit. This was at a time when legal scholarship was engaging in the debate over the Constitution as a “living document” (Supreme Court justice Oliver Wendell Holmes, Jr., first referred to the ‘Living Constitution’ in *State of Missouri v. Holland, United States Game Warden* (1920), saying “case before us must be considered in the light of our whole experience and not merely in that of what was said a hundred years ago” (See *State of Missouri v. Holland*, 252 U.S. 416.)

<sup>17</sup> Wilbur Cohen and Robert Ball, *The Report of the Committee on Economic Security of 1935 and Other Basic Documents Relating to the Development of the Social Security Act*, 128.

<sup>18</sup> *Steward Machine Company, Petitioner v. Harwell G. Davis, Individually and as Collector of Internal Revenue*, 301 U.S. 548 (1937).

Congress under the Constitution.”<sup>19</sup> The Court ruled that Social Security was an appropriate measure by Congress to provide for the general welfare that did not violate the Tenth Amendment, noting that “Congress did not improvise a judgment when it found that the award of old age benefits would be conducive to the general welfare;”<sup>20</sup> rather, the CES had already done the research to arrive at this conclusion. The Supreme Court looked to federal research and the lessons of the Depression to validate the need for social insurance.

Falk wrote to Edwin Witte, the executive director of the Committee on Economic Security under FDR, that the president was directly reviewing a draft of its recommendations and the final report would depend on his reactions to the details of the program. The architects of the program realized that like legislation developed along state lines, “compensation funds cannot remain solvent in such a severe depression...without governmental aid”<sup>21</sup> Using ‘governmental aid’ in lieu of ‘governmental *intervention*’ illustrated a psychological hesitation to be interpreted as proponents of the latter, even as federal researchers in a time of intense national need.

Again, this nuance suggests that the legal basis for social insurance was at least partly informed by the need for it in a time of economic distress. FDR called “the security of social insurance... a minimum of the promise that we can offer to the American people. They constitute a right which belongs to every individual and every family willing to work...[and] are the essential fulfillment of measures already taken toward relief, recovery and reconstruction.”<sup>22</sup> The *right* to recovery from devastating (national) financial loss was a universal one, and the intensity of feeling with which this sentiment resonated with the American people as they moved from the

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<sup>19</sup> Wilbur Cohen and Robert Ball, *The Report of the Committee on Economic Security of 1935 and Other Basic Documents Relating to the Development of the Social Security Act*, 128. Guy T. Helvering, Commissioner of Internal Revenue v. Davis, 301 U.S. 619 (1937).

<sup>20</sup> Wilbur Cohen and Robert Ball, *The Report of the Committee on Economic Security of 1935 and Other Basic Documents Relating to the Development of the Social Security Act*.

<sup>21</sup> Isidore Falk, “Re: Committee Report,” January 4, 1935, 42 Folder 331, Isidore Falk Papers.

<sup>22</sup> Statements by President Roosevelt, 139, Wilbur Cohen and Robert Ball, *The Report of the Committee on Economic Security of 1935 and Other Basic Documents Relating to the Development of the Social Security Act*.

Depression Era into World War II is difficult to overstate.<sup>23</sup> The right to recovery encompassed the right to insurance from risk, as “the essence of insurance is the *distribution* of risk.”<sup>24</sup> In his public writing, correspondence, and speeches, Isidore Falk stressed the need for “public action”<sup>25</sup> in order to achieve this wide distribution of risk, even in times of economic recovery – or at any point during the macroeconomic concept of a business cycle. In 1943, he identified the importance of harnessing the wartime boost in economic productivity in order to solidify social security. He named full employment and social insurance as the pillars of security in a post-war society regardless of its economic state, saying, “the essence of social insurance is *wide* distribution of risk through public action, so that those who are or may at any time find themselves on the lowest rungs of the economic ladder, those who need protection most, can be assured at least basic security.”<sup>26</sup> Falk was not necessarily appealing to a charitable American nature, but looking ahead to sustaining security as the economy transitioned from a wartime one to a peacetime one.

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<sup>23</sup> Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (Basic Books, 1983), 278. Public opinion in 1936, 1937, 1938 and 1942 overwhelmingly agreed that government ought to help people pay for the medical care that they need. Starting in 1943, according to Starr, polls also asked “whether people thought it was ‘a good idea’ if Social Security also paid for doctors’ and hospital care that Americans might need in the future.” The answer, again, was yes: 58% in 1943, then 68% in 1944 and 1945 felt that Social Security could be a suitable and reasonable source of funding for health care. However, compared to these numbers, support fell when the idea to raise Social Security taxes in order to pay for health insurance was put forth.

<sup>24</sup> Isidore Falk, “Social Insurance and the Abolition of Want (League for Industrial Democracy, New York),” May 8, 1943, Isadore Falk Papers, MS 1039, Box 161 Folder 2367, Yale University Manuscripts and Archives, New Haven, CT. (Hereafter Falk Papers).

<sup>25</sup> *Ibid.*

<sup>26</sup> *Ibid.* Falk named two challenges for the postwar era: “The first challenge to all who look ahead to the post-war period is to devise means of perpetuating wartime levels of national income and of ensuring that full employment of manpower and resources which is prerequisite to a large national income. The second challenge is to assure the adequacy of social insurance to abolish or, at least, to minimize want. Together, full employment and social insurance are the guarantees of social security.”

A wide distribution of risk would result in replacing the financial risk of sickness for an individual with a lowered average cost of risk for members of a larger group.<sup>28</sup> This reliance on the statistical law of large numbers (here, the reduction of the average cost with a larger pool of individuals who band together) would help alleviate the otherwise devastating effects of two main costs to a person who falls ill or sustains an injury: “loss of earnings of wage earners on account of disabling sickness, and the costs of medical care.”<sup>29</sup> Put another way, Falk argued, “volume and variety of care is predictable for the group, but not for the individual. The principle problem[s] [are] uncertain, variable and budgetable costs and uncertain support for practitioners and institutions.”<sup>30</sup> This is especially important considering the fact that, along with medical technology in the postwar era, costs for care also rose.

### *Postwar Aspirations*

As an advocate and architect of social insurance, Falk may have considered the economic expansion during World War II a boon and an unprecedented opportunity. Departing from the economic crisis argument, he suggested instead that the economic boom of the war now offered the ideal time to proceed with a permanent system of economic security through expanded social insurance. In late 1943, Falk contended that “a period of full employment like the present is the most favorable time for initiating a contributory social insurance program [because] the initial impact of the contributions can be more easily borne by works and employers than at any other

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<sup>28</sup> Isidore Falk, “Economic Security Against Sickness (Address given before the Social Problems Forum, Johns Hopkins University),” May 15, 1936, Box 161 Folder 2344, Yale University Manuscripts and Archives, Isidore Falk Papers.

<sup>29</sup> *Ibid.*

<sup>30</sup> Isidore Falk, “Costs of Medical Care” May 7, 1934, Box 161 Folder 2341, Yale University Manuscripts and Archives Isidore Falk Papers.

time.”<sup>31</sup> Whereas a decade before the uncertainty of depression emboldened proponents of the right to security, by 1943 increased employment and employer contributions to tax revenue made a contributory program seem plausible.

Policymakers and researchers considered various types of public insurance: old-age insurance, sickness insurance, and health insurance besides the private market. In 1936, Falk had noted that though the 1935 adoption of the Social Security Act gave the United States a federal System of old-age insurance, and a federal-state system of unemployment compensation, “we do not have any large-scale compulsory health or sickness insurance...or any public medical provisions of equivalent magnitude except in the services for the care of the legally and medically indigent.”<sup>32</sup> There was little progress made in health insurance, compulsory or otherwise, in the immediate years following this statement. Edwin Witte admonished the lack of progress made to establish national health insurance by 1948: “health insurance is the oldest form of social insurance... it has been discussed for 30 years, but so far not a single state has enacted a compulsory health insurance law.”<sup>33</sup> The debate surrounding why comprehensive health insurance reform had not taken place was as complicated as the factors that went into making such policies.

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<sup>31</sup> Isidore Falk, “Proposed Extension of the Social Security Program, with Special Reference to Health and Medical Aspects (Massachusetts Conference of Social Work, Boston),” December 2, 1943, Box 161 Folder 2369, Yale University Manuscripts and Archives, Isidore Falk Papers.

<sup>32</sup> Isidore Falk, “Economic Security Against Sickness (Address given before the Social Problems Forum, Johns Hopkins University).” Falk identifies the medically indigent as those who are too poor to pay for healthcare, but did not qualify for insurance. The real problem about medical costs, according to Falk, was not that they were high. Rather, the fact that they were variable and uncertain was what made large-scale programs difficult to design and implement. The only way to avoid market failures like adverse selection (where sicker people tend to opt for insurance, driving up premiums and driving out the marginal member of the pool) was to construct state wide compulsory programs that could draw from sophisticated means of revenue, such as a sliding scale for taxing different income groups and contributions from industry.

<sup>33</sup> Edwin Witte, *Social Security Perspectives*, 1948.

Although architects of Social Security like Witte envisioned it to be a “only the beginning... [of an] extension to other fields [such as] health insurance,”<sup>34</sup> charges that a compulsory health insurance program would lead, in incremental steps, towards “socialized medicine” did surround their work. It is worth examining this term, and its implications, with some detail, even before Cold War-era paranoia exacerbated the debate surrounding it. Isidore Falk made clear that the phrase “socialized medicine,” a rallying cry in later years for pro-American Medical Association groups in their crusade against compulsory health insurance, did not carry as much weight in the late 1930s. Its many different “implications”<sup>35</sup> led to inaccurate accusations against proponents of a state-wide or nation-wide compulsory program, which Falk emphasized was key for success for addressing one of the essential needs of the time.<sup>36</sup> As early as 1934, doctors had indignantly opposed the idea of government dictating their practice, prompting a defense from Falk: “Regarding my attitude on health insurance, I never concerned myself much with this subject until the barrage of letters and telegrams from state and county medical societies reached Washington...in which our committee was unfairly charged with trying to force a health insurance measure upon the country without consulting the [medical] profession.”<sup>37</sup> In fact, Falk explains, the *rejection* of his expertise by the medical community *induced* his advocacy of a greater representation of federal research and involvement in healthcare: “If since then, I personally and our committee, has given more attention to this subject it has been largely

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<sup>34</sup> Ibid.

<sup>35</sup> Isidore Falk, “‘The Pro and Con of Socialized Medicine as It Would Affect the Negro People and the Negro Professional Group,’ National Medical Association Annual Meeting, New York: Text of Introductory Remarks,” August 17, 1939, Box 161 Folder 2355, Yale University Manuscripts and Archives, Isidore Sydney Falk Papers. Falk wrote about a concern regarding African American health, saying “there has been much concern as to whether there are adequate safeguards...to protect Negroes against disadvantageous discriminatory treatment in the *actual operation of State and local health plans.*” The concern was threefold in terms of delivery and access: a patient’s access to service, a [black] physician’s right to practice, and the reimbursement of physicians.

