The Evolution of the US Healthcare System

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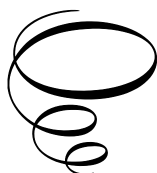
A Legacy of Opportunism and Greed

By

Richard L. Douglass

Cambridge Scholars
Publishing



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This book first published 2023

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

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ISBN (10): 1-5275-9445-9
ISBN (13): 978-1-5275-9445-6

This book is dedicated to Marian

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ACKNOWLEDGEMENTS

Any book that draws on over 50 years of experience is indebted to countless individuals and learning experiences that would require a separate volume to fully acknowledge. The numbers of such influences on this book are countless and I am immeasurably grateful. There are a few acknowledgments that still need to be identified.

When I joined the faculty of Eastern Michigan University in Ypsilanti, I entered into a world of undergraduate teaching that I had avoided since entering graduate school in 1970. The day I arrived, I became responsible for three courses and directing the Program in Health Administration in the College of Health and Human Services. Taking on three undergraduate courses that I had not taught before at this level was a challenge. I needed to decide what needed to be taught, and all three of the courses were rewritten during the first semester simultaneously as I was teaching them. One of these courses became a vehicle for explaining how the U.S. healthcare system emerged, spanning from 19th-century science and philosophy to the present day; I considered it important for my students to know what a challenging field of practice they were entering. When we began teaching graduate students, the new material I gathered for the undergraduate course was added to a course for graduate and honors students. I need to thank my colleagues at Eastern Michigan University for giving me the academic freedom and license to create courses meeting my expectations of depth and content. I also need to acknowledge over 35 years' worth of students whose inquisitiveness, challenging questions, and expectations pushed my continuing education. Without that stimulus, for many years this book could not have been written.

Gloria Brooks is the editor of *The Beacon,* the monthly newsletter of the Iosco County Democratic Party in N.E. Michigan where I live. In 2020, we began to discuss how much the complexities and illogical processes of the U.S. healthcare system had confused people during the COVID-19 pandemic's first year. With Gloria's encouragement, I began writing a monthly column entitled "If You Don't Know What's Broke How Can You Fix It?" These columns were well received, both locally and, eventually, at the national level. When the opportunity came to weave the columns into a book, Gloria strongly endorsed the idea and now, nearly a full year later, the story has been told. Gloria and the members of the Iosco

County Democratic Party gave me support and feedback about form, style, and substance, and encouragement that I will not forget.

Bill Lavery, Jim Mortimer, Don Stansloski, Lew Perin, Ed Garrison, and Tom Davidson have put up with excessive e-mails and text questions, requests for ideas, and my pleas for editorial or substantive responses to draft and trial texts for over two years. They will now be liberated from the project that this book became. All photography reproduced here is the work of Gwynneth VanLaven of Ann Arbor, who also offered innumerable insights about patients' perspective in complex chronic medical care. My respect, admiration, and gratitude to these colleagues and friends are beyond mere words. Thank you.

The opinions, observations, recommendations, and positions in these pages are mine. I did not take this on with the idea of going "gently into that good night" and I accept responsibility for everything that I have written.

PREFACE

Why am I writing this book?

I am writing this book to fill a void that I first noticed when teaching undergraduate and graduate students who were studying to be managers and administrators in healthcare services and government offices. Hardly any of these students knew about how the system in which they chose to spend their professional lives came to be. I also realized from the rest of my career that most physicians, nurses, managers, administrators, and clinicians in all health professions were working in jobs that were part of a much larger healthcare environment that they often did not fully understand. Very few people, other than academics in contemporary history or health policy, knew why the way we deliver healthcare services worked in ways that were tremendously complicated, and often irrational, confusing and inefficient. Over the last 50 years, I also came to understand that few elected officials, at the local, state, or national levels, knew anything about how our healthcare system evolved, how it is, or is not, articulated with public health, and why it is so complex and difficult to understand. At each phase of my career, I came to wonder more intensely how people could function within such a system without understanding its origins and the forces that drive it at economic or political levels. I confronted incoming medical, nursing, and allied health students who did not understand the difference between Medicare and Medicaid or did not understand the words "medical indigence". I was confronted by incoming students who did not even know that Medicare was a government program or that it was part of the amended Social Security Act (1935). It became clear during cycles of political debate and contention over the Affordable Care Act (2010), years of media coverage of indigent healthcare and homelessness, insufficient care for HIV and AIDS, and finally with the COVID-19 pandemic, that the general public was largely clueless.

