

CHAPTER 1

A BRIEF HISTORY OF THE DEVELOPMENT OF HEALTHCARE IN AMERICA

IMPORTANT TERMS

- Adverse selection
- Affordable Care Act
- Clinical integration
- Community rating
- Electronic health record (EHR)
- Employer-sponsored insurance (ESI)
- Germ theory
- Health maintenance organization (HMO)
- Hill-Burton Act
- Iron triangle
- Managed care organization (MCO)
- Medicaid
- Medicare
- National health expenditures (NHE)
- Social insurance
- Social Security Act of 1935

LEARNING OBJECTIVES

After reading this chapter, you will be able to do the following:

- Understand that the US healthcare system has evolved over time
- Understand the relationship between cost, quality, and access
- Understand the importance of germ theory to the development of the US healthcare system
- Understand the historical development of health insurance
- Understand that public policy decisions affect the healthcare system

CASE STUDY: THE HILL-BURTON ACT: A MAJOR LANDMARK

One of the monumental legacies in American healthcare is a little-known piece of legislation popularly referred to as “Hill-Burton.” Formally named the Hospital Survey and Construction Act, this bill was signed into law by President Truman on August 13, 1946. The Hill-Burton Act provided federal funding to states to build hospitals. The government distributed funds based on relative state wealth, such that poorer states received more money while wealthier states received less. Although construction of hospitals was part of Truman’s broader national health agenda, some members of Congress, on both sides of the aisle, saw this bill as an opportunity to “do something” about healthcare while cooling the ardor of those who espoused the provision of national health insurance coverage.

The significance of Hill-Burton, however, goes well beyond its model of bipartisanship; it also provided funding for the backbone of American healthcare. When Hill-Burton appropriations ended and some of the law’s provisions were folded into the Public Health Services Act in 1975, it had provided funding for more than 4,200 new hospitals and long-term care facilities. Most of these hospitals were located in poor communities or those with fewer than 10,000 people. For a hospital to receive the federal funds, the only stipulation was that it had to provide a certain amount of free care to those who could not otherwise afford it. Thus, Hill-Burton not only was a major impetus in building the infrastructure of American healthcare but also extended medical care to those who could not otherwise access it. The Hospital Survey and Construction Act of 1946 occupies a position in the pantheon of American healthcare policy initiatives similar to that of Medicare and Medicaid.

INTRODUCTION

People routinely describe the American health system as the best in the world. However, a number of questions should come to mind when we hear this declarative comment. First, does the United States really have a “health system”? Second, how does one define “the best in the world”? Does it have the best technology? Does it provide universal access to care? Does it provide the lowest-cost care? Is the access to and quality of care evenly distributed among all classes of our society? Finally, does the US health system provide high-quality care to the patient?

The answers to these questions are complex and compel us to ponder many variables. For now, a broad review of the US health system may be useful. What kind of “system” does the United States really have? And how did that healthcare system develop?

No one sat down and said, “Let’s design a health system.” The US healthcare system is the result of many economic and public policy outcomes sewn together like patchwork over roughly the past 240 years. Events of specific eras created certain economic or social conditions, to which the market and public policy makers responded. During one era,

additional government involvement might have seemed appropriate, while conditions in other eras may have evoked a greater embrace of private markets and traditional capitalism. Indeed, even within eras of waxing or waning government engagement, some elements of the health system were more appropriately left in the hands of the free market while other elements required scrutiny by public authorities. Looking at the US health system through the prism of history will help explain how the system developed and will provide a foundation to answer questions about how well it really works.

BEFORE THE 1860s

The provision of care today—the medicine and the venues—bear no resemblance to the delivery of care before the 1860s.

ALMSHOUSES AND CHARLATANS

Before the 1860s, hospitals were largely almshouses or places where people went because they could not get care at home. During this time, when a person fell ill, a family member or neighbor most frequently administered care in the home. Hospitals were enterprises established by a community's elite to provide charity care in the community for those who could not afford anything else. Most patients were residents of urban areas who could not pay for services and who suffered a wide variety of maladies. This era predates Louis Pasteur's germ theory and Joseph Lister's development of antiseptic procedures. Thus, hospitals were often not clean; it was common for patients to share a bed, and frequently there was a stench permeating every corner. There were no "unit" or "ward" distinctions: A person with typhus might be in the bed next to a person with an unstable compound fracture (Rosenberg 1995).

Physicians during this era were little more than snake oil vendors and charlatans. There was no real scientific foundation nor were there academic standards on which to claim the title of "medical doctor." It was an "open market," meaning that virtually anyone could get into the business of "healing." Barbers frequently provided something akin to medical services, using leeches sometimes in the belief that "leeching" blood from a patient would alleviate the illness. No licensure standards prevented people from rendering all manner of care from leeching to selling potent elixirs designed to "cure" a wide range of ailments (Starr, 1983).