<sup>36</sup> Isidore Falk, “Opportunities for Voluntary Insurance (Speech at the Suburban Club)” March 26, 1934, Box 161 Folder 2340, Yale University Manuscripts and Archives Isidore Falk Papers.

<sup>37</sup> Isidore Falk, “Letter to Dr. Olin West,” December 21, 1934, Box 42 Folder 231, Yale University Manuscripts and Archives Isidore Falk Papers.



because we have been *forced* to do so by the misrepresentation of our attitude.”<sup>38</sup> His opposition only had its own zeal and mischaracterization of him to thank for his progress.

What Falk called a chronic “misrepresentation in the United States about insurance against medical costs”<sup>39</sup> in 1934 cast future attempts to develop national health insurance policy as gross overreaches of government. The relationship between doctors and policymakers, and between the states and the federal government, struggled to find an equilibrium that could find support from all parties. Falk insisted that the design of such programs were not only for “the welfare of the public and of the individual person...[but also] for the proper support of the professions and our medical institutions,”<sup>40</sup> echoing the sentiment of FDR and his encouragement of the rising prestige of medicine. In one of several defenses of proposed programs of compulsory health insurance at the *state* level, Falk wrote, “This is not a program of state medicine or public medicine or socialization of medicine. Nor is it anything else a clever person might call it to confuse this issue. Our proposal is merely for a system which would make it possible for people to *budget* the costs of medical care and receive the services which they need.”<sup>41</sup> He then repeated the principle of reducing average risk of loss through aggregating individual risk, and emphasized the unpredictability of healthcare expenses to do so. He pointed out, for example, that individual expenses can differ greatly from the average: “[On average] we spend about \$30 a person [a year] for health and medical care; but as individuals or families we spend from nothing to as much as we earn in a year or more.”<sup>42</sup> The economic difference between individual costs and average costs are a critical factor, but average costs cannot be

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<sup>38</sup> Isidore Falk, “Letter to Dr. Olin West,” December 21, 1934, Box 42 Folder 231, Yale University Manuscripts and Archives Isidore Falk Papers.

<sup>39</sup> Isidore Falk, “Costs of Medical Care.”

<sup>40</sup> Isidore Falk, “Opportunities for Voluntary Insurance (Speech at the Suburban Club).”

<sup>41</sup> *Ibid.* Emphasis added.

<sup>42</sup> *Ibid.*

achieved as an expected expense organically: “If each of us had to spend only the average costs for our income class, we should not be worried by medical costs and we should be able to have all the medical care which we really need,”<sup>43</sup> or even afford more medical service. Simple economics could realize what seemed infeasible.

The *only* way to combat high expenditures was to construct a public insurance system, Falk wrote; other benefits of an insurance system include better quality of care and the opportunity to plan and budget for expenses based on a budgetary constraint with less uncertainty. Falk argued that beneficiaries of a health insurance program could actively invest in their health with the help of the insurer, *without setting up a profit guarantee for the provider*. In fact, the system seems to be one of minimal profit for the insurance provider, as “a nonprofit scheme whereby people could budget their costs and pay them into a non-profit, non-commercial fund, [and] from this general fund the hospital, the doctor, the nurse or other agency could be remunerated for the services which they may furnish to the insured persons.”<sup>44</sup> Since Falk believed the government could be more capable of playing this nonprofit role than multiple private insurers, he envisioned the federal government as the provider. Furthermore, a nonprofit entity would be more palatable to the public than a for-profit one.

Characterizing health insurance as a fund for predictable reimbursements based on usage would have also appealed to labor groups and organizations. Looking beyond the end of the war, Witte confirmed the relative popularity of health insurance among certain groups in 1943 in *Postwar Economic Problems*, and in doing so, pointed out the link between a foundation of private insurance and the potential for public insurance to build on top of private insurance’s

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<sup>43</sup> Ibid. Falk wrote that “if we are to pay the average costs, we must have an insurance system. We could afford to spend even more than we now spend and feel the expenditure less. In addition we could afford to get more and better service.”

<sup>44</sup> Isidore Falk, “Opportunities for Voluntary Insurance (Speech at the Suburban Club).”

ubiquity, all in spite of organized medicine's opposition. He wrote that despite progress in voluntary medical and hospital insurance, compulsory health insurance "seems remote"- and yet, in actuality, "actual socialized medicine" was gaining traction:

While organized labor, farmers' organizations, and women's clubs [endorse] [compulsory health insurance]... organized medicine fights it relentlessly as 'socialized medicine.' In the meantime, actual socialized medicine – medical care at public expense – has increased at a rapid pace... During the Depression and still more in wartime, the public part of this mixed system [of public and private care] has become increasingly important. It is probable that this trend will continue.<sup>45</sup>

This hybridized system of medical care should be neither threatening nor unfamiliar, he argued. Expanding an existing public role should not be cause for controversy. Witte simultaneously defined the nebulous phrase "socialized medicine" as an ideological and political charge, while also seeking to distinguish it from services *already provided* by the government. Importantly, he also notes that compulsory health insurance is *not* the same thing as socialized medicine, despite organized medicine's protest: the former "seems remote" and far away in the future, while the latter "*has* increased at a rapid pace" – that is, it already exists. Even though "[social security] [was] a new term that still lacks precise definition..., used only in the United States and in this country... unheard of before 1935,"<sup>46</sup> New Deal health reformers wanted to innovate "mechanisms that would help pay for individually dispensed medical care."<sup>47</sup> The international surge towards similar programs proved that the intersection of private and public was, in fact, more necessary than ever.

Yet the American approach to social insurance differed from that of most other countries, even in realms that only overlapped with health insurance. Regarding the need for social insurance to provide income to replace lost wages in cases of "(one) illness and (two) permanent

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<sup>45</sup> Witte, *Social Security Perspectives*. (27).

<sup>46</sup> Witte, *Social Security Perspectives*, 3.

<sup>47</sup> Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton: Princeton University Press, 2003), 117.

disability,” Witte wrote that in most countries the former is provided through compulsory health insurance, the latter in connection with old-age insurance. In this country, however, “because compulsory health insurance has met with such violent opposition from the doctors, the Social Security Board has proposed that compensation for both temporary and permanent disability be administered along with old-age and survivors’ insurance.”<sup>48</sup> Though it was “hoped that such a program would be acceptable to the doctors,”<sup>49</sup> in a bitterly disappointing turn for Witte, “organized medicine...seems fearful that anything of this sort will serve as an *entering wedge* for compulsory health insurance.<sup>50</sup> His writing does not denote surprise, but nonetheless exposes a disappointment with the medical profession for refusing to experiment with anything that might become an increment towards compulsory health insurance.

By linking compensation for illness (temporary disability) and permanent disability to old-age and survivors’ insurance, which had already passed a constitutional test, the Social Security Board was constructing a compromise in which Social Security takes on a significant portion of what health insurance would normally cover separately. Perhaps some of the opposition from the medical profession stemmed from the fact that the Social Security Board was still an arm of the federal government, and both the medical profession and the insurance industry were regulated, minimally, at the state level. With AMA refusal to accept a more conservative version of an insurance infrastructure many other countries had already adopted, Witte desperately tried to convince policymakers that social security “consistent with an economy of free enterprise differs from social security in a planned economy.”<sup>51</sup> Social security, he contended, “appropriate to our old Federal system of governance in which there were sharp lines of distinction between

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<sup>48</sup> Witte, *Social Security Perspectives*, 27.

<sup>49</sup> *Ibid.*

<sup>50</sup> *Ibid.*

<sup>51</sup> *Ibid.*, 29.

the...national and state governments is different from that which suits a...unitary government,”<sup>52</sup> towards which Witte saw the United States moving. The medical profession, federal boards and its members, and the economy would dictate the genesis of a distinctly American welfare state with respect to health insurance, rooted not in the Bill of Rights but in the inter-state commerce clause and the Congressional power to tax and spend.

The idea of the “welfare state” came about in the postwar era, during which Witte strongly pushed back against the usage of what he called “alarmist” terms to describe the welfare state. He believed these alarmists’ objective was to “oppose pending legislative measures”<sup>53</sup> that would improve the health security of Americans. In 1948, he made clear: “I believe in the ‘welfare state,’ but only in the meaning in which ‘welfare’ is used in the Constitution of the United States and in which our American government has always been a welfare state.”<sup>54</sup> Thus, even after World War II, the “general welfare clause” continued to be invoked by liberals, and became ever more important after the death of FDR and the 1946 Republican resumption of control of Congress for the first time since 1932.<sup>55</sup> Yet, with the intensifying Cold War and coalescence of Federal Loyalty investigations, political conservatives and Republicans questioned his commitment to *Americanism* itself; in response, he made clear that he “look[s] upon the Constitution as the finest political instrument ever conceived by man,”<sup>56</sup> emphasizing its “remarkable adaptability...to changing conditions.”<sup>57</sup> Witte and his colleagues believed that the Constitution mandated, and granted, the responsibility to pursue the fulfillment of the four

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<sup>52</sup> Ibid.

<sup>53</sup> Ibid., 39.

<sup>54</sup> Ibid.

<sup>55</sup> Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (Basic Books, 1983), 284. According to Starr, the Republican Congress in 1946 had no interest in enacting national health insurance. The new chairman of the Committee on Labor and Public Welfare, Senator Robert A. Taft (R-Ohio) had “his own plan for the nation’s health: a system of welfare medicine for the poor financed by federal aid and administered by the participating states.”

<sup>56</sup> Witte, *Social Security Perspectives.*, 40.

<sup>57</sup> Ibid.

freedoms FDR had outlined in his 1941 State of the Union Address.<sup>58</sup> Since the Constitution was the blueprint for American freedom and law, it was important to Witte that he be viewed as a *contributor* to expanding the benefits the document had to offer, if not to constitutional theory itself. Liberal ideas of the adaptability of the Constitution and the reach of the federal government in compensating health and medical care were ideals that moved Falk and Witte to pursue programs that would only partly come to fruition in the following decades.

### **“Socialized Medicine” in the 1940s**

The phrase “socialized medicine” has had an illustrious career in American political discourse. In the Progressive Era, members of the American Medical Association (AMA) were sympathetic to public health reforms and “believed compulsory health insurance would inevitably come to the United States, as it had to Europe.”<sup>59</sup> It is important to note that in the first decades of the twentieth century, the AMA’s *Journal* and Committee on Social Insurance agreed that physicians’ “opposition [or] repudiation...of [compulsory health insurance] is less than useless;”<sup>60</sup> indeed, their editorial solidly backed national health insurance, saying “no other social movement in modern economic development is so pregnant with benefit to the public.”<sup>61</sup> Such opinions, however, quickly soured.

The usage of “socialized medicine” in debate in both houses of Congress in the mid-to-late 1940s impacted the national conversation that would affect its connotation and legislative future. Just after the end of World War II, the House of Representatives convened hearings to

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<sup>58</sup> The Four Freedoms were Freedom of Speech, Freedom of Worship, Freedom from Want, and Freedom from Fear. In Witte’s view, health security fell under the ‘freedom from want’ category.

<sup>59</sup> *Steward Machine Company, Petitioner v. Harwell G. Davis, Individually and as Collector of Internal Revenue*, 301 U.S. 548 (United States Supreme Court May 24, 1937).