People usually do not know why our healthcare system is fundamentally flawed in its ability to provide adequate and equitable preventative and curative care for the whole population, because the history and structures of the system are unknown to them. Most people either assume that "it's always been this way" or that such complex systems simply evolve in organic ways. It seemed to me that it was time to challenge this

level of misunderstanding and lack of factual knowledge of why the system is as it is and, therefore, why it is so difficult to change. But change it must, because we've discovered in profound ways during the COVID-19 pandemic that the system we all depend upon is fragile, vulnerable to manipulation, and shocks from economic, political, and epidemiologic influences. We need to know about this system because we live with assumptions of being able to live healthy lives and get the care we need when our lives or health are in peril. And so, this book is designed to fill the gap in understanding for everyone about how our healthcare system came to be the excessively complicated industry that it is today, why we lose significant proportions of our "medical care dollar" to opportunistic, parasitic industries, and how I think we can get more for our investment through simplification and reform.

Like all others who venture into a large and esteemed literature, I am influenced by those who came before me. Four books, in particular, inspired me when I first read them and have now motivated me to follow the paths that they laid out. Paul Starr's *The Social Transformation of American Medicine* (1982) connected the dots of my understanding of the organization of medicine as a profession, an academic tradition, a pillar of society, and a political entity. Evan Melhado, Walter Feinberg, and Harold Swartz edited *Money, Power and Health Care* in 1988, and the book has held its place in my students' reading lists and my lectures for over 30 years. Conceptualizing the healthcare delivery system in the context of the power that money can establish became a central issue in my teaching. David Drake's *Reforming the Health Care Market: An Interpretive Economic History* (1994) validated my multidisciplinary understanding of the system as part of society and was consistent with how I believe public health, embracing medicine and medical care should be recognized as a ‘big tent’ enterprise in which dozens of fields of inquiry and practice are all active participants. Finally, the most recent major influence in the decision to pursue this book was Elizabeth Rosenthal's *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back* (2017), in which she courageously called out profiteers and corporate greed as a threat to our national wellbeing. Rosenthal was audacious enough to suggest that the problem could be fixed. I have little, if any, dispute with these authors, and their work. What I have done hopefully complements and expands upon this existing body of work, or integrates material and ideas that they did not include.

My critique of the current literature is that there is little real acknowledgment of how we have moved as a society from a public health and preventative mentality to a medical and curative mentality, and what

that means for those who serve, or profit from, the healthcare business. If we've learned anything from COVID-19, it is that once the horse is out of the barn it is too late to think in terms of health spending efficiency and we are compelled to work in a mindset of crisis management instead of crisis prevention. For instance, few scholarly historians, journalists, or pundits have connected medical indigence and the ongoing prevalence of chronic disease as "essential supplies" for the ongoing enterprise of medical, nursing, and allied health education. Why is it that most writers stay away from discussing the influence of the for-profit healthcare systems that have joined the pharmaceutical industry with a Fortune 500 status, and are directly connected through exploiting the medical care markets filled with well-insured citizens instead of the poor, underserved, populations in greatest need? Not many writers have directly challenged some of the fundamental system flaws that we face, especially what I consider to be the excessive complexities that are now structural, such as state-administered Medicaid programs, state-level insurance commissions, and other redundancies that also create unnecessary confusion for the general public and professionals alike. The inbred costs of the private sector's accreditation of healthcare organizations, the consequences of market-driven medical systems that flee from rural populations, and the impact of medical education student debt on the availability of primary care are issues that, to me, are intimately interconnected, and must be addressed simultaneously. Fixing this broken system can't be accomplished by tinkering around the edges but is necessary if we are ever to improve access and establish healthcare justice for the whole population. I try to raise all of these issues here.

I am not writing this book for the elite audience of career scholars and advanced students of public health, public policy, or medical history. Nor am I aiming to influence the highest levels of scholarly discourse. The abundant, and often outstanding, literature dealing with these broad issues, within disciplines of political, and economic history, health economics, business, and finance, healthcare management, social epidemiology, sociology, political science, and public health administration is already available. However, to the non-specialist, this literature is often like listening to an evangelist speaking in tongues. The jargon and academic, discipline-bound acronyms, and linguistic shorthand make much of the literature impossible for most people to comprehend. That is how disciplines and professions often protect their intellectual turf, but it is a barrier to public comprehension. I hope that my effort is accessible to most people who wonder why their medical care and protecting their health status is such a chore.

Our healthcare system in the United States accounts for nearly 20% of the domestic economy and is the leading source of employment in most urban settings. Because it is a system that we all need to use any barriers to universal access is a threat to our wellbeing and domestic security. We cannot be informed consumers, or decision-makers about policies and strategies to improve the system, or be capable of judging quality without being able to learn how it all works and where it came from. Ignorance is not bliss.

Therefore, I am writing this book not to be a definitive political, economic, epidemiologic, or contemporary history of our vast healthcare system but to offer an accessible introduction to how it is that we have what we've got and how it came to be the way it is. I am writing it to be accessible for everyone, not just the discipline-bound academics, because there is some truth in the notion that academic inquiry is defined by learning more and more about less and less. I hope that this book will open the gates of curiosity and will stimulate questioning by those who read it, allowing them to wonder how we, as reasonably intelligent people, have allowed or facilitated the mess of a system that we have today, even when much of the very best care and most advanced medical research and technology are derived from a century of investments by us as taxpayers. Reading this book is the first step many might take to learn more, using the extraordinary sources that are available, to lay claim to the healthcare system in the United States. It is time for a more educated, aware, and curious public. It is past time for our economic and political leaders to make informed decisions about why a radical change to the healthcare system in the United States is crucial for the nation.