ABSENCE OF STANDARDS

One poignant example of "care" in this tradition comes from the July 2, 1881 assassination of President James Garfield. The assassin shot Garfield in the Washington, DC, train station,

and the first doctor on the scene inserted his ungloved, unwashed finger into the bullet hole in search of the bullet, without success. Later, another physician used an unwashed probe for the same purpose (and with the same result). As the president lay suffering in the White House—because Garfield could receive care at his home, avoiding the hospital was imperative—he received brandy and morphine intermittently. His condition gradually worsened until he died two and a half months later, on September 19. Commentators have observed that Garfield likely would have survived the gunshot wound alone, as it did not involve any vital organs. The infection he contracted from his treatment is, ultimately, what killed him (Millard 2012).

During this era, medical schools were proprietary institutions with no uniform standards. There was no public investment in medical education, no authoritative governing bodies mandating curriculum standards, and, certainly, no experts who could be trusted to decide what topics should be taught.

In short, the delivery of care and the places in which that care took place were vastly different from one facility to the next. No agency or institution assured the public that such services would be effective. Patients turned to medicine out of personal belief amped up by the siren call of a panacea from the purveyor of an elixir on the town square. Healthcare was a crude combination of charity and chicanery with limited basis in science, often providing the illusion of hope rather than efficacious treatment.

GERM THEORY TO THE GREAT WAR

From the middle of the nineteenth century to beginning of the twentieth, several events combined to revolutionize medicine, thereby dramatically improving the delivery of healthcare in the United States.

GERMS AND EPIDEMIOLOGY

During the 1800s, medical science increased its understanding of the etiology of diseases—that is, their causes—and how diseases worked. Perhaps the best example is the story of Dr. John Snow, a London physician, who in 1854 uncovered the origins of cholera and, in the process, became the unofficial father of epidemiology.

Panic was widespread in mid-nineteenth-century London due to a series of seemingly random deaths throughout the capital. While London was quickly becoming a modern, industrialized metropolis, it still lacked the infrastructure needed to support its growing population. The accumulation of garbage in the streets and in the sewers that drained into the Thames River provided a perfect breeding ground for disease. Indeed, that is precisely what happened.

Because London did not provide a central water system, people obtained their drinking water from different companies throughout the city. One of the companies on the south

side provided water to customers through what residents called the Broad Street pump. Snow observed that a population of people living in the same area all suffered from this strange and fatal disease at a disproportionately high frequency. He investigated by going door to door to learn where residents obtained their water and concluded that residents using the Broad Street pump had intercepted a bacterium that caused cholera, later known as *vibrio cholera*. Residents were dumping sewage and other materials into the Thames, thus exposing people who used water downstream from that location to the toxic bacterium (Johnson 2006).

The prevailing theory before Snow's discovery was that the great foggy mist that frequently enveloped the city, referred to as a miasma, caused the disease. Such was the context for medicine at the time: It was an emerging science with relatively few believers. Snow's breakthrough, however, demonstrated that the science of medicine could provide answers to questions left unanswered by the chorus of faith-based adherents of the miasma theory.

EARLY "GERM"-RELATED SCIENCE

A decade after Snow's discovery, the work of the great French chemist Louis Pasteur, centering on microbes and fermentation, contributed to the growing **germ theory** of disease. Pasteur's eponymous method to eliminate contamination in milk—pasteurization—added to the body of thought about diseases and their origins. While Pasteur is not responsible for germ theory itself, his work provided scientific foundation to disprove the notion of "spontaneous generation": the impression that disease somehow spontaneously develops and spreads through the air. Pasteurization works by applying a mild heat to eliminate pathogens. Having thus shown how to eliminate germs, it was possible to prove that the existence of germs caused disease. Snow had already disproved the spontaneous generation theory regarding cholera; Pasteur's work made it possible to develop a more generalized theory on the way disease spread (Rosenberg 1995).

In 1867, a few years after Pasteur's findings were published, Joseph Lister, a Scottish surgeon, used the Frenchman's work as the foundation for developing methods to sterilize surgical instruments and patient wounds. As his technique became more widely adopted, it dramatically reduced hospital-based infections (Rutkow 2010). President Garfield certainly would have benefited from this technique had American physicians of the day not been so reluctant to embrace it (Millard 2012).

Germ theory

The theory stating that invisible micro-organisms invade the body to cause disease.

APPLICATION OF SCIENCE AND IMPROVEMENT IN MEDICAL EDUCATION

Contemporaneously in the United States, both "public health" (it was not called by that name at the time) and medical science advanced, though not at the same pace.

During the Civil War, the Union created the Sanitary Commission to help its army understand the nexus between disease and cure. The commission opened hospitals,

encouraged the use of antiseptic techniques, and provided its active soldiers and veterans other forms of support focused on health and hygiene (Stille 1866).