<sup>60</sup> As quoted in Oberlander, *The Political Life of Medicare*, 19.

<sup>61</sup> *Ibid.*

consider proposals and professional opinions on national health insurance in November of 1945. Representative Homer A. Ramey (R-Ohio) spoke about the health care system in New Zealand and Russia; he had “had the pleasure of visiting socialized medicine hospitals in Russia and the observations of the activities there constrains [him] to emphatically say [he] hopes it never happens here”<sup>63</sup> in the United States. Statements such as these linked socialized medicine to the Soviet Union on the eve of the Cold War, without explicitly criticizing the country or its healthcare system. Indeed, Ramey takes care to note otherwise.

Representative Ramey went on to cite New Zealand’s allegedly less-than-ideal experience with socialized medicine as a reason for the American resistance to implementing its own “nationwide government medical system.”<sup>65</sup> He quoted a doctor on this subject:

No person of intelligence will oppose constructive social legislation, and least of all the medical profession whose chief concern is human welfare. It is extremely difficult, however, to determine where constructive measures end and destructive paternalism begins, especially when administered by an impersonal and an entrenched bureaucracy. Our problem is the provision of medical care of high quality to the Nation *without sacrifice of liberty*. Sacrifice of small liberties leads to sacrifice of greater liberties and eventual loss of all. It is not likely that the working people and the employers of this Nation are ready to commit to a compulsory taxation to support a medical care plan administered by a Federal bureaucracy.<sup>66</sup>

This statement is as notable for what it leaves out as it is for what it includes. The physician quoted above emphasized the American medical profession as open to social legislation it deems constructive, without describing or defining the parameters of such legislation. He represents social security and the welfare state not as citizenship entitlements but as destructive

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<sup>63</sup> Extension of Remarks of Rep. Homer M. Ramey, November 19, 1945. U.S. House of Representatives, “Appendix to the Congressional Record, 79th Congress, Session 1. November 19, 1945.” (1945), Congressional Proquest. Representative Ramey also echoed a common physician refrain when he expressed a significant horror at the Soviet system’s tendency to treat human bodies “just as though they were another machine.” A hallmark of American medicine was apparently personalized attention and privatized medicine was the only way to maintain this unique American feature.

<sup>65</sup> Extension of Remarks of Rep. Homer M. Ramey, November 19, 1945. U.S. House of Representatives, “Appendix to the Congressional Record, 79th Congress, Session 1. November 19, 1945.” (1945), Congressional Proquest.

<sup>66</sup> Congressional Proquest, Appendix to the Congressional Record, 79th Congress, Session 1. November 19, 1945.

“paternalism” that will lead inevitably down a “slippery slope” to state authoritarian control; indeed, this language echoes that of prominent conservatives such as Friedrich Hayek and Ludwig von Mises. He considers physicians the safeguards of liberty – a dear American tradition – without specifying which liberties. While emphasizing quality of care as a priority for physicians, he did not mention access to care as another priority. He also appeared to be convinced that American physicians embodied the opposite of impersonal care and paternalism.

The phobia of a federal bureaucracy is a complete reversal from the AMA’s position a few decades prior. (Jonathan Oberlander points to 1920 as the approximate time at which its political position shifted. In 1920, conservative members of the AMA voiced opposition to the idea of national leadership, along with concerns that “compulsory health insurance would threaten the growing incomes and social status American physicians were achieving”<sup>67</sup> in the age of growing scientific prestige.) Interestingly, the concern this unnamed doctor voices about the loss of liberties does not specify *whose* liberties are at stake – they could very well be those of the physician, and his liberty to receive compensation for his care at a level that he finds acceptable.

### *Truman, Dewey, and an American Referendum*

The scope of the debate extended beyond the medical profession, much to the delight of its members. If the 1936 presidential election had brought the constitutionality of FDR’s initiatives to the forefront, lawmakers in 1948 treated national health insurance as an election topic, a potential referendum from the American people. On August 3, 1948, Senator James P. Kem (R-Missouri) spoke about the candidates that election year, incumbent President Truman

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<sup>67</sup> Oberlander, *The Political Life of Medicare*. 19.



and his challenger, Republican Thomas Dewey, and their stances on the question of socialized medicine:

Mr. Truman believes as an ‘ultimate aim’ there must be a compulsory comprehensive insurance system to apply to all our people. Governor Dewey believes that ‘compulsory socialized medicine is no good’... I believe that the position of the Republican candidate, Governor Dewey, is sound, and backed up by theory and experience. I believe the ideas of the Democratic candidate, President Truman, are a distinct threat to the medical and allied professions as we now know them and to the American way of life.<sup>68</sup>

Kem did not elaborate the ‘theory and experience’ that backed Governor Dewey’s ideas.

Instead, he cites the model of “two ways of life competing for supremacy in the world today”<sup>69</sup> – one is that of the Russians, “based on the Marxian principles of the abolition of private enterprise as the means of production,”<sup>70</sup> while the other is the American system, which is “based on the principles of free enterprise and personal initiative.”<sup>71</sup> The American aversion to a Marxist influence in health, an intimate facet of Americans’ lives, is evident here, as is the attempt to categorize two large nations’ health systems into binary terms.

Senator Kem insisted that American institutions and professional organization of medical care are “sound,”<sup>72</sup> and that any shortcomings can “be corrected within the framework of our time-tried, time-tested system of nonpolitical medicine.”<sup>73</sup> His characterization of American medicine as nonpolitical is curious after a world war that amplified the scale of public health efforts, including a vast public maternity care system for wives of servicemen and an expanded

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<sup>68</sup>Statement by U.S. Senator James P. Kem, August 3<sup>rd</sup>, 1948, U.S. Senate, “Congressional Record - Senate, 80th Congress, Session 2. August 3rd, 1948” (1948). As Governor of New York from 1943-1954, Thomas Dewey had appointed Thomas Thacher (from the Introduction of this paper) to the New York State Court of Appeals in 1943. Both of Governor Dewey’s presidential bids in the 1940s came very close to succeeding. Dewey had already run against FDR as the Republican nominee for the presidency in 1944, but he lost to FDR in the closest of the latter’s reelection campaigns. The 1948 presidential election would turn out to be one of the greatest upsets in U.S. history, since predictions nearly universally agreed he would defeat Truman. Famously, the *Chicago Daily Tribune* ran thousands of copies of papers with the headline “DEWEY DEFEATS TRUMAN” before the final tallies came in.

<sup>69</sup> Statement by U.S. Senator James P. Kem, August 3<sup>rd</sup>, 1948, U.S. Senate, “Congressional Record - Senate, 80th Congress, Session 2. August 3rd, 1948” (1948).

<sup>70</sup> Congressional Proquest, Congressional Record - Senate, 80th Congress, Session 2. August 3rd, 1948.

<sup>71</sup> Ibid.

<sup>72</sup> Ibid.

<sup>73</sup> Ibid.

veterans health care system. In addition, a year after the war, the passage of the Hospital Survey and Construction Act (the Hill-Burton Act) in 1946 with the arrival of the new Republican-led Congress<sup>74</sup> explicitly linked federal financial support to locally controlled hospitals, and the influence of the American Medical Association in politics grew tremendously.

During his single term in the Senate, Kem made opposition to Truman his top priority. He listed some of President Truman's public statements on universal health insurance as evidence of the threat that he posed, and implied that Truman was attempting to ease in his proposals as mainstream ideas. According to Kem, despite the fact that Truman in November 1945 had assured Congress that his compulsory health insurance plan was 'not socialized medicine,' by his February 1948 State of the Union Address he was telling a different story. In that address, Truman said 'Our ultimate aim must be a comprehensive insurance system to protect all our people equally against insecurity and ill health,' and that such a system must be compulsory in order to 'equally protect all our people.' Kem interpreted this specification as a clear indicator of "where Mr. Truman stands on socialized medicine," despite the fact that "apparently he found the term distasteful."<sup>75</sup> Senator Kem cast the president as disingenuous, suggesting Truman was attempting to sell the American people on something well outside the boundaries of acceptable American political culture.

Kem aimed to expose Truman and his allies as agents who professed to distance themselves from the nomenclature of socialized medicine while painting the system as essential for the success of American healthcare. Kem equated 'compulsory' with 'socialized' in order to

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<sup>74</sup> Oberlander, *The Political Life of Medicare*, 21. The new Republican Congress coincided not only with the start of Truman's presidency but also with what Oberlander calls the *third* campaign for national health insurance. Unlike the hesitant Roosevelt, Truman supported the Wagner-Murray-Dingell bill, becoming the first president to endorse national health insurance.

<sup>75</sup> Statement by U.S. Senator James P. Kem, August 3<sup>rd</sup>, 1948, U.S. Senate, "Congressional Record - Senate, 80th Congress, Session 2. August 3rd, 1948" (1948).

arrive at his conclusion that Truman was deliberately unclear and thus misleading about his intentions. Truman's preferred protection against "insecurity and ill health" invoked the language of the Social Security Era and the Great Depression, when protections against economic insecurity (the costs that come with illness) were the primary motivator in constructing the legislation. As Paul Starr notes, the "politics of health insurance revolve around four sorts of cost: 1) individual losses of income; 2) individual medical costs; 3) the indirect costs of illness to society; and 4) the social costs of medical care."<sup>76</sup> From the point of view of Truman, the derivative costs of health, direct and indirect, drove the debate about socialized medicine. For his opponents, this was not so; instead, they saw a dangerous rhetoric that sought to import failed ideas about health insurance from abroad into the United States. Truman was the first American president to formally endorse national health insurance,<sup>77</sup> and knew Republican obstruction in the year of a general election "could be a valuable issue"<sup>78</sup> with "favorable public opinion."<sup>79</sup>

### *The Hill-Burton Act After 1946*

A lot was at stake in a general election year, including American exceptionalism. Senator Kem cited a statement from party colleague, Republican Governor Dewey, who claimed that fledgling compulsory health insurance experiments in other nations had failed. In his view, such efforts had dragged countries down to the level of the Socialists, and that America risked losing its superior status if it attempted implementing the same system. However, it is unclear by what

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<sup>76</sup> Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (Basic Books, 1983), (236). Reformers at this time were becoming increasingly aware of the many societal costs of poor health, or inaccessible health care. Lost wages and future health expenses were only two of the concerns; employers

would also suffer from an unhealthy workforce. Difficulties for middle-class families who did not have health insurance were becoming more widespread as well.

<sup>77</sup> Oberlander, *The Political Life of Medicare*. 21.

<sup>78</sup> *Ibid.*, 22.