INTRODUCTION

"How can you fix it if you don't know what's broke?" This common-sense question was what I was raised on, in a family with very limited resources in the industrial wasteland of the far south suburbs of Chicago in the 1950s. We couldn't always replace things when they were broken or damaged, so we fixed them to serve another day. Minor car maintenance, home repairs, getting a lawn mower to work again, and fixing the heating or electrical appliances all came under the do-it-yourself umbrella. But to do what we needed to do, we had to know what was wrong and why.

When I began my career in public health, social epidemiology, gerontology, and health administration and policy, I drew upon my family's philosophy of living on an extremely limited income. Much of the healthcare system that we deal with today is beyond the scope of even the most hopeful of imaginations of half a century ago, and there is no doubt that the majority of us have available the very best medical technology, remarkable pharmaceuticals, and extraordinarily trained medical and nursing professionals. However, apparently, that isn't enough. It is unlikely that at the end of WWII any political or private sector leaders would have envisioned that healthcare spending through government programs, private insurance, and private out-of-pocket payments would exceed 18% of the GDP in 2022. No other country produces such a statistic. Something must be wrong, but rather than trying to fix a system on the assumption of limited resources, we have a broken system that is being tinkered with under the apparent assumption that money is no problem.

In the United States today, and particularly in rural America, the benefits of world-class medical care are often hard to find. In rural America, due to the migration of wage earners to the population centers, the loss of economic activity in small towns, the flight of healthcare providers and systems from sparse populations, and the costs associated with healthcare delivery prevent equitable care for most residents. Healthcare in northeastern Michigan suffers from inadequate availability, insufficiently insured communities, and modest median household incomes in local economies that do not attract healthcare industrial investment. We have spotty coverage of primary care, family medicine, and all specialists. Our families experience vulnerability from marginal expenses like transportation

and hotel costs that become necessary to allow rural residents to take advantage of medical care in a downstate urban center. Traveling to urban centers for care might require three or more hours. The consequences of insufficient and unjustly distributed medical care resources, combined with draconian cuts in the state-level public health budgets for the last 40 years, have contributed to excess mortality and morbidity. Rural America has a persistently high prevalence of obesity, drug addiction, depression associated with isolation, alcohol abuse, suicide, and unhealthy diets. This prevalence is combined with the delayed diagnosis of cancers and cardiovascular diseases and neglected care for advanced dementias such as Alzheimer's Disease. For many Americans, rural, suburban, and urban alike, the healthcare system is broken and does not provide adequate or equitable care. Those most vulnerable to being underserved are most often members of minority populations, single parents, the isolated elderly, and the poor. This is one of the most significant issues of the moment for individuals, families, and our national security.

Why has the "American Way" of healthcare evolved to be inadequate for the task? Answering "why" is impossible if we don't address and understand how we got here. A few guiding questions will make my point:

1. How is it that the United States, unlike any other industrialized nation, bases insurance coverage for most citizens on their employment, and the ability or willingness of their employer to purchase insurance from a private health insurance industry? How did that happen? Was it because we wanted to have a superior model within the private sector, or was it more of an accident? Was this the result of political dogma of the early 1950s or was it simply expedient?
2. Medicaid was designed to provide medical care for low-income Americans. The Medicaid Program was given administrative control to the states, unlike Medicare which is a uniform national program. What happened to Medicaid that made it far from adequate to insure the poor and did multiple state legislatures controlling Medicaid diminish Medicaid's ability to deliver the goods?
3. Where does the money come from? Corporate payments for private health insurance for employees are highly tax-deductible business costs; this makes such investments by the private sector foregone federal tax-based revenues. Medicare is fully funded with Social Security contributions and tax revenues, and Medicare's creation

in 1964 set the stage for graduate medical education into specialties; this level of medical education was comparatively rare before Medicare. Did the opportunity for graduate medical education and specialization diminish our ability to provide family medicine and primary care? How much of the modern hospital-based system is dependent upon Medicare? What was the American healthcare system like before Medicare and Medicaid?

4. We are an aging population, thanks largely to the availability of antibiotics that eradicated many of the most common causes of death between 1940 and 1955. But with aging comes an increased prevalence of chronic diseases of all kinds. What is the cost of chronic disease care versus acute medical problems that are most frequently incurred by younger people? How many of the "near old" who are still working get up and go to work each day simply because they need their employer-based insurance until they become eligible for Medicare?
5. It would be fair to say that well over 60% of every dollar spent on healthcare in the United States comes from the federal government, but this money is spent within the private sector. How many Americans know that their healthcare system is dependent on the federal government and federal taxes?
6. Why is it that the United States spends much more on medical care than any other industrialized nation, yet we are not healthier and do not live longer? Despite how much we spend, we often still experience delays or obstacles when seeking needed care. Why does the way healthcare is defined, provided, and financed in the United States impoverish many people who need acute medical care, long-term care, mental health services, and more during their most vulnerable moments?
7. What is the real relationship between the pharmaceutical industry, the health insurance industry, and the government? What influence do lobbyists from these industries have on legislation, government spending, research priorities, and the availability of care to the population? Who pays for this lobbying?

