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# Health Care in the Early 1960s

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My topic, health care in the early 1960s, has a double set of meanings for me. I am a historian, and the 1960s are now "history," ripe for new interpretations. Yet I was also an immigrant to the United States in 1961, fresh from working as an administrator in the British National Health Service. The period immediately before the Medicare legislation in 1965 shines in my memory with the vividness of new impressions: those of a young health care student trying to make sense of the U. S. health care system, and indeed, of the United States.

The health care system and the United States as a society stand, in many ways, as proxy for each other, now as then: The whole tells you much about the part, and the part about the whole. In the early 1960s, health care was already a massive enterprise. By the late 1950s, hospitals employed far more people than the steel industry, the automobile industry, and interstate railroads. One of every eight Americans was admitted annually as an in-patient (Somers and Somers, 1961). To study health care, with all its contradictions and complexities, in the 1960s as in the present, is to explore the character and ambiguities of the United States itself, that vast, brash, divided yet curiously hopeful Nation.

On the face of it, the United States was a country blessed by plenty in the 1960s, with hospitals and professionals that were the envy of the world. Among the marvels of modern hospitals that provoked

comment from a visiting delegation from Britain in 1960 were complete air conditioning and artificial lighting systems, adjustable electric beds, carpets in private rooms, pass-through refrigerators in the kitchen, central milk kitchens, central sterile supply services, automatic X-ray processors, autoanalyzers in the laboratory, plastic bags for blood, identification bracelets for patients, pneumatic tube systems for communications and, not least, massive power plants (Hurst, 1960). In the United States, the hospital was readily compared with industrial corporations.

Yet the gaps and variations in both rhetoric and service were extraordinary. To the new migrant, the vast cross-continental network of superhighways appeared to connect cities—indeed swept through, around, or over them—without stopping to recognize their problems, character, or differences. Similarly, in both the larger society and the smaller domain of health services, there were searches for a unifying common purpose, overlying conflicts and ambiguities. Great leaders defined heroic, rallying causes: John F Kennedy, Lyndon Baines Johnson, Martin Luther King, Jr. Yet the structure and financing of the health system made little intuitive sense. More than 70 percent of the population had some form of hospital insurance by 1965 (though less than one-half of the elderly population did), 67 percent had surgical insurance, and there was a growing market for major medical insurance (Health Insurance Institute, 1980). But few were insured for primary or out-of-hospital care. Of the members of the general population who reported they had "pains in the heart," 25

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percent did not see a physician (Andersen and Anderson, 1967).

The elderly were particularly hard hit. The classic example of the proposed Medicare beneficiary was the elderly school-teacher, blameless after a career of work. "I am one of your old retired teachers that has been forgotten," went one story in congressional hearings in 1959:

I am 80 years old and for 10 years I have been living on a bare nothing, two meals a day, one egg, a soup, because I want to be independent.

I am of Scotch ancestry, my father fought in the Civil War to the end of the war, therefore, I have it in my blood to be independent and my dignity would not let me go down and be on welfare.

And I worked so hard that I have pernicious anemia, \$9.95 for a little bottle of liquid for shots, wholesale, I couldn't pay for it (Subcommittee on Problems of the Aged and Aging of the Committee of Labor and Public Welfare, 1959; Corning, 1969).

Members of the initial Medicare population, born in the late nineteenth century, had survived two world wars, a major economic depression, and enormous changes in the organization of work, mass production, rapid urbanization, and modern communications. As beneficiaries of the 1935 Social Security legislation, they were members of a culture of entitlement. By 1964, 83 percent of the population 65 years of age or over were eligible for Social Security benefits; and there were almost three times as many aged Social Security beneficiaries as there were 10 years earlier.<sup>1</sup> Yet before Medicare there were no entitlements

<sup>1</sup> Not all those who were eligible for benefits received them; the comparable figures were 63 percent in 1960 and 74 percent in 1964 (U.S. Department of Health, Education, and Welfare, 1965).

for the potentially catastrophic burdens of hospital and doctors' bills.