<sup>79</sup> *Ibid.*

parameters Dewey placed the American system above other nations' attempts to deliver healthcare:

Compulsory socialized medicine is no good. It cannot be done... I don't want to run the risk of happening to the health of our people what has happened to the health of every group of people which has tried to drag the medical profession down to the Socialists' level... You will enlarge the volume of medical care but you will utterly destroy the quality of medical care... This idea [that] you can improve medical care by passing a law must be stopped.<sup>80</sup>

The elision regarding the passage of the Hill-Burton Act, which precisely aimed to improve medical care by passing a law, is remarkable. Dewey was also concerned with the tradeoff between quantity and quality, implying that there was no way to improve quantity of care provided without sacrificing the quality of care at that time. The editor of the *Journal of the American Medical Association* would present a different concern a few months later. Using Great Britain's National Health Act as an example, Dr. Morris Fishbein wrote that national health insurance had resulted in a change in attitudes that threatened private insurance: "if a person can get free medical service, why should he pay for it? As a result... private medical practice has virtually disappeared since the Act went into effect."<sup>81</sup> Dr. Fishbein would agree with Governor Dewey about the 'downward path'<sup>82</sup> on which socialized medicine would lead a nation, but the threat to medical practice is more real for the physician than it is for the politician and presidential candidate.

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<sup>80</sup> Statement by U.S. Senator James P. Kem, August 3<sup>rd</sup>, 1948. Congressional Proquest, Congressional Record - Senate, 80th Congress, Session 2. August 3<sup>rd</sup>, 1948. Dewey made his record of having protected 'American medicine' quite clear: "Accordingly I have spent the last two years of my life knocking down every proposal that anybody has made to regiment the medical profession and the people of America through any program of socialized medicine."

<sup>81</sup> "Dr. Fishbein Assails Socialized Medicine," *The New York Times*, December 7, 1948.

<sup>82</sup> *Ibid.* Dr. Fishbein had delivered a similar doomsday message in 1945 (reported in the *Chicago Daily Tribune*, "Fishbein Blasts Truman Health Plan as 'Worst.'") He said that socialized or state medicine was the first step towards "regimentation" of resources, and that this regimentation had led to Germany's totalitarianism. He also attacked the *language* that Truman and his team had used to promote their proposals, calling it trite and unoriginal in the attempt to force the proposals on the American people. Perhaps the greatest offense committed by Truman and his team, however, was their neglecting to consult the AMA on their project.

Senator Kem also referred to the report of the Subcommittee on Health of the Senate's Committee on Labor and Public Welfare on the issue of compulsory health insurance. The April 1948 report, issued in conjunction with the nonpartisan Brookings Institute, had four conclusions: first, that "no great nation in the world has among its white population better health than now prevails in the United States;" second, that the United States, "under its voluntary system of medical care, has made greater progress in the application of medical and sanitary science than any other country;" third, that health disparities between whites and nonwhites were not "due to unavailability or inadequacy of medical care;" and fourth, that the advances in health among both the whites and nonwhites that have been made in the United States in the past four decades do not suggest basic defects in the American system.<sup>83</sup>

The Committee's conclusions centered on American exceptionalism in the outcomes that the American health system (and American research) offered. It also sought to shift responsibility for the poorer health of nonwhites from the system which treats (or refused to treat) nonwhites, including geographical inequities and structural racism, to these citizens themselves. Second, the report suggested a link between the 'voluntary' system of medical care and the progress that has been made under it; if not causal, then a facilitating environment that fostered scientific progress is definitely implied. The third point acknowledges a health discrepancy between races but does not hold the provision of medical care accountable. It is unclear if 'unavailability of medical care' refers to lack of access to it because of inability to pay or a lack of medical providers. Whereas Dewey conceded that there are improvements to be made in the 'American system,' this report concluded that any shortcomings in delivery or outcomes are not the responsibility of the American voluntary system. Despite its nonpartisan

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<sup>83</sup> Statement by U.S. Senator James P. Kem, August 3<sup>rd</sup>, 1948. Congressional Proquest, Congressional Record - Senate, 80th Congress, Session 2. August 3<sup>rd</sup>, 1948.

nature, this report fully supported Dewey's opinions about the superiority of the American institutions and political culture; any change to private medical care and individual payment must then be viewed with suspicion.

Senator Kem and Governor Dewey emphasized the concerns that many doctors expressed about a national health insurance system. They cited the general superiority of the American healthcare system and the necessity for it to remain unique among the healthcare systems of the world, looking to health outcomes in its white population for proof. They joined Dr. Fishbein in listing the failed or failing attempts other nation-states had experienced in implementing national health insurance (Senator Kem's example was New Zealand; Dr. Fishbein's, Great Britain) and, despite their insistence on American superiority, expressed fear that the United States would go 'down' the same path towards socialism. Each of the men predicted an adverse effect socialized medicine would have on the current system, from damaging the health of Americans to endangering American private insurance.

Yet their objections to a comprehensive socialized medical system did not include references to constitutional concerns about mechanisms that would bring in the forty-eight states under a federal infrastructure of healthcare. Republicans Senator Kem and Governor Dewey focused on the macro-level effects of national health insurance efforts, treating a nation as a unit. Earlier in this section, their points seemed to conflict with the idea of the Hill-Burton Act and its aim to improve the American healthcare system by increasing federal oversight. When it was drafted, its main architect, Senator Lister Hill of Alabama, stressed, "that the principle of states' rights and local initiative be preserved and encouraged is essential to the success of any health program."<sup>84</sup> Despite the provisions of the Act, Senator Hill made the role of the states the focal

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<sup>84</sup> Beatrix Hoffmann, *Healthcare for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2012), 74. From "Statement by U.S. Senator Lister Hill of Alabama before the

point of the legislation. He had a consistent record of citing states' rights in the Constitution as reason for action or inaction on the part of the federal government; in discussing poll taxes in 1948, he declared that the decision to outlaw poll taxes on a federal level would "be to rape the Constitution of the United States; and if the Congress should once commit this rape...no one could foretell... how many rapes there might be of the rights of the States as safeguarded by the Constitution."<sup>85</sup> This extreme, gendered language portrayed the Constitution as a vulnerable entity, even as it protected individual states from the excesses of government. Further, it suggested that Congress itself could be a danger to the Constitution, the very document that authorizes its existence and which Congress was sworn to protect.

Senator Hill voiced his support for causes like improving the health outcomes of African Americans, but only to the extent that his interpretation of the Constitution and of the 10<sup>th</sup> Amendment allowed the federal government to take measures to do so.<sup>86</sup> His commitment to the states (and especially to his own state of Alabama) shaped his construction of the Act.<sup>87</sup> Hill-Burton's priority was not the prestige of the medical profession, but its emphasis on the infrastructure of the healthcare system; bolstering the rights of the states to use federal dollars provided the basis for the arguments of Representative Ramey, Senator Kem, and Governor Dewey.

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Committee on Education and Labor of the Senate in Support of the Hospital Construction Bill, February 26, 1945," Folder 1.11, Series 17.11, Dean's Administrative Files, UAB Archives. Hill meant what he said quite literally. According to Hoffmann, Hill intentionally engineered the bill to disproportionately benefit rural areas, or his native South. Federal funds were allotted to meet what was required for a certain person-to-hospital-bed ratio, and rural states had more to gain.

<sup>85</sup> Statement by U.S. Senator Lister Hill, August 3<sup>rd</sup>, 1948. Congressional Proquest, Congressional Record - Senate, 80th Congress, Session 2. August 3<sup>rd</sup>, 1948.

<sup>86</sup> Hoffman, *Healthcare for Some: Rights and Rationing in the United States since 1930*, 74.

<sup>87</sup> Ibid.

### Isidore Falk and the Research of Socialized Medicine

Since the late 1930s, the Social Security Board/Administration drew together a new generation of social scientists and public health experts to generate research and data that would undergird development of social welfare policies and programs. Long part of the New Deal network, Isidore Falk became the Director of the Bureau of Research and Statistics at the Social Security Administration after World War II. A native of Brooklyn, New York, Falk worked at a laboratory in the Department of Public Health at the Yale School of Medicine in order to pay his way through college.<sup>88</sup> Eventually, he matriculated at Yale in 1917, and graduated in 1920 from the Sheffield Scientific School with a degree of bachelor of philosophy, *magna cum laude*.<sup>89</sup> Staying on at Yale for graduate studies, Falk's thesis was on the subject of bacteriology, with a focus on the chemical and physical properties of dying bacteria.<sup>90</sup>

After a stint as an instructor at the Yale School of Public Health, Falk left for the University of Chicago, where he taught courses in bacteriology, immunology, vital statistics, and public health. He left his tenure at the university at the end of fall 1929 to take an appointment with the Committee on the Costs of Medical Care,<sup>91</sup> which would go on to publish the landmark 1932 report ("Final Report," or "Medical Care for the American People," of the Committee on the Costs of Medical Care), the first comprehensive study of national health expenditures and

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<sup>88</sup> "National Health Program, Part 4 (HRG-1947-LPW-0025)," § Subcommittee on Health; Committee on Labor and Public Welfare. Senate (1947), [http://congressional.proquest.com/congressional/result/congressional/pqpdocumentview:pdfevent?pgId=a1a2c297-cc63-42c9-a7b6-cc90243d5e83&rsId=159F491A5FB&pdf=/app-bin/gis-hearing/e/7/7/2/hrg-1947-lpw-0025\\_from\\_1\\_to\\_497.pdf](http://congressional.proquest.com/congressional/result/congressional/pqpdocumentview:pdfevent?pgId=a1a2c297-cc63-42c9-a7b6-cc90243d5e83&rsId=159F491A5FB&pdf=/app-bin/gis-hearing/e/7/7/2/hrg-1947-lpw-0025_from_1_to_497.pdf).

<sup>89</sup> *Ibid.*, (1695). Falk notes that some people do address him as Doctor, though he does not encourage it, since he works in a field relevant to medicine and the term may cause some confusion as to whether he is a doctor of medicine.

<sup>90</sup> *Ibid.*, (1698). Here, Senator Donnell asks Falk if his thesis was not in some way related to influenza – perhaps because of the timing of Falk's graduate studies after the 1918 Spanish influenza pandemic.

<sup>91</sup> *Ibid.*, (1700).



their trends in the United States since the 1910 Flexner Report.<sup>92</sup> The points of the Committee's Report that Falk anticipated would generate the most opposition were "that medical care could be more effectively provided through groups rather than solo practices and that the costs of care could be best met through some sort of voluntary group prepayment arrangement"<sup>93</sup> that would dilute the risk for an individual on such a plan. Naturally, Dr. Morris Fishbein, the head of the American Medical Association, denounced the report. In 1936, Falk joined the Social Security Board as the Head Medical Economist for the Board.

On July 23, 1947, Isidore Falk – at the time, was asked to come to testify on the subject of medical insurance for the Senate subcommittee on Health, of the Committee on Labor and Public Welfare. This testimony is important for several reasons, not the least of which is that it is somewhat autobiographical. It gives context for the correspondence and writings of a figure whom the historian Jill Quadagno describes as a "quiet, competent, and politically liberal professor"<sup>94</sup> who had worked on the Committee on the Costs of Medical Care (CCMC) for five years. In her book *For All These Rights*, the historian Jennifer Klein notes that the CCMC "emphasized that the solution to the health problems and economic security problems of workers could be resolved through health insurance that would help families pay for individual medical services."<sup>95</sup> This committee conclusion was completely in keeping with Falk's own writings.

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<sup>92</sup> Thomas B. Gore, "A Forgotten Landmark Medical Study from 1932 by the Committee on the Costs of Medical Care," *Baylor University Medical Center Proceedings* 26, no. 2 (April 2013): 142–43.