I could offer twenty more similar questions, but my point is that we cannot understand how or why healthcare is not equally or justly available to everyone unless we know how the system evolved. We have major problems to solve regarding most aspects of public health, primary care, tertiary care for chronic diseases and mental illnesses, prescription drug availability, costly long-term care, and preventative services that

cannot be addressed unless we know the answers to why and how. Becoming educated about these basic issues will help us, as communities in need, figure out how to "fix it." This is a challenge with historic significance for all of us as we recover from the COVID-19 pandemic and, perhaps, learn from that experience. The call for reform must come from a well-educated and motivated public.

FROM MOM-AND-POP TO MEGASYSTEM

I begin with a discussion to share what I have learned from a half-century of direct field work, advocacy, research, and teaching. It turns out to be quite a story and I must say at the onset that if I read this for the first time in the context of a modern industrial, highly educated, society I would assume that it was fiction. Rational people would not create the healthcare system we live and work with today in the United States. Sometimes truth is stranger than fiction.

After WWII, several forces pushed us to create the 'system' that we have. The GIs returning from war had become accustomed to getting medical and dental care on demand when they were in uniform. Did you know that by today's standards for nutrition and health, over 20% of all men inducted into the military between 1941 and 1945 were malnourished? Did you know that about 11% of all men inducted through the Selective Service and about to go to war tested positive for syphilis? Before WWII, over half of all babies were born at home and most people knew that hospitals were dangerous places full of diseased and potentially contagious people. Infant mortality was high and life expectancy was not great. In fact, we were not a healthy nation coming out of the Great Depression. The lack of antibiotics within the general population until around 1940–1942 left many bacterial diseases, such as tuberculosis, pneumonia, hepatitis, and syphilis, or infected wounds from accidents or trauma without effective treatments.

During the war, penicillin and other new antibiotics became secret weapons. Wounded troops were treated and sent back to the fight. Combat mortality in WWII was cut by 75% for our service men and women compared to WWI. Axis forces without antibiotics, especially the Japanese, died from wounds that we were able to treat. The production of penicillin, sometimes in repurposed beer brewing plants, provided antibiotics to our civilians who grew the crops and churned out war material in our factories. Leading causes of death, including dozens of common bacterial diseases and categories of infection, all but disappeared in short order. When the GIs came home, they were not keen on giving up access to medical care.

After returning from war, the troops went back to their old jobs or went to college on the newly minted GI Bill. The 'temporary labor' of women in heavy industry concluded and the women were sent home to take care of their homes and usher in the baby boom that began in 1946. Labor

contracts in steel, aviation, ship building, automobile manufacturing, mining, and related sectors became a real issue when corporations essentially said to the returning GIs, "Thanks for your service and we saved your job for you. Welcome home! How about 10 cents an hour more than you earned in 1941?" Unhappy with insulting levels of offered pay raises, the combat-experienced leaders of the unions insisted on improved compensation. The ensuing labor unrest was a dark post-war chapter in our history – but labor prevailed, and wages went up dramatically compared to pre-war levels.

When those first contracts expired, however, organized labor had a new demand. The Texas Public Teachers' union embraced a new kind of insurance: Blue Cross, and Blue Shield for hospital care and physician services. This established access to medical care that was much better than the ‘cash & carry’ way medical care was traditionally delivered; it was almost like the care on demand that workers remembered from their military service. And so, organized labor across the nation wanted Blue Cross and Blue Shield; the troops remembered access to care during the war and wanted it in their new lives.

On the heels of WWII, the global confrontation with the USSR's brand of communism and the solidification of communism in China led to the Korean War. President Truman had a war on his hands and the U.S. was the only nation left standing and able to confront communism's spread on the Korean peninsula. There was no place for labor unrest in heavy industry when there were tanks, armored personnel carriers, and new jet aircraft to produce. It was clear that the arsenal of democracy needed to get to work. Industries wanted billions of dollars from Federal contracts but were hesitant to concede health insurance as a matter of labor contracts. It was a standoff and strikes became likely.

President Truman set the wheels in motion for a strike-free settlement, and then newly-elected Dwight Eisenhower finished the deal. The deal was that workers would get their health insurance as a contractual matter and would go back to work right away. They could go home and brag to the rank and file that they had won. Corporate executives could go home to their stockholders and boards and brag that they also won and there would be no hit to the bottom line. How? Because health insurance premiums that were paid to private health insurance companies on behalf of the workers would be 100% deductible from federal corporate tax liabilities. Wow, what a deal!