Government programs were segmented into programs designed for apparently "deserving" Americans, notably veterans and Federal employees, and for different categories of the poor, State by State, who were by definition "less deserving." Social class, like race, was a topic to which many health practitioners had as yet given little thought, although the topic had important ramifications, both for clinical practice and for national politics. As one contemporary doctor pointed out, "lower-class" patients were often dissatisfied with their medical care and "many of them would prefer government medicine" (Storrow, 1963). They were also, he wrote, easily angered, perhaps "physically aggressive when aroused," expected frustration from those in authority, and tended to behave in unexpected ways. But for the poor, the impersonality and rudeness of large hospitals were often deterring factors in seeking care at all. The rift between doctor and patient was evident, and nineteenth century attitudes toward poverty lingered among the more affluent in general. At least one-third of the population said, when polled in 1963, that an individual was personally responsible for his or her own poverty (Schiltz, 1970). By 1960 though, there were notable shifts toward medical care for those of retirement age. Recognizing the special economic needs of the elderly, the Kerr-Mills Act of 1960 established a new category of "medical indigence" for beneficiaries of Federal grants to the States for the elderly. Legislation for mental health in 1963 targeted another previously stigmatized group—a major step toward de-institutionalizing the mentally ill. The health system seemed full of exceptions, exclusions, and contradictions, while national leaders stressed high-sounding, unifying social principles.

John Kenneth Galbraith (1958) had come up with one apparently unifying argument when he labeled the United States "The Affluent Society." In theory, Americans were now all "middle-class consumers," with standard expectations. Television, the new vehicle of mass culture, celebrated modern medicine as part of a culture of consumerism. All three of the major television networks carried hospital dramas in the early 1960s, centering Americans in the fictional worlds of Doctor Kildare (NBC), Ben Casey (ABC), and the Nurses (CBS). The main issues for health policy in this context were to define needy groups as middle-class and to ensure that they could behave like middle-class consumers by having the means to do so, that is, by having adequate hospital insurance coverage, backed up where necessary by public assistance.

Yet, as sociologist Michael Harrington (1962) demonstrated eloquently in his own best-seller in 1962, the highest mass standard of living in the world was definitely not shared by all. There was "another America": 40 to 50 million citizens who were poor, who lacked adequate medical care, and who were "socially invisible" to the majority of the population. Within this poverty-stricken group were more than 8 million of the 18 million Americans who were 65 years of age and over, suffering from a "downward spiral" of sickness and isolation. And although there were half a million Americans in nursing homes, less than 60 percent of the homes were considered acceptable (Harrington, 1962). Medicare was formed in a society with idealistic expectations of wealth for all—at least for all of those who "deserved" it yet increasingly isolated its minorities and its poor.

There were evident rifts in American society in the early 1960s, by race, age, class, and gender. Demographic changes after World War II had created communities

filled with contrasts. The flight of relatively young, affluent, middle-class families to new suburbs created inner cities with disproportionate numbers of elderly and minority Americans. The stage was set for summers of racial violence, urban decay, and declining tax revenues for city schools, hospitals, and social services. In cities such as Newark, New Jersey, and Washington, DC, African-Americans represented a majority of the population by the early 1960s. Physicians migrated to the suburbs with other white-collar workers, leaving the hospital emergency room as a primary source of care for many urban dwellers. Emergency department visits increased by 16 million, or 175 percent, between 1954 and 1964, and the quality of care was often tenuous. Among the complaints: Physicians were overworked; they were reluctant to take on weekend and evening duty; and as suburbanites beset by worsening traffic conditions, they could not respond promptly to emergency calls (Silver, 1966).

Wider social rifts permeated the structure of health care and its institutions. These too were often socially "invisible"; that is, taken for granted and commented on rarely until the late 1950s. Herbert Klarman (1962) did a study of hospital patients in 1957 that described the rigid pattern of stratification and segregation by class and race in New York City. In New York's for-profit hospitals and in the private and semi-private accommodations of not-for-profit hospitals, patients designated "white" were virtually the only patients (97 percent and 96 percent, respectively). The wards of not-for-profit hospitals provided accommodations for poorer (or uninsured) members of society; here the proportion of white people was lower (66 percent). But in the municipal hospitals, the backbone of welfare medical care, the great majority of patients were Puerto Rican, African-American, and members of races other than

white (Klarman, 1962). In the South, there was formal racial segregation, although this was beginning to be challenged effectively. "Disease and Death Know No Race" proclaimed the signs carried by protesters at the Grady Hospital in Atlanta in 1962, where a group of African-Americans had taken over the lounge of the "whites-only" outpatient clinic (*Newsweek*, 1962).