<sup>93</sup> Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance*.

<sup>94</sup> *Ibid.*

<sup>95</sup> Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton: Princeton University Press, 2003), 121.

*Marjorie Shearon and a Blueprint for Discrediting Falk*

National health insurance opponents decided to dig into Falk's past and his transition from academic to government research in order to discredit his testimony. A pamphlet distributed during his testimony on July 23 titled "A Blueprint for the Nationalization of Medicine: Plans to Enchain Medicine by Unwarranted Regulative Interference"<sup>96</sup> sought to personally discredit Falk, Arthur Altmeyer, and other key members of the SSA, as well as the health insurance proposal itself. The author of the *Blueprint*, Marjorie Shearon, was a former employee of the Social Security Administration. Her discontent with the Board apparently stemmed to 1939, when "Falk had refused to publish her report on the constitutionality of the social security program."<sup>97</sup> After leaving the Social Security Board, Shearon became the research analyst for the Republican State Minority Conference and worked closely with conservative Senator Robert Taft. In her writing, Shearon cast Falk as a figure with potential to allow his ambitions to get in the way of research, or to invalidate such research. Presented in its entirety at the Senate hearing, this *Blueprint* maps out the impossibility for the proponents of socialized medicine to also uphold American ideals that fundamentally conflict with those required for a system of compulsory, nationalized medicine.

First, the *Blueprint* begins by establishing the Webster Dictionary's definitions of "socialism," "state socialism," and "state medicine" as the working definitions for the rest of the indictment against Falk and his coworkers. By "aiming to replace competition by cooperation"<sup>98</sup>

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<sup>96</sup> National Health Program, Part 4 (HRG-1947-LPW-0025). The *Blueprint* was authored by Marjorie Shearon, a legislative consultant and a consultant for the Senate Committee on Labor and Public Welfare.

<sup>97</sup> Jaap Kooijman, *...And the Pursuit of National Health: The Incremental Strategy Toward National Health Insurance in the United States of America*, Amsterdam Monographs in American Studies (Rodopi Bv Editions, 1999), 113. The resulting antagonism became both bitter and mutual. With regards to Shearon's attitude, Falk complained that "it was as though someone had throttled her infant at birth or in its cradle, and she apparently never forgave any of us for this series of events." He also called her a "professional fear and smear-monger who had no respect for truth or integrity."

<sup>98</sup> National Health Program, Part 4 (HRG-1947-LPW-0025), 1706.

and to “equalize incomes and opportunity”<sup>99</sup> via mechanisms like compulsory sickness insurance, proponents of socialized medicine ostensibly “favored a great extension of governmental action,”<sup>100</sup> especially in the cases of policy. The Webster definition of ‘state’ medicine that followed was succinct: “medical treatment provided or controlled by a government and subsidized by public funds,”<sup>101</sup> with public funds including income taxes, social security taxes, premiums, or contributions. Importantly, under this mechanism of public funds, doctors would become salaried employees of the government, as was the case in Great Britain at the time.

In the *Blueprint* Shearon directly juxtaposed the idea of the socialized state as theorized or executed in Hitler’s *Mein Kampf* and the Social Security Administration of the United States,<sup>102</sup> conflating fascism and socialism as the same authoritarianism, warning “people failed to take seriously the avowed intentions of Hitler” and that the danger for a similar scenario in the United States vis-à-vis the Social security Administration existed. According to Shearon, the “infiltration by Socializers into the Federal Government”<sup>103</sup> had occurred between 1935 and 1947 after years of acquiring research about medical economics and public finance. These Socializers (who apparently comprised a conspiratorial “House of Falk”<sup>104</sup>) were committed to reviving previous efforts to follow a propaganda plan in order to disseminate the ideas for

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<sup>99</sup> Ibid.

<sup>100</sup> Ibid. Shearon carefully chose her words according to the Webster definitions of state medicine and socialism.

<sup>101</sup> Ibid.

<sup>102</sup> Ibid., 1707. Falk definitely held that Shearon’s views were one of extreme paranoia. However, Jaap Kooijman points out that her views were indeed influential. She was the darling of conservative congressmen and members of the AMA. Her efforts continued until Falk’s resignation from the Social Security Board in 1954.

<sup>103</sup> Ibid. In 1940 (during this period of supposed infiltration), Falk had given a talk titled “What is Americanism?” at the Baltimore Open Forum. He wanted to highlight the connection between American ideals and collective security, and the right to be free from wants, as Roosevelt had said in previous years. This talk foreshadowed the attacks Falk would sustain from self-proclaimed protectors of American ideals like Shearon.

<sup>104</sup> Jaap Kooijman, ...*And the Pursuit of National Health: The Incremental Strategy Toward National Health Insurance in the United States of America*, 113. Shearon actually had a diagram outlining the “House,” which described the many “lines of control” originating from the “mid-level official.” See Derickman, “The House of Falk: The Paranoid Style in American Health Politics,” *American Journal of Public Health* November 1997: Vol. 87, No. 11, 1836-1843.

socialized medicine into the American mainstream. What Shearon neglected to mention here is the dual role of social protection that Paul Starr describes in *The Social Transformation of American Medicine*; Starr notes that social insurance in this iteration “departed from the earlier paternalism... by providing a right to benefits instead of charity.” The new demand for compulsory contributions was certainly “an extension of obligations,”<sup>105</sup> but it also “constituted an extension to social welfare of liberal principles of civil and political rights.”<sup>106</sup>

Isidore Falk’s opponents or critics (including Shearon) clearly were most concerned about the question of rights, but in a different capacity. They feared that Falk and his mentor, Michael Marks Davis, had actively consolidated the scattered pushes for social reform “and gradually [taken] over the program for socialization of medicine in the United States”<sup>107</sup> in the years between 1926 and 1934, and, after the auspicious coincidence of the Great Depression’s beginnings, the New Deal, and the rise of labor,<sup>108</sup> had begun a massive propaganda campaign ever since the passage of Social Security. Actually, Davis had been encouraged by the positive response of the American Medical Association back in 1915 to “hope that America might be able to ‘improve on’ Britain and Germany in the organization of services”<sup>109</sup> and delivery of medical insurance. His visit to the Mayo Clinic in Minnesota had inspired him with many ideas about medical organization that would make sure that if health insurance were “tied to a system of individualized private practice”<sup>110</sup> like many physicians preferred, “cooperative medical work in

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<sup>105</sup> Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*.

<sup>106</sup> Ibid.

<sup>107</sup> National Health Program, Part 4 (HRG-1947-LPW-0025).

<sup>108</sup> Ibid., 1710.

<sup>109</sup> Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*, 247.

<sup>110</sup> Ibid. Physicians apparently equated organization with “a bureaucratic hierarchy” that would “subordinate” them under officials and policies that were not medical experts.

diagnosis and treatment”<sup>111</sup> would come along as well. Ultimately, however, the attitude of the American Medical Association was heavily dependent on physicians’ preferences for indemnity payment under health insurance, and this obscured the benefits of reforming medical work dealing in diagnosis and treatment.

Equally uncertain between 1926 and 1935 was the stance of the American labor movement. Samuel Gompers, the president of the American Federation of Labor (AFL), had “repeatedly denounced compulsory health insurance as an unnecessary, paternalistic reform that would create a system of state supervision of the people’s health.”<sup>112</sup> Once the New Deal was in motion, the AFL did not have a uniform opinion regarding this matter, especially with the rising popularity and success of Social Security; in fact, by 1948 (a year after this particular session of Falk’s testimony in the Senate) the AFL and the Congress of Industrial Organizations (CIO) released a joint statement relating their “staunch support for a national social insurance program with provisions for medical care.”<sup>113</sup> The AFL and the CIO wanted a medical program that is “broad in scope, encourages preventative medicine, and assures high quality of care.”<sup>114</sup> According to Shearon’s accusations, Isidore Falk had spent much of his time “wooing” labor and giving talks with titles such as “Formulating an American Plan of Health Insurance”<sup>115</sup> for groups like the American Association for Labor Legislation (AALL) or the International Labor Organization (ILO), to extract support such as the above. Not surprisingly, Falk had attempted to

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<sup>111</sup> Ibid. Physicians strongly objected “to any form of contract practice as a result of their experience with fraternal lodges and industrial firms that forced them to bid against each other for group business.” What terrible experience physicians had with these ‘lodges’ is unclear, but this objection meant that they strongly preferred to be paid per visit instead of per capita, or the number of patients who signed up to be seen by them per year.

<sup>112</sup> Ibid., 249.

<sup>113</sup> Franz Goldmann, “Labor’s Attitude toward Health Insurance,” *ILR Review* 2, no. 1 (October 1948): 90–98, doi:10.2307/2519259. Apparently, both the AFL and the CIO had both officially expressed support for pertinent bills introduced in Congress in 1939, 1943, 1945, and 1947. Labor’s goal for a health insurance program was for it to be “broad in scope, encourag[e] preventive medicine, and assur[e] high quality of care.” Cost is conspicuously missing from labor’s list of concerns; as a lobbying force, perhaps cost was not their top priority – after all, legislation had to transform into law for cost to kick in.

<sup>114</sup> Ibid.

<sup>115</sup> National Health Program, Part 4 (HRG-1947-LPW-0025).

gauge potential responses to or support from different sectors just before Senator Robert Wagner and Representatives Robert Doughton and John Lewis of the House Ways and Means Committee introduced their 1935 economic security bill. But, strategically and ideologically linking at domestic political institution (AALL) with an international one (ILO), by Shearon, was meant to discredit the health insurance project as “non-American” or even “un-American.”<sup>116</sup>

### *The Wagner Bills*

A curious clause and editing process made the “Wagner-Doughton” Bill significant, according to Falk’s skeptics. The original bill introduced by Wagner, Doughton and Lewis had apparently included a clause that listed the research of health insurance as one of the duties of the Social Security Board in section 402. (This clause made sense, since the Committee on Economic Security’s reports such as “Risks to Economic Security Arising from Ill Health” were providing the basis for compulsory health insurance proposals given to Roosevelt<sup>117</sup>). In other words, President Roosevelt had expressly stated he would not pursue health insurance architecture in the 1935 bill, but its authors inserted a requirement for the Social Security Board to study it. After an amendment or two, this clause was removed (the newer version of the bill, introduced on April 4, 1935, did not have this clause),<sup>118</sup> and eventually this bill became the Social Security Act in August 1935. Retrospectively, then, individuals like Shearon could claim that Congress had specifically weighed the debate of whether or not the Social Security Board (later, the Social Security Administration) “was to have a mandate to study health insurance, and decided in the negative.”<sup>119</sup> This was certainly a setback for Falk. He would start preparing for

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<sup>116</sup> Ibid., 1714.

<sup>117</sup> Ibid.

<sup>118</sup> National Health Program, Part 4 (HRG-1947-LPW-0025), 1715.