Of course, what this means is that insurance premiums for unionized labor were paid by all of us. Tax deductions simply offset other Federal tax revenues (think income tax) and the cost of buying private health insurance for unionized labor was born by the entire U.S. taxpaying

population, including millions of workers who were not members of unions like farmers, domestic laborers, agricultural workers, and small business owners. The next contract cycle in heavy industry embraced health insurance for the families of the workers. There were few calls for strikes or labor unrest this time. Why not? It's tax-deductible!

The first real national health policy initiative by the United States government also was derived from American troops' exposure to the larger world in the European theater of the war. In every European country, most communities had clinics or hospitals that made the availability of healthcare resources widely available. This was particularly true in France and the United Kingdom where Lister Hill and Harold Burton took notice. As members of the Senate and sensitive to the relative paucity of community-based hospital resources, especially in the U.S. South, they wrote the legislation that created the last New Deal project. The Hospital Survey and Construction Act of 1946 was a bipartisan law that now is known as the Hill-Burton Act. As noted by Baxter in 2020:

> The healthcare system…is in large part a creature of the law that bears these senators' names, the Hill-Burton Act. It financed the construction of some 6,800 hospitals, nursing homes and mental health facilities in more than 4,000 communities.
>
> A disproportionate number of these were in the South, vast swaths of which were lacking in even the most basic healthcare services. Hill-Burton was the last great New Deal project, and one of its express purposes was to bring the region closer to the level of the rest of the country. The law was altered several times, and in 1975 its programs were rolled into the Public Health Services Act. (Baxter, 2020)

I think it is impossible to overstate the significance of the Hill-Burton Act's influence on healthcare delivery, the profession of medicine, or the systems that define healthcare in the United States today. Most critically, this law made it possible to pay attention to the idea that populations should have a minimum number of hospital beds available to serve the population properly. The idea of sufficiently supplying hospital beds had been an active concern in organized medicine for over a half-century by the time that the Hill-Burton Act went into effect, but no national policy resulted because of the Great Depression and the Second World War. In 1946, this law made it possible to address the needs of the non-urban, remote, and neglected communities.

It is easy to understand why the Hill-Burton Act was popular. Small towns where people had traditionally needed to travel for hours, or even days, to reach academic and urban medical centers could have a

hospital locally. New Hill-Burton facilities fed civic pride and the post-war flush of optimism combined with the recognition of unmet needs in places where medical resources had been absent. Existing hospitals expanded and added maternity wings because babies were now being born in hospitals instead of at home. New technologies from wartime research and development found a place in the upgraded surgical suites and laboratories. A better understanding of infection control and emergency care made it important to bring the nation's hospitals up to new standards and Hill-Burton offered a means to make it happen.

Some restrictions also changed the way we began to understand medical care. The Hill-Burton Act only provided federal funds to non-profit or public hospitals, and in 1945 nearly 30% of America's hospitals were for-profit, as corporations or facilities that were owned and operated by physicians as local businesses. It did not take long for the for-profit hospitals to reorganize and become relicensed as non-profit organizations in order to be eligible to apply for Hill-Burton funds. It was an opportunity not to be denied. The for-profit hospital sector in America nearly disappeared (Baxter, 2020; Brinker and Burley, 1962; Pearlstadt, 1995; American Medical Association, 1946; Bargo, 2020).

There were, however, problems with Hill-Burton too. The law did nothing to reduce racial segregation in the hospitals that were built or expanded in southern states, where Jim Crow laws and blatant racism were still prevalent. Lister Hill was a southern man and he was not about to challenge racial bias and beliefs in his political caucus. The long-term implications of ignoring racial segregation in southern hospitals are still being documented today (Largent 2018).

Another problem that Hill-Burton did not address was the notion of cost. The law had no end date, it was very popular, and from 1946 to 1960 the costs of hospital construction and expansion were modest by today's standards. Population-based metrics of how many beds a community should have were built into the law, and it was straightforward for community leaders to work with their member of Congress to seek more Hill-Burton investments over the next 30 years to keep pace with actual or anticipated population growth. Hill-Burton resources poured into American communities like pastries flowing into a schoolyard for a festive holiday until, many years later, someone began to wonder about how much it was costing. There is no doubt, however, that Hill-Burton-based hospital expansion created a supply of resources that was ever-expanding to meet the growing demands of the people who expected no less.

This can all be summarized neatly by considering that The Servicemen's Readjustment Act of 1944 (the G.I Bill) and the tremendous

success of the wartime distribution of antibiotics created a healthier, better educated, longer living, and a more demanding population that understood and wanted more and better healthcare. The Hill-Burton Act greatly expanded the supply of hospitals and other resources in which medical and other health services could be delivered, and the emergence of private employer-based health insurance removed economic barriers for millions of Americans. More supply, more demand, and less economic restraint created a happy place for medicine and medical care in the United States.