The contrast between wish and reality (the wish for a truly Great Society and the reality of conflict and division) forms an essential first theme for understanding the years before Medicare. In effect, Medicare was to be a means of transforming the elderly into paying consumers of hospital services. Medicaid, with its continuing welfare stigma, was to cover those who were "indigent." Legislative proposals from the first Forand bill in 1957, through the Kennedy-Anderson proposals, to the signing of the Medicare legislation in July 1965, stressed the inability of the private market to meet the needs of older, retired Americans who could not afford medical care when they were sick, rather than the needs of all Americans who were uninsured. As a group, the elderly were significantly poorer than the working population, their medical needs were much greater, and insurance coverage, where it did exist, included only a minority of total health care costs.<sup>2</sup> Nevertheless, the elderly represented only a minority of all who were poor.

Medicare was thus to add to the paradoxical nature of insurance coverage. It was designed as socially unifying legislation in that it embraced all social classes on equal terms within one age group, in effect accepting them all as middle-class consumers.

<sup>2</sup> Across the population as a whole, insurance covered 33 percent of private consumer expenditures by 1964, up from 12 percent in 1950, skewed toward hospital care and surgical services. Of surgically treated patients 65 years of age or over who were discharged from short-stay hospitals in 1963-64, 55 percent of the surgeon's bill was paid partly or entirely by insurance (U.S. Bureau of the Census, 1966).

Yet it was also narrowly conceived and demographically selective, in that it singled out the elderly (and later the disabled and those with end stage renal disease) as a distinct and privileged population group. In short-and not surprisingly-Medicare reflected wider social ambiguities in U.S. attitudes to national unity, social class, and equal opportunity.

If one defining theme for the years before Medicare was the nature and concept of social entitlement, a second defining theme was the clear appreciation by the early 1960s that modern scientific medicine had brought serious technical, organizational, and financial problems in its wake. Anne and Herman Somers (1961), in an influential book published in 1961, highlighted the confusion that distinguished the health care system (and its portrayal in the press) in the early 1960s: "On the one hand, attention is called to increasing evidence of astounding progress: the discovery and application of cures, drugs and techniques, which can only be described as 'miracles.' On the other hand, there are constant allegations of inadequate medical care, of unfilled health needs among the American people, and apparently widespread discontent with various medical institutions" (Somers and Somers, 1961). Among these institutions were the professional associations, insurance plans, and hospitals.

Historian John Burnham (1982) has aptly called the period from the beginning of the 20th century up to the late 1950s "American medicine's golden age." The conquest of infectious diseases seemed near completion, and the promise of medical science continued to be compelling. Antibiotics had drastically reduced the dangers of pneumonia and other infectious diseases. By 1964 the United States was producing \$86 million worth of penicillin,

more than \$7 million worth of streptomycin, and almost \$7 million worth of the sulfa drugs. Tranquilizers were in widespread use; the sale of tranquilizers almost doubled between 1960 and 1964, from \$4 million to almost \$8 million. There was concern about their overuse (U.S. Bureau of the Census, 1966). Even for apparently intractable conditions, medical science held out considerable hope for cure. For example, it was estimated in the early 1960s that about one-third of cancer patients were free of disease 5 years after diagnosis, and it was thought that the percentage could be raised to one-half (Somers and Somers, 1961). Even mental illness seemed increasingly susceptible to treatment, for by the early 1960s, an array of mental illnesses was being treated by the new psychotropic drugs.

It was quite possible in the early 1960s to anticipate the changing focus in epidemiology from acute to chronic disease that we are grappling with today. However, from the perspective of the 1960s, the advantage of conceiving of chronic diseases as treatable along the same lines as acute conditions meant that the U.S. system of health services and health insurance (premised, as it was, on cure rather than on care of long-term, continuing sickness) need not be tampered with to fit the changing patterns of disease. Put a different way, if heart disease, cancer, and stroke could be "fixed," then the aggressive style of American medicine-science-based, disease-focused, technological, and interventionist-might be justified as a primary basis for national health policy in the future, as it had, successfully, in earlier decades without radical changes in the system. Further, the United States would be well advised to invest in biomedical research and ensure population access to hospital and specialist care, rather than worry about primary care, long-term services, and comprehensive

national health insurance. In essence, this was what Medicare was to do. Assuming the possibilities of cure in its acute, hospital-oriented focus, Medicare ratified the social value of curative medicine over the more tenuous possibilities of palliation and prevention. But there were other, more immediate reasons why Medicare was designed to be responsive to the technological and high-cost side of medicine rather than to chronic illness. Paramount concerns in the early 1960s were the financial needs of the expanding hospital system, and the pocketbook needs of the retired population. The debates that led up to Medicare focused almost entirely on providing income to hospitals and on easing the burdens (or lack) of hospital insurance for the elderly, especially for the Blue Cross plans, which were seriously concerned about coverage of this group.