<sup>119</sup> National Health Program, Part 4 (HRG-1947-LPW-0025).

the next wave of a peaking in interest for government-provided or government-subsidized sickness insurance, which, after the early years of the Roosevelt administration, would come again in the early 1940s.<sup>120</sup>

By 1943, after some more planning and campaigning on Falk's part, the "stage was set for the long-planned, all-out attempt to force through Congress a comprehensive social insurance law. 'Now or never!' Was the slogan."<sup>121</sup> That year, the Wagner-Murray-Dingell Bill was introduced in Congress.<sup>122</sup> Critics made various allegations about the true nature of this bill and others like it. They alleged that power struggles engulfed the rollout of the bill: "When the [first] Wagner-Murray Bill was introduced on June 3, 1943, a great hue and cry was raised about the alleged power that would be given to the Surgeon General... However, Falk who drafted the compulsory sickness insurance provisions without consulting the Surgeon General, presumably had no intention of granting any power to him."<sup>123</sup> They also claimed that there existed at least one other version of the 1943 bill; the one that had been introduced by Senator Wagner called the "A.F. of L" bill (for American Federation of Labor), and the second known by members of Falk's staff as "our bill," or the Social Security Board's bill.<sup>124</sup> Falk allegedly used the second bill to mislead Surgeon General Parran and lead him to believe that he was being consulted for this legislation, despite his exclusion described above.

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<sup>120</sup> Jonathan Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965* (Duke University Press, 2006), 29.

<sup>121</sup> National Health Program, Part 4 (HRG-1947-LPW-0025), 1716. Falk also assisted legal counsel to the president in formulating a message on national health insurance. Truman would deliver this message in 1945; the *second* Wagner-Murray-Dingell Bill would incorporate Falk's research and Truman's message.

<sup>122</sup> Oberlander, *The Political Life of Medicare*, 21. Oberlander rather cheekily observes that starting in 1943, the "introduction of national health insurance legislation in Congress [by Wagner, Murray, and Dingell] became an annual event." Importantly, the 1943 bill contained *both* a federal (national) health insurance program and a joint federal-state hospital construction program, reminiscent of the 'mixed system' that Witte had written about a few years before.

<sup>123</sup> National Health Program, Part 4 (HRG-1947-LPW-0025), 1717.

<sup>124</sup> National Health Program, Part 4 (HRG-1947-LPW-0025), 1717. This claim was made in the footnotes of Shearon's *Blueprint for the Nationalization of Medicine: Plans to Enchain Medicine by Unwarranted Regulatory Interference*.

Just how “complicit” Senator Wagner was in the Falk “clique’s conspiracy” to push the socialized medicine agenda onto legislative efforts is unclear. Based on the information that Wagner *failed* to disclose to the Senate, Shearon claimed, the “leading health experts” that Falk often cites in the legislation were often not physicians but rather academics who had never practiced medicine in the United States, or were figures associated with “foundations long active in the movement to socialize medicine” and longtime allies of Falk and Davis.<sup>125</sup> Some were even indirectly linked back to the menace presented by *Mein Kampf*: it was noted that a Dr. Goldmann, a professor of public health at Yale University and the author of *Labor’s Attitude toward Health Insurance* above, was born and raised in Berlin and had worked with the Health Section of the League of Nations. He had also written works on “Public Medical Care” and on German sickness insurance benefits for the International Labor Organization.<sup>126</sup> Dr. Goldmann’s heritage alone made Falk’s association with him suspect in the years immediately following the Second World War. Nazis and Soviets, Germans and Russians could be balled up into one nebulous, but ominous, totalitarian threat.

The American Medical Association certainly had its own complaints about the Wagner-Murray-Dingell Bill and the supporting documents Wagner referenced. For example, the AMA claimed that the 1944 statement “Medical Care in a National Health Program” had been adopted by the American Public Health Association via an undemocratic process, without the votes of all of the active members and fellows of the association. The dissatisfaction with a “shrewdly manipulated performance by public officials, economists, [and] bureaucrats”<sup>127</sup> echoes the main complaint that the American Medical Association and its allies would voice about national health

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<sup>125</sup> Ibid., 1719.

<sup>126</sup> Ibid.

<sup>127</sup> Ibid. This characterization recalls Dr. Morris Fishbein’s complaint that bureaucrats had engineered their program without consulting members of the AMA. See note 75 on page 26 of this paper.



insurance as a whole for decades to come. They disliked the implicit assumption that a single central agency (“a bureaucratic machine”<sup>128</sup>) would handle all the administrative details of all public health activities and all medical activities on a federal level. Although bureaucracies, of course, managed even local and state governments, the generic term “bureaucratic” was turned into a sinister, unconstitutional one that implied rigid centralized authority of a socialized state.

Falk’s critics were most committed to proving that Falk’s longtime agenda to establish socialized medicine in the United States was rivaled only by his desire to control every aspect of its research and administration. They claimed that he was “assumed active leadership in discussing administration and financing of the hospital construction program”<sup>129</sup> as the main consultant for the committee formulating what would become the Hill-Burton Act. It was not only his penchant for producing statistical tables for this project that irked his critics, but also his directing the Bureau of Research and Statistics to “furnish one document after another showing the ‘need’ for compulsory sickness insurance, the ‘need’ for Government intervention, and the way in which the proposed scheme would ‘operate.’”<sup>130</sup> Here, the historian Beatrix Hoffmann would disagree with Falk’s critics’ assessment of his contribution to the Hill-Burton effort. Hoffmann writes that the Hill-Burton Act was actually a politically palatable *alternative* to national health insurance, since it was a “juggernaut, seemingly bulletproof”<sup>131</sup> – after all, no one could possibly be against hospital construction and expanding access to healthcare nationwide. The Act instead expanded the presence of federal dollars in American healthcare in the form of new hospital buildings, and simultaneously successfully avoided the question of expanding the

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<sup>128</sup> Ibid., 1720.

<sup>129</sup> Ibid., 1721.

<sup>130</sup> Ibid.

<sup>131</sup> Beatrix Hoffman, *Healthcare for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2012), 69. Opponents of Truman’s national health program liked the Hill-Burton Act because “it tackled health care shortages without inviting government intervention, and national insurance experts also supported it because they had included hospital construction...in the reform platform as far back as 1938.”

right to care, which would have required an expansion of access. Historian Jonathan Engel would agree; he writes that proposals to improve healthcare during this time period “shied away from the provision of *clinical* care,”<sup>132</sup> because the idea of government involvement in clinical care was a politically volatile one (“research, construction, public health works, and infant immunizations were politically palatable; government doctors were less so”<sup>133</sup>). According to Hoffmann, “In the Hill-Burton program a formula for grant allocation and statutory prohibition of federal intervention in hospital policy limited political discretion;” instead, “states’ rights and community autonomy were invoked as the basis for limiting federal intervention. These claims have a constitutional heritage behind them.”<sup>134</sup> ‘Federal dollars and local control’ was the theme of the legislation.

So explosive was the idea of government involvement in medical care that its proponents were automatically labeled as conspirators who used “stealth and adroit maneuvering” to “jockey” the nation “into acceptance of a national compulsory sickness insurance scheme because the true meaning of the legislation would be concealed from the people and even from Members of Congress.”<sup>135</sup> Always one step of legislators themselves, these masterminds allegedly even were able to execute a bait-and-switch and evolve their demands: “Plans for socialization of medicine now call for nationalization rather than for State action which was the goal in 1939 and earlier.”<sup>136</sup> Falk’s role in all of these accusations was, according to Marjorie Shearon, providing “leadership for the nationalization movement; integrating lobbying movements inside and outside Government; ...supervising drafting [of compulsory sickness

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<sup>132</sup> Engel, *Poor People’s Medicine: Medicaid and American Charity Care since 1965*.

<sup>133</sup> Ibid.

<sup>134</sup> Hoffman, *Healthcare for Some: Rights and Rationing in the United States since 1930*, 351.

<sup>135</sup> National Health Program, Part 4 (HRG-1947-LPW-0025).

<sup>136</sup> Ibid.

insurance proposals]; manipulating committee findings,”<sup>137</sup> and more. (Falk never formally studied economics, although he wrote extensively on medical economics in books like *Security Against Sickness: A Study of Health Insurance* (1936), and was appointed as the principal medical economist at the Social Security Board in 1937 after confirmation by the Senate.)<sup>138</sup>

Falk asked for an opportunity to leave a record of his commentary of Marjorie Shearon and her allies’ “malicious and unfair and untruthful attack”<sup>142</sup> contained in the *Blueprint for the Nationalization of Medicine*. The attack on his level of expertise was not as grave or extensive a charge as the implication that he had or represented a hidden agenda, as was suggested by the articles that her camp introduced into the record, including *Labor’s Program to Socialize Medicine Internationally – Wagner Bill Revealed as a Product of the International Labor Organization* from Medical Economics in 1945.<sup>143</sup> The level of publicity for such titles was notable.

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<sup>137</sup> Ibid., 1723.

<sup>138</sup> Ibid., 1754. Falk summarized the main points of the CCMC as a five-prong recommendation of objectives to target: the expansion of public health and maternity and child care clinics, the expansion of hospitals and clinics in general, the provision of medical services for “needy and medically needy” persons, the “financial burden and the economic insecurity” which sickness creates even for those who are not indigent, and the problem of income loss resulting from disability.

The birth of health economics as a field is often attributed to a landmark 1963 paper by the economist Kenneth Arrow, entitled “Uncertainty and the Welfare Economics of Medical Care” and published in the *American Economic Review*. Years after Falk’s arguments for the responsibility of the federal and state governments to intervene in health insurance, Arrow made a case for the necessity of intervention in a market where failures like asymmetric information frequently arise.

<sup>142</sup> National Health Program, Part 4 (HRG-1947-LPW-0025), 1769. According to Jaap Kooijman, these allies included the House Subcommittee on Government Publicity and Propaganda, the chair of which led an investigation into the alleged propaganda activities of the Truman administration. (Ironically, Kooijman writes, the committee’s first target was Surgeon General Parran, whom Shearon claimed Falk had snubbed in policymaking.) Truthfully, Shearon’s attacks found validity in the fact that “the national health insurance movement had indeed been led by a small group of reformers.” Falk hated the idea of getting caught up in the crossfires of politics, but could not escape this fact. See *...And the Pursuit of National Health: The Incremental Strategy Toward National Health Insurance in the United States of America*, 114.

<sup>143</sup> Ibid.

### **Franz Goldmann, Labor, and Suspicion**

Franz Goldmann, a professor of public health first at Yale and then at Harvard in the 1930s and 40s, was one of the targets of opponents of “socialized medicine” for his research on the relationship between labor and health insurance in America as well as in Britain. (Both sides of the argument were fond of referring to Great Britain as an example and template of what could go wrong, or right, with national health insurance.) Goldmann wrote in 1939 that “in all civilized countries some medical care is supported by taxation, [which] is used for three purposes: (1) To carry out the campaign against specific diseases of social and economic importance; (2) to protect certain groups exposed to health dangers due to their... socioeconomic conditions; (3) to establish and maintain institutional facilities and professional services for all the people.”<sup>144</sup> In this writing, he suggested that taxation collected by the government had a distinct role to play in the delivery of health insurance and in realizing it as a reality for people of different occupations or socioeconomic backgrounds. He envisioned the federal government as an intermediary that transforms taxation dollars into public health campaigns, prevention efforts, and institution building, respectively – this trend was taking shape in Great Britain.<sup>145</sup> Starting with the control of acute communicable disease, which all Americans seemed to agree was the responsibility of the government, the British government had taken steps to expand its role in public health.