The impact of this sequence of events was remarkable. Think about most major cities in the U.S. and identify the tallest buildings in the downtown areas. What are the names of the tallest and grandest structures built between 1955 and 1975? If you look at the cornerstones you will find the names of the largest providers of health insurance. A new industry was born because we needed to mobilize for war in Korea and did not have the time or interest in finding an alternative, such as the National Health System (the NHS) that the British were creating at the same time. Foregone federal revenues in the form of corporate tax deductions for insurance premiums underwrote the U.S. healthcare enterprise during a moment in history when we simply could not imagine that anyone else could do anything better. American exceptionalism and dedication to capitalism thrived during the 1950s, along with a virtual silencing of issues that would soon throw the nation into social conflict.

Medical societies, hospitals, government agencies, and other elements of the service side of healthcare had little choice but to respond to public opinion, lobbying, and political influence. Employers who offered health insurance packages to their employees still wanted lots of availability of services and looked for insurance policies that were valued from a financial perspective. Tax deductibility was not the only issue for employers if they wanted happy workers and good industrial relations with the unions.

But creating a welcoming environment for the whole population was not the goal of all of the principal actors. For instance, increasing the availability of medical care to the common citizen was never a high priority to the American Medical Association (AMA), because the AMA was an organizational advocate of American physicians, acting like an organized labor union with a devotion to economic benefits for its members. The AMA resisted options to the private practice business model of medicine and was a potent political player in Washington D.C. for all of the 20th century. The AMA and other well-organized advocates rewarded increased medical specialization and compensation and dismissed efforts to expand primary care for the greatest good. In 1994, David Drake, who was senior vice president of the American Hospital Association, said:

> …the American Medical Association, built its reputation as a powerful political force in America by obstructionist tactics that were harmful to its principal constituents, general practitioners. Its opposition to health insurance in the 1930s and Medicare in the 1950s and 1960s caused health insurance benefits to encourage a high-tech, specialized style of medicine practiced in hospitals rather than the high-touch, caring style of primary care practiced by generalists and family physicians" (Drake, 1994, 145).

If a 'system' is defined as an assembly of parts that communicate and depend upon each other, then we do not have a system at all; we have the results of an historic accident. Entrepreneurial interests, competition among providers, opposition by powerful lobbyists to resist change, differences in medical philosophies, and raging competition in the emerging drug and pharmaceutical industry reduced the free flow of information, created uneven distribution of medical innovation, and created a range in the adequacy and quality of care across the nation. Federal money through the Hill-Burton Act ensured that nearly every Congressional District got its hospital, vastly increasing the number of facilities. But it was still a "mom & pop" operation in many places because the highest levels of talent in medicine, nursing, pharmaceuticals, and administration were concentrated near large cities, as they had always been.

Because the United States, unlike any other industrialized nation, bases the health insurance coverage for most citizens on their employment, and the ability or willingness of their employer to purchase insurance from a private health insurance industry, millions of Americans were left out and continued to face fundamental economic barriers to receiving medical care. Individual health insurance policies for an individual, family, or small business establish a risk pool for the insurance company that was so small that the policy became prohibitively expensive. The growing demands of these under-insured populations, combined with the aging of the population and the realization that chronic diseases were becoming much more prevalent as we survived longer, soon combined to rekindle interest in finding ways to embrace a government program that would finance their medical care.

Such an idea was not new and in fact, was written into the original Social Security Act drafts in 1935. The idea of a government-based insurance program, however, was strongly opposed by the American Medical Association. The Social Security Act of 1936 would not have been passed if President Roosevelt kept the medical insurance proposal in place.

Efforts to reintroduce a national health insurance program failed several times in Congress between 1930 and 1958 because of the same opposition.

When John Kennedy took office in January 1961, the profiles of medical care, hospitals, life expectancy, and medical technologies looked very different than today. The designers of the legislation that would lead to Medicare lived in a world that was often very simple in comparison to the complex, enormous, prestigious, and wealthy medical institutions that define medical care in the United States now. The ultimate passage of the Medicare law as part of the Social Security Act Amendments became the force behind today's healthcare system. This legislation also established Medicaid. Without the 1965 law and the previous Hill-Burton Act, our medical care system would be unrecognizable, disorganized, pathetically under-financed, and primitive. The critical fact, however, is that it was federal money, federal tax laws, and federal policies, not charitable donations or for-profit investors, from the end of WWII onward, that built or expanded most of the healthcare system that we know today (Congress of the United States 79 Stat. 286-Social Security Amendments of 1965).

When I was just 19 years old, I worked as an orderly in a suburban hospital in Harvey, Illinois in the industrial core of southern Cook County. I worked on the night shift, from 11:00 P.M. to 7:00 A.M. I vividly remember the summer of 1965, especially the difference between what was going on in the hospital in June compared to after Medicare and Medicaid went online on July 1. What we did not fully appreciate in June was that thousands of elderly and poor residents of the surrounding communities were waiting for their Medicare and Medicaid entitlements to become vehicles for receiving medical care that they put off because they couldn't afford to pay for it.