Many of the changes in clinical medicine by the early 1960s were the result of pharmaceuticals: the antibiotics, psychotropics, tranquilizers, hormones, and other drugs. It was estimated that 90 percent of the drugs prescribed in 1960 had been introduced in the previous two decades, and that 40 percent of the prescriptions could not have been filled in 1954 (Somers and Somers, 1961). Americans' enthusiasm for producing and ingesting drugs was a marked feature of American medicine, compared with other countries. Drugs and other medical non-durables represented 20 percent of all private expenditures for health care in the United States in 1960, almost all spent out-of-pocket—that is, without insurance coverage.<sup>3</sup> A writer in the periodical *Saturday Review* stated a common belief of the early 1960s (and since) that the United States was the most overmedicated

<sup>3</sup> In 1990, in contrast, expenditures for drugs and other medical non-durables represented 14 percent of all private national health expenditures and 9 percent of total (private and governmental) health expenditures (Levit et al., 1994).

country in the world (Ratner, 1962).<sup>4</sup> However, drugs (which were largely ignored in Medicare) were relatively inexpensive, compared with the rapid development of hospital-based medicine. "With ingenious substitutes for human organs and bold experiments in transplants," proclaimed *Life* magazine, "man becomes a master mechanic-on himself" (*Life*, 1965). Kidney transplants were being performed by 1965, raising difficult questions of the harvesting and allocation of organs. So strong was the curative logic of renal dialysis and renal transplantation that Medicare was to be modified in 1972 to include them in a separate, yet extraordinary, new category of benefits, to be made available to beneficiaries of all ages.

But the most dramatic medical technologies focused on the heart. Reconstruction or total replacement of the aortic valve and ongoing experiments in heart surgery might, proclaimed the popular press, eventually lead to heart transplants (*Business Week*, 1961). Emergency care of heart attack patients was also receiving considerable attention. "Reversing death is perhaps the boldest feat of modern medicine," wrote one enthusiast in the *Saturday Evening Post* in 1961; once again, the goal was cure by intervention (Severino, 1961). Restarting the heart after the cease of heartbeat altogether or correcting for fibrillation through electrical stimulation-commonplace emergency procedures today-were exciting prospects in the early 1960s. Events such as the opening of a specialized cardiac center at the Peter Bent Brigham Hospital in Boston in 1965 were heralded in the national press. Reportedly, 30 percent of individuals suffering heart

<sup>4</sup> Ratner was quoted by Seymour E. Harris (1964) in a book that provides a good overview of the issues addressed in the well-publicized committee hearings under the chairmanship of Senator Estes Kefauver, which paid special attention to the large profits generated by the major drug companies in the late 1950s and early 1960s. Regulation of drugs was also an important issue, highlighted by the dispute over thalidomide in 1962.

attacks were then dying, not much different from a generation earlier (*Newsweek*, 1965). The growth of highly competent emergency medical technicians, trauma specialists, and emergency networks was largely in the future. Nevertheless, the promises of medical electronics in particular and bioengineering in general were clearly evident by the mid-1960s.

Except for the smallest hospitals, the intensive care unit was commonplace by the mid-1960s. Coronary care units were appearing, and there were premature nurseries, special respiratory units, and in the larger hospitals, units dealing with postoperative care after open-heart surgery and neurosurgery (Russell, 1979; Stevens, 1989). A writer in *The New Republic* wrote in 1963: "Today's hospital and yesterday's hospitals are both called hospitals, but otherwise the resemblance is coincidental (*The New Republic*, 1963)." The increasing intensity of hospital service was represented in steadily increasing staffing levels. The number of hospital personnel doubled between 1950 and 1964; in the latter year, there were 2.4 staff members per patient, for an average hospital stay of approximately 9 days-more than 2 weeks for those 65 years of age or over (U.S. Bureau of the Census, 1966). Death, as well as birth, typically occurred in a hospital; the great killers were heart disease, cancer, and stroke, accounting for well over two-thirds of all deaths in the mid-1960s (U.S. Bureau of the Census, 1966).