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<sup>144</sup> Franz Goldmann, “Recent Developments in Tax-Supported Medical Care in Great Britain” 1939, MS 1318 Box 1, Yale University Manuscripts and Archives.

<sup>145</sup> Goldmann, “Recent Developments in Tax-Supported Medical Care in Great Britain.” Goldmann wrote that the British story in pursuing this three-prong application of tax funds for healthcare is full of interesting details and history, but they reveal two key points: “there has been a steady growth in government responsibility for organizing and providing medical care – a growth expressed by the increasing number and improved quality of tax-supported facilities and services for the sick.” In addition, “there has been a slow but final abandonment of the proviso ‘destitution’ as the sole basis of eligibility for medical care at public expense” – in other words, indigence as a prerequisite for government-provided care was falling out of favor.

Goldmann was aware that “the development of a broad and well-balanced program of medical care has been curbed by heterogeneous concepts of the extent of government responsibility, has been sterilized by antiquated laws, and has been seriously handicapped by lack of planning and integration”<sup>148</sup> – a challenge not unique to the United States, but a stinging rebuke of the American reluctance to address the issues with the same determination that Britain had. In his writings on what American medicine and healthcare meant to the farmer, or on evaluating union health programs, Goldmann brought in a key player in the discussion about disability and health insurance - namely, that of organized labor in America. Whereas Jill Quadagno argues that the absence of a strong labor movement in America has contributed to the failure of health insurance efforts in the United States,<sup>149</sup> it seems instead that the fact that different branches of labor were unable to agree on a united stance towards such proposals contributed to the stalemate. In Goldmann’s article *Labor’s Attitude Towards Health Insurance*, he predicted an “increase in collective bargaining agreements with provisions for ‘health insurance,’”<sup>150</sup> suggesting that some of the different labor groups’ objectives were nevertheless the same.

### **Strategy and the American Medical Association**

The conservative coalition that had formed in 1937 in opposition to President Roosevelt’s perceived overreach and accused him of attempting to destroy the “constitutional separation of powers,” in the midst of post-war inflation, rode to power by taking Congress in the 1946

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<sup>148</sup> Franz Goldmann, “Recent Developments in Tax-Supported Medical Care in Great Britain.”

<sup>149</sup> Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance*, 132.

<sup>150</sup> Franz Goldmann, “Labor’s Attitude toward Health Insurance,” 92.

elections.<sup>151</sup> Unable to contain their pressure and seeking some accommodation, the rather inexperienced President Truman began to dismantle the most interventionist war-time measures in the New Deal mold such as the Office of Price Administration and the Committee on Fair Employment Practices. This same conservative coalition *aligned* itself with the American Medical Association (AMA) in between 1946 and 1950 to guarantee the defeat of Truman's 1949 and 1950 national health insurance recommendations.<sup>152</sup> This rejection of Truman's policies and the Fair Deal would have been especially painful for him, because he had been "troubled by seeing so many sick people unable to get the care they need, turned away from hospitals because they had no money"<sup>153</sup> and rejected by physicians as well – contributing to a "strong feeling"<sup>154</sup> that Truman would remember about their negative attitudes, which in turn informed his prioritization of health insurance. This antagonism clashed with a postwar trend noted by Paul Starr in *The Social Transformation of American Medicine*, in which "both liberal and medical opinion supported a broad mandate for professional authority,"<sup>155</sup> creating an "alliance" especially in an era of unprecedented medical and economic expansion in the postwar years.

Long before 1949 and Cold War escalation, however, the AMA had engineered effective methods of opposition to many ideas put forth about any form of national health insurance that was not private insurance. According to Jill Quadagno, it was the "intransigence" of the AMA regarding voluntary insurance that had convinced Isidore Falk to push for a compulsory

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<sup>151</sup> See Julian E. Zelizer, *The Fierce Urgency of Now - Lyndon Johnson, Congress, and the Battle for the Great Society* (New York: Penguin Press, 2015).

<sup>152</sup> *Ibid.*, 18-19.

<sup>153</sup> Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance*, 9.

<sup>154</sup> *Ibid.*

<sup>155</sup> Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*.

government program for the rest of his career.<sup>156</sup> While the AMA did not represent all physicians as individuals, it was becoming an increasingly powerful political entity.

Yet its collective mode of action also raised legal issues. Thus the constitutional or legal questions about a modernizing medical sector applied not only to questions of insurance but also to the monopolization of care. In 1942, the Department of Justice (DOJ) sued the AMA, charging that it had violated antitrust law (the 1890 Sherman Antitrust Act) in the late 1930s by attempting to prohibit its members from working for health maintenance organizations (a type of insurance grouping) like the Group Health Association.<sup>157</sup> This lawsuit set up the controversial question of whether a physician's practice of his profession constitutes trade under the Sherman Act.<sup>158</sup> The Supreme Court agreed with the DOJ, based on the holding that "the fact that the defendants were physician and medical organizations is of no significance if the purpose and effect of their conspiracy was obstruction and restraint of the business of Group Health."<sup>159</sup> There was clearly no love lost between the physician organization and the Justice Department, which was not convinced by the American Medical Associations' argument that it did not, and could not, engage in the same collusive behavior that was usually accused of in corporations. Truman's relationship with the AMA was not likely to have been very warm either based on his experiences. This meant that combined with the Social Security Supreme Court cases of the 1930s, the AMA had little history of legal success at the nation's highest court. Without a

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<sup>156</sup> Ibid., 5. The relationship between the AMA and the federal government was a complicated one. Franklin Roosevelt had been a huge advocate of promoting medical science and its prestige despite a personal history of misdiagnosis for his bout with polio and the consequent disability that stayed with him for the rest of his life. FDR therefore wanted to ensure that others had early medical intervention and advances in medical research reached ordinary folks who needed assistance. Moreover, when he looked at economic deprivation in regions such as the American South, he understood the lack of economic modernization, poverty, and health as integrally linked. See Michael Grey's work, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration*.

<sup>157</sup> Joseph Roshenheck, "The American Medical Association and the Antitrust Laws," *Fordham Law Review* 8, no. 1 (1939): 82.

<sup>158</sup> Ibid. The Court decided that there was no need at the time to address this specific question.

<sup>159</sup> *American Medical Association v. United States*, 317 U.S. 519, No. 201 (United States Supreme Court January 18, 1943). According to Stephen Brown of the American Bar Association, for this case, the Supreme Court approved "the admission of evidence that the AMA had...induced various hospitals to exclude physicians."

precedent of success, the AMA did not launch attacks on socialized medicine initiatives on which they could hope to construct a strong constitutional argument against such initiatives.

The AMA's issues with the concept of national health insurance did not dwell on the constitutionality of proposals for its expansion. Yet their rhetoric melded well with what Truman decried as the propaganda of "die-hard reactionaries,"<sup>160</sup> or "those who want to cripple labor unions...[and] who started a campaign of confusion against all...measures for the welfare of the people. [These reactionaries] say they are for extending and improving social security – but they call our proposals a bureaucratic system that will destroy the character of every American."<sup>161</sup> These reactionaries also lamented the change that could occur over a few months: "In June of 1948, compulsory health insurance...was considered by many as only a remote possibility... The result of the November [1948] election has completely reversed the prospect."<sup>162</sup> The fear that "compulsory health insurance...is an imminent probability"<sup>163</sup> mobilized the campaign against Truman's initiatives in 1949 and 1950.

Following some criticism from "middle of the road" physicians who chastised the American Medical Association for "its failure to come forward with a comprehensive, constructive plan [an alternative to presidential proposals] to extend and improve medical care,"<sup>164</sup> the AMA proposed a twelve-point program as a substitute for national health insurance legislation. The *Journal* of the AMA stated that "this program is far more comprehensive than any yet proposed by either the President of the United States or the Federal Security

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<sup>160</sup> "National Health Insurance - Imminent Probability?" n.d., MS 1318 Box 1, Yale University Manuscripts and Archives.

<sup>161</sup> Ibid.

<sup>162</sup> Ibid.

<sup>163</sup> Ibid.

<sup>164</sup> "The AMA's 'New' Program," April 1949, MS 1318 Box 1, Folder 7, Yale University Manuscripts and Archives.



Administration,”<sup>165</sup> but it admitted that the plan to then set up “general standards for medical care”<sup>166</sup> based on new guidelines was lacking. The AMA, then, did not produce a comprehensive alternative to compulsory health insurance, despite characterizing the latter as a danger to the doctor-patient relationship, American medicine, and physicians’ livelihoods. The organization was certainly not a legal one – instead, its most effective weapons at swaying popular opinion relied on the cultivation of the American system of private insurance as a sacred one that must be protected from bureaucracy, much in the same way that politicians felt that the American system of insurance must be protected against foreign influences.

## Conclusion

The *Physicians Forum Bulletin* for March-April 1949 reprinted a Barnaby Comic from the *New York Star*. It depicted a boy describing a dragon named “socialized medicine” to a curious friend. He explained, “Dragons, in our culture, are believed to be of no use to Man. Except for their metaphorical value. And, invariably, the intent in any prosopopoeial [personified] use of a Dragon is to portray some abstract concept or other as onerous, indeed, even evil. And, so, the bias against a really useful specie perpetuates.”<sup>167</sup> This bias, utterly toxic to reform efforts in the Roosevelt and Truman years, has prevailed to the present day.

The portrayal of national health insurance as socialized medicine, and of its proponents as anti-American or deep threats to American values, was as significant a barrier to the effort for national health insurance as the combined efforts of the AMA and the conservative coalition that was skeptical of FDR, of his advisors like Isidore Falk, and the continuing fruition of the New

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<sup>165</sup> Ibid. The points included a Cabinet-level role for a Federal Department of Health (an interesting concept, given the AMA’s aversion to federal oversight) as well as an attempt to redefine eligibility for government insurance with a more conservative approach.

<sup>166</sup> Ibid.

<sup>167</sup> “National Health Insurance - Imminent Probability?”

Deal's broader social democratic potential. The failure of a precedent like Social Security and social insurance to gain traction on the national level was not entirely due to some very effective propaganda campaign by the AMA, although their efforts were indeed significant. Instead, the failure of the AMA to work with the federal government to find a mutually beneficial approach to reducing risk for groups of individuals led to the stagnation of health reform in the years following the Second World War.

The meaning, discourse, and orientation of liberalism perhaps altered course as a result of the alliance of Cold War politics and social welfare politics. The basis for this alliance emerged long before the Cold War, and even before the end of the Second World War. The conservative backlash to what seemed to liberals to be a natural progression of the responsibilities of the welfare state after the Depression-era resulted in a stalemate where conservatives contended that public health insurance initiatives, if not unconstitutional, were anti-American. Legal precedents from FDR's era established the constitutionality of social insurance programs, and conservatives and the AMA turned to emotional and personal attacks in order to prevent more from becoming law.