The halls and parking lot were nearly empty when I took my Fourth of July three-day break. When I returned to the hospital on July 6, it was a new world. The parking lot had a big tent for patient registration. The halls were stuffed with rented beds and all the rooms were full. We faced a shortage of staff, supplies, and space as these patients who were not insured before suddenly brought their medical problems to the door. It was an experience I will never forget. The critical importance of insurance coverage for communities and patients in need was suddenly crystal clear – this was a learning experience that affected my life then, and it still does now.

Medicare did more than just offer insurance to the elderly and selected groups with disabilities — much more. Medicare offered resources to turn community hospitals into teaching hospitals, so hundreds of hospitals began offering residency training to new physicians, and while

these young doctors were in training their salaries were covered by Medicare. This salary subsidy for teaching hospitals is alive and well today and has been a continuous source of revenue for teaching hospitals since 1965. Why would any hospital not seek to be a teaching hospital?

Hospitals needed to convert space into patient care rooms quickly. So, the hospital-based nursing schools moved to local colleges and universities nationwide, and the teaching spaces in hospitals became medical wards, laboratories, and medical supply rooms, increasing the inpatient capacity of local hospitals so that they could take on the flood of new patients. Nursing became a more widely recognized profession and not just an occupation that many women participated in before marriage and raising a family. Although non-hospital training of nurses began before WWII, the need for hospital space after Medicare's implementation accelerated the exit of such programs to community colleges and universities. The professionalism of nursing never looked back.

Nursing schools at academic centers evolved into degree-producing programs leading to B.S.N., Masters' degrees, and even Doctoral degrees over the next 20 years. With higher education and improved rigor in training, nurses demanded and received better compensation. Medicare resources made it possible because nursing salaries could be rolled into the daily cost of care in a hospital serving Medicare patients. Of course, the hospitals and employers have yet to properly or adequately compensate nurses compared to many other health professionals throughout the system (Lynaugh and Brush, 1996, 2008; Orsolini-Hain and Waters, 2009; Bullough, 2004).

Hospitals redefined the components and cost of hospitalization. Before Medicare, hospitals covered most institutional overhead costs through charities, gifts, and direct support from local cities, state and county governments. The cost of services with pre-Medicare hospitals was very modest compared to the sea-change that was set in motion in July 1965. Medicare regulatory documents defined billable costs for hospitals to provide consistent billing and reimbursement throughout the nation. These definitions allowed, even encouraged, hospitals to include the physical plant, heating, cooling, maintenance, food service, laundry, security, laboratory space, ventilation, air conditioning, maintenance equipment, and clinical care improvements such as surgical suites and salaries for non-clinical staff within the computation of daily charges. Suddenly, hospitals were directly compensated far beyond pre-Medicare levels for every day that a Medicare patient was in a bed. Medicare even paid for most autopsies. Hospital administrators quickly realized that keeping a hospital 100% occupied, especially with Medicare recipients, was a significant way to

increase institutional revenue. Private insurance companies quickly accepted the same fee schedules because their Medicare-eligible policy holders were already covered by Medicare for most of the costs. One of the reasons that the Medicare Program was passed by Congress was because Medicare became the first payer for people covered by Medicare plus private insurance like Blue Cross and Blue Shield.

This situation provided big money in places where such levels of compensation had never been seen before. Any illusion about the U.S. healthcare system being anything other than a publicly financed industry became mythical within months of Medicare and Medicaid going into effect in 1965. We have a hospital system that is largely composed of private institutions that are mostly financed by tax revenues through Medicare and Medicaid. It is even truer today than it was 57 years ago.

It could be argued that Medicare saved the private health insurance industry from becoming extinct. Because of improvements to healthcare, and especially the dramatic demographic impact of antibiotics after WWII, we were living longer, but not without chronic diseases that required hospital care. Cardiovascular and oncology services generated inpatient stays that could last for weeks. Long lengths of stay in a hospital can become very expensive, and anticipating the financial impact was on the minds of the private health insurance industry by 1960. The irony of better healthcare outcomes threatening the corporate bottom line of the private health insurance industry is only made more apparent by Medicare's rescue plan to the industry – they became the first payer for expensive patients with chronic diseases. Thanks to Medicare, the private insurance carriers paid a relatively modest proportion of costs that Medicare would not pay. The passage of Medicare must have put a smile on the face of every board member and stock holder associated with the private health insurance industry.