The messages of technological optimism that had distinguished American hospitals since the 1920s had focused on the relatively young and the acutely sick. The elderly, although represented to an increasing extent (an increasingly costly extent) in hospitals, were a minority of hospital patients in 1965: Almost 70 percent of all patients treated in short-stay hospitals were under 65 years of age (Stevens, 1989).

Even though the needs of the elderly were far greater than those of younger members of the population, the elderly were far less likely to carry insurance, and their numbers were rising steadily. Although there were still more children under 5 years of age than there were individuals 65 years of age or over in 1965, the latter group was growing fast while the birth rate was declining rapidly. Moreover, a majority of the more than 18 million Americans 65 years of age or over were women, whose life expectancy exceeded that of men (U.S. Bureau of the Census, 1966). The terms "young-old" and "old-old" had not yet come into currency, but for Americans who reached the age of 65, the prospects of an extended retirement were good: The average expectation of life at the age of 65 was 80, with women surviving in greater numbers than men. Lack of acceptable nursing home beds was becoming a serious problem as a greater proportion of the population survived into old age. Expenditures for nursing homes were rising rapidly, stimulated by the Federal-State Kerr-Mills program, which extended medical assistance to the aged.<sup>5</sup>

In the early 1960s, the choices for uninsured or underinsured elderly patients needing hospital service were to spend their savings, rely on funding from their children, seek welfare (and the social stigma this carried), hope for charity from the hospitals, or avoid care altogether. In parallel to the growing financial problem of hospital service for the elderly, though, the changing pattern of morbidity, away from acute episodes toward chronic diseases, was shifting attention to those with multiple conditions and long-term needs. By the early 1960s, the major causes for activity

limitation were heart conditions, arthritis, and rheumatism (U.S. Department of Health, Education, and Welfare, 1965).<sup>6</sup> As chronic diseases overtook acute illness as a focus of everyday experience, the need for hospital insurance became only one of many potentially expensive costs for the care of the chronically ill, including home care, nursing homes, and social, rehabilitative, and psychological support services.

To some extent Medicare can be seen as the response to the golden age of curative medicine, just as that age was passing from the scene. By the early 1960s, acute medical interventions in the face of chronic disease and death, although 'becoming commonplace, were questioned in the popular press. The hospital, seat of medical technology, was no longer isolated from question and criticism. "Is your hospital safe?" asked the journal *Good Housekeeping* in 1961, citing deficiencies uncovered by the Joint Commission on Accreditation of Hospitals. Each year, claimed the journal, "thousands of people go to hospitals where their lives are endangered by bad doctoring, unsanitary conditions or grim fire hazards. Or by a combination of the three" (Robinson, 1961). Surgery was a major focus of hospitals in the 1960s, accounting for more than one-third of all short-stay hospital admissions, yet less than one-half of all surgery was performed by board-certified specialists (Andersen and Anderson, 1967). "Is this operation necessary?" asked *The New Republic* (Lembke, 1963). "Should doctors tell the truth to cancer patients?" asked the *Ladies Home Journal* (1961). "What is the patient really trying to say?" asked *Time* (1964) magazine, on the need to improve doctor-patient communication. Specialists were reportedly less popular than general practitioners, but there was widespread concern about lack of time

<sup>5</sup> Expenditures for nursing homes represented 30 percent of payments to providers under public assistance in 1964. For the program of Medical Assistance for the Aged, more was being spent on long-term care than hospitalization (U.S. Department of Health, Education, and Welfare, 1965).

<sup>6</sup> For a good discussion of Federal policy in the face of the shift toward chronic conditions, see (Fox, 1993).

spent in the clinical encounter, and popular support of ongoing efforts to increase the national supply of physicians (Carter, 1961).

These concerns were joined by criticisms of widely varying standards of care: between hospitals; between cities and their suburbs, as the younger population migrated out of center-city, leaving the older and poorer population behind; and between broader geographical areas including States. But equally, at a time of acute concern about hospital costs, there seemed no case for unnecessary duplication of technology and facilities.