This conversation and the ideological tensions surrounding it did not end with the passage of Medicare in the 1960s. Revisited in each decade since, with each landmark legislation that expands health insurance nationwide, there has been fierce debate and regression - the most recent example, of course, is the Republican failure to repeal the Patient Protection and Affordable Care Act. Today, the threat of "communism" is not nearly as significant of an argument against expanding healthcare coverage or the role of the government in regulating insurance markets in the states. However, the legacy of an intense paranoia of the overreach of government in something as 'intimate' as healthcare and medicine persists, despite the fact that

the healthcare sector in America comprises seventeen percent of the gross domestic product *and* a significant portion of the federal budget, with expenditures growing continuously. The United States remains an exception in the developed world in its historical inability to reconcile health security as a right with the role of the government that such a right would require.

Isidore Falk once told his critics, “The phrase ‘socialized medicine’ means little or much. It has many different implications for those who use it and to those who hear it. It would be only by chance that I could guess what it means to you.”<sup>168</sup> Reformers today would do well to remember his words and what different meanings ‘national health reform’ holds for legislators, for economists, for physicians, and for Americans as a whole. National health insurance need not be a foreign concept, nor a dragon-like metaphorical one – the United States still has a unique opportunity to realize it.

Word Count = 12, 500

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<sup>168</sup> Isidore Falk, “‘The Pro and Con of Socialized Medicine as It Would Affect the Negro People and the Negro Professional Group,’ National Medical Association Annual Meeting, New York: Text of Introductory Remarks.”

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### **Bibliographical Essay**

As an Economics major at Yale, I became increasingly intrigued by a field I did not know existed before coming to college: health economics. Health economics seemed, and still seems, to be the field that perhaps has the best shot at illuminating the intricate details that characterize the imperiled American healthcare system. I learned some basic tenets in courses dealing with health economics: one, that the relationship between healthcare and health is neither causal nor linear; two, that healthcare (or demand for medical care) does not function like other goods – hence the need for the field to study what it means to have a certain supply (of health stock), or to invest in health. Other debates driving research in this field deal with how to measure returns to investment in health, or how to finance the perpetually burgeoning cost of healthcare and medical care. I have researched the economics of collaboration in the American pharmaceutical industry and helped conduct small randomized control trials to incentivize participants to quit smoking. Yet I became caught up by a more fundamental question: why our society, which has such strong ideals of natural rights and extensive commitments of state aid to citizens, has not combined the two in the context of healthcare and its provision. Relatively late in college, I decided to major in History, not only because I loved the subject generally but also to be able to further pursue this profound, and indeed urgent, question.

There are many points in U.S. history in which I could have begun to study the emergence of public health efforts and involvement at the federal or local level in the provision of medical care. I was determined, however, to start with the question of our rather tortured history of attempting to establish a national health insurance system. There certainly exists a wealth of material on this topic, as well as plenty of historical reasons why a uniform, comprehensive system never has become law. Today, ‘healthcare in the United States’ is nearly



synonymous with bureaucratic red tape, overlapping and redundant private enterprises and services, and excessive spending (an increasing rate of growth in addition to the level of spending overall), with mediocre results. As someone who was thirteen when Barack Obama was first elected president, I have grown up hearing about the Affordable Care Act and the continued tug-of-war over it from the legislative branch and the judicial branch of our federal government (including *National Federation of Independent Business v. Sebelius (2012)*, which upheld the major provisions of the ACA.)

I wanted to know if the aversion to extending the single payer system from Medicare to the rest of the population was an *American* attitude; Jill Quadagno argues that it is in *One Nation Uninsured: Why the U.S. Has No National Health Insurance*. She argues that four factors have worked together to ensure that the United States would never establish such a system: a strong sense of antistatism or distrust of the government, the absence of a strong labor movement, the racial politics of the South, and the decentralized nature of the American government that intentionally diffuses power. The dissonance between our inherent distrust of a strong central government and our conviction that it nevertheless is responsible for our welfare was very apparent here. Also compelling is her argument that race had permeated even the universal need for and debate over healthcare.

It was a good start, but I was wary of a book title as confident as Quadagno's. I originally wanted to look at the fight for Social Security and the struggle for Medicare and Medicaid that came nearly three decades later, after the end of a Great Depression and a World War, as a comparative study that looked at the different applications of constitutionality at two high points of liberal social reform, the 1930s and 1960s. After all, Medicare had Social Security to build upon and draw inspiration from. I soon became intrigued though by the documents produced

during the nebulous years of the 1940s and 1950s, in which Social Security faced its first significant challenges after becoming law and the debate over the need for a national health insurance system surfaced. “Social insurance” was rapidly becoming a common term in the dialogue. I turned to Paul Starr’s *A Social Transformation of American Medicine*, a source I could not miss, for his take on the ‘origin’ of health insurance, which he identifies as the “breakdown of a household economy, as families came to depend on the labor of their chief wage earner for income and on the services of doctors and hospitals for medical treatments.” He claimed that the “politics of health insurance revolve around four sorts of cost: 1) individual losses of income; 2) individual medical costs; 3) the indirect costs of illness to society; and 4) the social costs of medical care.” Medical care and health lay at the intersection of positive and negative public externalities.

To further contextualize these costs and cost-saving results of legislation, I started looking in two avenues of research that I now think would be better played out separately, in essays of their own. At first, I went about trying to look at some of the legal cases that established the constitutionality of the Social Security tax (*Helvering v. Davis*, 1937) and the fact that the Justice Department could sue the American Medical Association on antitrust charges (*American Medical Association v. United States*, 1943). I quickly found that the legal intricacies of the arguments made analysis difficult for someone with no background in legal history or in law. Still, I had some important takeaways from *Helvering v. Davis*, which confirmed the application of the tenth amendment to Social Security. The second avenue involved using economic data and insurance enrollment numbers to gauge the impact of Medicare on the insured population. I hoped to use another database with Yale access called “Historical Statistics of the United States” – it listed numbers such as “Persons with hospital and surgical benefits, by type of

private health insurance plan from 1939-1992.” At first, I considered incorporating an economic history approach but I think the sociopolitical history can best help illuminate any economic analysis about impact of this legislation. After all, this legislation cannot have been a shock to a market that was only emerging, and the numbers for social security (public insurance) were more challenging to find. The descriptive statistics, I concluded, would add just as much to my final analysis.

For some insight into the interaction between the right to health and the government’s responsibility for its maintenance on a large scale, I turned to Beatrix Hoffmann’s *Healthcare for Some*, which argues that healthcare’s dual nature as a right and as a commodity contributed to its high costs in the United States. She explores various forms of rights and rationing; she takes the example of the right of healthcare providers to be reimbursed, which called for more oversight from a federal actor that would guarantee these payments in order to reimburse and encourage charitable behavior on the part of physicians. Hoffmann also addresses the question of North-South tension in conversations about healthcare expansion. The 1946 Hill-Burton Act, she points out, was the “politically palatable alternative” to national health insurance, setting in place an infrastructure that valued expansion and construction of healthcare facilities over expansion of access and ability to pay. At the same time, it disproportionately favored Senator Lister Hill’s native South by design; it awarded funds to build hospital beds in rural areas to reach an ideal hospital bed-person ratio.

The focus of my project was not to research and ‘expose’ evidence of regional politics and bias in the national discussion for health security, but I thought the Hill-Burton Act was another fitting example of the balance between federal legislation and states’ power. To extend Hoffmann’s argument, rationing was, in a sense, built into this legislation in order to limit health

access according to geographic division, race, and the ability to pay. This is another departure from what we think of, perhaps, as classical economic thought – in most markets, price is at least partly determined by willingness to pay; an agent’s willingness to pay is *revealed* through the market-clearing price. In the world that Hoffmann describes, one’s *ability* to pay for a health service overshadows willingness because of societal and political constraints like race and class.

The Depression and the Second World War left a legacy of rationing that influenced the health insurance debate. My goal was to comb through the many congressional records available to examine some of the debates that were happening in the 1940s and 1950s. With the direction of Yale librarians, I visited the database Congressional ProQuest for records of extensive testimony given by Isidore Falk; in 1947, he was the director of the Bureau of Research and Statistics at the Social Security Administration; he was at the Administration from 1941 to 1954. He is also a Yale figure: the teenage Isidore Falk first came to Yale as a laboratory assistant, and eventually returned as professor of public health. In an exciting “first” for me as a Yale student, I visited the Yale Manuscripts and Archives and found many of Isidore Falk’s writings, correspondence, and addresses stored there. His correspondence with Edwin Witte, often called the “father of Social Security,” was also of particular interest. It was in their writings that I came across the many terms that were used in various permutations and combinations to describe the still-nebulous concept of health insurance: economic security, health security, and ‘economic security against sickness,’ among other terms.

In reading his statements and addresses, I was struck by the frankness with which Falk discusses the term “socialized medicine,” which was to have an increasingly controversial connotation in later years. When he used it in 1939 at a national meeting of the National Medical Association in New York, he said, “the phrase ‘socialized medicine’ means little or much. It has

many different implications for those who use it and to those who hear it. It would be only by chance that I could guess what it means to you.” I believe this statement adequately sums up the approach with which I myself should approach this essay – I cannot guess what the term meant to any given physician, or lawmaker, or patient, but I think it speaks volumes about the uncertainty that characterized the era that was facing a lot of simultaneous upheaval: a world war was happening, and postwar Keynesian economics along with its emphasis on public spending was on the horizon. Edwin Witte’s writings and speeches are organized into a collection called *Social Security Perspectives*. His writings also convey a cautious and wry tone when it comes to loading the meaning of “socialized medicine” or any public effort to define the term.

I thought it fitting to also consider a landmark paper by economist Kenneth Arrow, published in 1963 in the *American Economic Review*: “*Uncertainty and the Welfare Economics of Medical Care*.” I do not believe it a coincidence that this important article was published when it was, just before the passage of Medicare. Arrow lists taxes and subsidies as the most obvious examples of “the redistribution of purchasing power among individuals.” This definition re-centers the focus of health economics on the interaction between these individuals, and the government as well. It *is* true that the Social Security and Medicare taxes are paid over the course of one’s working career in order to redistribute spending on health and life in old age to a future consumption period. Arrow also emphasizes what we know today: that the actual medical market (that is, the market for medical care) differs from the theoretical competitive market. In addition, he points out that where there is uncertainty, information becomes a commodity. This language reminded me of when Hoffmann referred to healthcare as a commodity in the American mindset.

This project would not have been possible without the support of my advisor, Professor Jennifer Klein. She took me in as one of her advisees in the summer, giving my latecomer self a historian's perspective on my subject *and* how to go about tackling it, making my project possible. I want to also thank Professor Alan Mikhail for introducing me to Professor Klein over the summer. I am also grateful for my fellow seniors under her tutelage; I have learned a lot about how we think, and how we ought to think, about American history in the last century in our discussions. I would also like to thank the many librarians who helped me hone in on books and databases, and discover for myself what sources worked for me: Brent Salter, my Law School librarian, and Melanie Maksin and Michelle Hudson of the Center for Science and Social Science Information.