Medicare set a fee scale that permitted hospitals and physicians to set the price of services if prices were judged to be "fair and reasonable." These prices were published and it didn't take long for regional hospital finance officers to find out if they were under-charging for specific services and then adjust their prices accordingly. This led to persistent medical care cost inflation within the hospital sector. Also, admitting physicians (those with patient-admitting privileges in a hospital) determined the length of stay and could admit a Medicare patient "for observation" before there was any diagnosis or treatment plan. Under such ‘observation’, patients could remain in a hospital for days or even weeks without any clear diagnosis or planned medical intervention except tests and examinations. In one hospital I am familiar with there was always full status during the baseball World

Series in the fall. I remember a six-bed ward in this hospital during the World Series, with six men admitted for observation by their personal physicians, who spent their days watching the hospital-provided color TVs that they did not have at home. They were all discharged after the World Series was over and the hospital was paid by Medicare for all six beds. Today we might call this a Medi-Vacation. Physicians and hospitals were exploiting a public insurance program for very dubious reasons. The taxpayers covered the bill.

Far more physicians became specialists immediately after graduating from medical schools than before Medicare because residency training and teaching hospitals became widely available. Physicians could spend their careers paying attention to an increasingly narrower piece of the medical pie, increase their incomes, and be better able to contend with the vastly increasing medical research literature. The quality of medical care certainly improved, the medical science currency of physicians in their specialties improved, and there were suddenly far fewer general practitioners (GPs) and family doctors. This led to the lack of primary care physicians we still face today. And, by the way, hospitals that hosted residency training programs not only had Medicare paying the salaries of attending physicians (because they were in residency training programs), but also could increase the hospital's prices for day rates of patient care to cover the increased expenses to host the medical faculty and teaching resources. Most hospitals of any size sought ways to become teaching hospitals because the decision paid big dividends.

Fee-for-service schedules and the vastly increased frequency and length of hospitalizations made it impractical and financially silly for physicians to make house calls. A doctor could see ten patients in a visit to the hospital in the time it would take to travel and see one patient at their home. House calls largely vanished from medical practice. As a negative consequence, physicians' knowledge about lifestyles, home situations, and environmental and household risk factors like carpets that cause people to trip and fall no longer informed physicians about why patients became sick or injured unless the patients raised such issues at the clinic or in a hospital room. We still do not know enough about the influences of living situations to understand such factors for high-risk people and, therefore, we do little to prevent problems based on poor nutrition, falls, burns, a patient's lack of understanding about how to take prescription medications, and similar issues. The economics of medicine became more potent driving forces for how physicians communicated with patients than before the big money came into the equation. However, physicians greatly increased the number

of patients seen in a week. It was a tradeoff, and there would be many more in the years to come.

So, the situation became like this: Medicare (and Medicaid) suddenly and profoundly increased demand for medical services. Institutions and communities realized quickly that the capacity to address such increased demand was vastly inadequate. Medicare and Medicaid, as public insurance programs, pushed demand and the response was a flood of applications to the Hill-Burton program for new hospitals, increased capacity, renovation, and other kinds of brick-and-mortar growth. New construction, as evidenced by the cornerstones of thousands of hospitals, became symbols of civic pride in cities throughout the United States. Public tax money, via Hill-Burton, poured into communities to contend with the demand for medical care stimulated by public money via Medicare and Medicaid.

It was not recognized or defined as a problem because it demonstrated the pent-up demand for services by millions of people who needed care before Medicare and Medicaid but could not afford to pay for it and did not have private insurance. The populations left out during the rise of private, employer-based health insurance of the 1950s included most of the highest-risk groups of the population in terms of medical care — the poor and the elderly. Epidemiological determinants, aging, social factors associated with medical risks, and the influx of big money suddenly and profoundly redefined what hospitals and physicians did and how they were compensated.

No longer to be characterized as a mom-and-pop operation, medical care and hospitals in the United States became different kinds of institutions throughout society. During the 1950s and 1960s, the social environment glowed with the pride of growth, success, and the heralded images of organized medicine. Scientific discoveries, especially in medical science, were regularly featured on the front pages of newspapers and the evening TV news. This was a time in our society when the United States was a magnet for students and scholars from around the world. Universities were filled with eager minds who competed for discoveries, fame and fortune through medical science. Our medical scientists, the unprecedented enrollment of the baby boomers into colleges and universities, and the members of "The Greatest Generation", as coined by Tom Brokaw in 1998, who were now senior scientists and university professors, generated more science, more discovery, and more breakthroughs in less time than in any previous period in history. Open heart surgery, life support systems, new rehabilitation methods, and diagnostic technologies became routine news. Public attention was riveted to medical genius and scientific heroes.

Public opinion of medical science and medical professions surged as never before because discoveries in medical science worked and we began to see reductions in mortality from heart disease and many other conditions. Each new ‘good news day’ in medicine increased expectations by the public and increased the demand for services. Hill-Burton financing and Medicare were able, willing, and ready to respond, and these public financing sources vastly increased the capacity for medicine and hospitals. It was a golden moment. Medicare become the new financial bedrock of modern medical care and hospital care in the U.S. Medicare introduced the financial resources for unprecedented growth of the political and economic influence of the healthcare sector. The megasystem was born.