There were two possible models for reorganization of health care in the 1960s into a system that might more nearly meet the needs of changing morbidity on the one hand and the efficient deployment of expensive technology on the other. Unfortunately, neither was generally available. The first model would have been to develop self-contained service systems, that is, encourage the development of what we now call health maintenance organizations (HMOs) or managed care systems. However, even in the late 1960s, only 2 percent of the entire population were covered through prepaid group practice (renamed HMOs in 1970) (Stevens, 1971). A representative from the Kaiser Foundation Health Plan, Clifford H. Keene, argued during the Medicare hearings that Medicare would disadvantage the fledgling HMO movement by encouraging greater use of hospitals and nursing homes, and greater reliance on them than on other approaches to care. He was correct (Committee on Ways and Means, 1965). But it was difficult in the early 1960s to conceive of reforming the U.S. health care system in any model that was not based on hospitals, for this was a hospital-dominated system. There was not a strong primary care base on which to build comprehensive services that would include both acute and long-

term care. Nor was it generally appreciated in the 1960s how compelling the influence of insurance and other money flows would be (and was, to some extent) as the primary driver of the U. S. health care system.

The second possible vehicle for reorganization was communitywide planning, regulation, and priority-setting by government or quasi-government agencies. However, here the idiosyncratic structure of the U.S. hospital system militated against decentralized planning efforts that, summed together, would create a common pattern of services across the Nation. Hospitals were organized neither into a competitive profit oriented market, which might have achieved efficiencies through mergers and acquisitions, nor into a governmental system, which might have planned by fiat. Most hospitals were small, locally oriented institutions in the early 1960s; 3 out of 5 general hospitals had fewer than 100 beds. The traditional American "voluntary" or community hospital was a not-for-profit organization. Private support of local hospitals upheld, at least traditionally, the more general goals of social stability, community building, and charity-giving in the broadest sense. Through the 1950s and into the 1960s, voluntary (not-for-profit) hospitals consistently reported 70 percent of all short-term general hospital admissions, more than 70 percent of hospital expenses and personnel, and 75 percent of hospital assets. Of the 1.4 million employees in short-term hospitals in 1965, 1 million worked in the voluntary sector. Another million adults and teenagers worked as hospital volunteers, reinforcing allegiance to a specific community institution (Stevens, 1989). Hospitals represented a patchwork of virtually autonomous institutions, each with its own agenda and communities of interest. This was not a promising setting for organizational consolidation and priority-setting, let alone for the

development of comprehensive health services for the elderly (or others), geared to chronic disease and disability.

Federal policy, from 1945 through the implementation of Medicare, served, moreover, to reinforce this system. The most visible Federal grant programs were the Hill-Burton hospital construction program and funding for biomedical science through the National Institutes of Health. Legislation for university-based regional medical planning for heart disease, cancer, and stroke in 1965 (Public Law 89-239),<sup>7</sup> and for State and areawide "comprehensive health planning" in 1966 (Public Law 89-649),<sup>8</sup> were half-hearted, without teeth. These proposals suggested that professional and altruistic motivations would override institutional interests-based on the technocratic logic of forging connections between a tertiary specialty center and local hospitals (for regional planning), and on the nostalgic dream that communities would get together on a voluntary basis to organize services for the collective good (for the comprehensive agencies). The real engine for change lay in fact in third-party insurance payments.

University-centered regionalism was in vogue in the mid-1960s and was a proposal recommended by the Commission on Heart Disease, Cancer and Stroke set up by President Johnson in 1964, and led by Houston heart surgeon Michael E. DeBakey. The commission recommended regional hospital networks based on university health centers with their associated medical schools; there were 87 medical schools in the United States in 1964, though more were planned or under way. Under university-based regionalism, hospitals in outlying areas could be linked with more specialized institutions, with the tertiary university medical center at the core. In turn, patients could be referred to university superspecialists with their batteries of heart-lung machines, artificial kidneys, radioisotopes, and sophisticated radiology and drug-delivery systems. The proposals for regional medical programs were watered down in legislation of 1965 (Public Law 89-239), just as Medicare was in the process of passage. Their continuing legacy is today's area health education centers. For a good contemporary description of the issues, see Committee on Labor and Public Welfare, (1965).

<sup>7</sup> There were at least 150 such agencies by 1974, when they were replaced under new legislation (Public Law 93-641) by new health systems agencies. But these too were soon to die a quiet death, victims of lack of consensus and rival agendas at the State and local level, and an intrinsic lack of authority in the money-driven markets of the health system (see Stevens, 1989).

Conceived as a solution to protecting the pocketbooks of the elderly, Medicare was not designed to address the wider issues of universal insurance coverage, chronic illness, health care costs, and organization. In some ways, indeed, the passage of Medicare was based on avoidance of these issues. With relatively focused goals and strong supporters, Medicare offered equality of economic opportunity for the elderly in the insurance market for hospital and specialist services. It was to succeed, first, by being based on prevailing structures of private hospital and medical insurance and second, by being incorporated as an entitlement into the Social Security system.

A third ingredient of its successful passage was that Medicare was built on the historical (utilitarian) assumption that health insurance in the United States should be centered on the idea of work. From the very early debates about compulsory health insurance as labor legislation between 1915 and 1920, the idea of health insurance seemed inextricably connected to work in the United States. Indeed, Medicare reflected a continuity of interest among social insurance experts, including I.S. Falk and Wilbur Cohen, in building a system of government health insurance as part of the Social Security system-a system that was itself based on work. In the private system of health insurance that blossomed after World War II, as well, the workplace was a major focus for determining eligibility for specific packages of benefits, typically negotiated through employer-employee bargaining agreements. By 1960 it was plausible to argue that most working Americans would be covered, in the future, via workplace insurance arrangements. Medicare, too, was to be tied to the idea of work, designed for retired workers as an entitlement of the Social Security system.

Fourth, Medicare was predicated on the assumption that the private marketplace of insurance and providers needed to be supported by government. It was taken for granted in the early 1960s that the U.S. government must and would intervene in some way. The alternative to Medicare was not to throw the whole issue of coverage to the private sector but to seek workable forms of Federal intervention. These proposals ran the gamut from Federal subsidies of private insurance to a government program for the entire population.

Medicare, as a government program, protected the status quo of private insurance for the working population and continued to focus this insurance on the idea of work. It was thus to become an essential element in the United States' apparent commitment to a system of health insurance based on work. This commitment is much shakier now, in the 1990s, than it once was because of major changes in the job market. Nevertheless, the idea has had continuing appeal over the past 30 years. If the pattern-card of the Medicare beneficiary in the 1960s was the retired school-teacher, the image of the uninsured American in the 1990s is a worker or would-be worker who, like the elderly before Medicare, acts as a productive and responsible citizen in a culture based on work, but cannot find or afford adequate insurance.

But this is looking ahead, from the 1960s to the present. What can we conclude about health care in the early 1960s? One set of conclusions must be drawn from the continuing dialogue in the United States between the myth of (or aspirations for) a truly great, unified society and the multiple constituencies and conflicts that actually exist; notably, between the policy pulls for equal opportunity and the continuing bias against, fear of, and isolation of the poor. The debates preceding Medicare and Medicaid recognized two medically deprived

social classes in the United States, vested with different social values: one class (the elderly) was approved, the other (the indigent) barely tolerated. (The rift between the "deserving" and the "non-deserving" poor continues to this day in separate policy discussion about Medicare, Medicaid, and the uninsured. Indeed, given both the stigma and the structural constraints of welfare medicine in the United States, coverage of the uninsured will probably not be addressed through the other logical program of the 1960s, Medicaid.)

Second, many of the problems in medicine that were observed in the 1960s are still with us: lack of insurance (now chiefly among those of working age and children), and instances of professional or bureaucratic carelessness, inhumanity, economic misbehavior, excessive expectations, and still a general bias toward superspecialist rather than primary care. A major challenge in the 1990s is whether the current managed care movement, geared to the discipline of the market, will prove successful in providing comprehensive care. We are replaying, though in a very different context, some of the debates about the public and private sector that distinguished the Great Society years.

Third, and finally, Medicare was itself-and is-a paradox. On the one hand, it has provided untold benefits for millions of elderly and disabled Americans. Together with the civil rights legislation of 1964, Medicare stands as a lasting national commitment to equal opportunity. On the other hand, Medicare has camouflaged the wider issues for which the Great Society was supposed to find solutions: providing for the health coverage of all Americans, from acute sickness to chronic illness. We are still, in many ways, at the point we were in the early 1960s, for the underlying questions remain the same. The broader challenge for the 1990s, as for the 1960s, is how

well, and on what terms, an insurance system based both on private insurers and on the concept of work can provide optimal service to the whole population.

The question "What kind of a health system do we want?" can still be posed in the language of the 1960s: How great a society is the United States to be? There is much to celebrate on this 30-year birthday. And there is still much to do.

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