Meanwhile, the number of American medical schools and students grew. This development, combined with an increasing number of legitimate practitioners and the enactment of licensure laws to keep unwanted pretenders on the sidelines, helped medicine slowly but inexorably assume a position of moral authority across the healthcare landscape (Starr 1983). The growing use of effective antiseptic techniques further helped the medical profession improve its reputation and standing. Science became the core of medical education, and students undertook internships and residencies to hone their classroom knowledge into a workable, salable set of skills. Doctors became more available and gained a greater degree of respect and acceptance. Licensure requirements erected barriers to the profession, making the proverbial “snake oil” charlatan a relic. No longer could one sell their cornucopia of potions and elixirs by simply purporting to lead unsuspecting citizens to healthier conditions.

In 1904, the American Medical Association called for minimum standards in education. That inspired further debate and review about what constituted the appropriate training of a “doctor.” In 1910, the Flexner Report—published after a five-year study of medicine in the United States—concluded that medical education should include two years of science and two years of clinical training in hospitals. Further, the report recommended that medical schools affiliate with universities to advance the intellectual underpinnings of the science. As those developments continued, the proprietary schools began to vanish from the landscape because they could not afford the laboratories to support the science component of the curriculum (Flexner 1910).

All these developments combined to improve the quality of healthcare offered to and obtained by Americans. Providers were learning about the science of the human body, and medicine was thwarting the spread of disease or working to eliminate it based on scientific understanding. This gave rise to expanding access to more qualified and competent care.

BEGINNINGS OF INSTITUTIONALIZED HEALTHCARE: FROM WWI TO WWII

While science led to advancements in medicine and hospital care during the late nineteenth century, the early twentieth century saw significant developments in the process of delivering care and in the way providers were paid.

THE BEGINNING AND PROLIFERATION OF HEALTH INSURANCE

Health insurance took a significant step forward in 1929 when Baylor University Hospital provided Dallas school district teachers 21 days of hospital coverage for 50 cents per month. The teachers were prepaying for care they might or might not need at some point in the future. This was the birth of Blue Cross plans, in which hospitals provided coverage for

the insured (Buchmueller and Monnheit 2009). (Blue Shield, the counterpart insurance covering physician care, came a decade later in mining and lumber camps in the northwest United States; Lichtenstein 2012).

Still, commercial insurance companies at that time maintained their focus on life, property, and casualty and avoided health as a subject for coverage because they feared **adverse selection**, which occurs when healthy people do not purchase coverage. The commercial insurers worried that if only people who were sick bought insurance, rates would skyrocket because the costs of care would also be quite high. With no (or relatively few) healthy people in the pool to balance the risk, commercial insurers were reluctant to enter the market (Starr 1983).

The Baylor plan, however, was strictly not-for-profit and included *all* teachers, healthy and sick alike. In addition, everyone paid the same “premium,” 50 cents per month. That this occurred in 1929, the year the Great Depression began, is not a coincidence. As individuals started to avoid healthcare to save money, hospitals found they had vacant beds and declining revenue. By enrolling large numbers of teachers, the 50 cents per month per teacher provided Baylor University Hospital with much-needed cash while protecting the teachers from at least some of the costs associated with a potentially catastrophic illness or injury, thereby spreading the cost over a larger group of people with varying health statuses.

As this idea caught on, 25 states enacted laws permitting Blue Cross to operate as a charitable foundation and waived the normally significant financial reserve required of insurance companies. Other organizations across the United States emulated the plan, and ultimately sister organizations known as Blue Shield provided similar coverage for physician services. “The Blues” continued to insure millions of Americans using **community rating** through late in the twentieth century.

Community rating is the practice of providing health coverage for a group of individuals where everyone pays the same amount for the insurance regardless of age, health risk, gender, or source of employment. This concept lost some of its appeal as commercial insurers became more active in the market in the post-Depression period. Employers, anxious to manage costs, engaged commercial insurers as they began to adjust for risk among various groups. “Risk adjustment” means that insurance companies adjust the premiums based on the relative risk of illness striking members of the insured group. Thus, for example, insurance for coal miners is likely to cost more, because of their exposure to coal dust and pollution-filled air, than insurance for office workers, who do not engage in any potentially hazardous activity associated with their employment.

Adverse selection

The phenomenon that occurs when there is a disproportionate percentage of patients with greater-than-average need for medical and hospital care enrolling in an insurance plan.

Community rating

The process of establishing insurance premiums based on the average healthcare demands of an entire community or population without regard to any risk factors, resulting in identical premiums for every plan member regardless of age, gender, or other health risk.

THE IMPACT OF WORLD WAR II

World War II also became a major impetus that forever changed the landscape in financing healthcare services in the United States. Not only did the federal government become more directly involved in providing and financing healthcare, but its war-time policies inexorably set in motion a trend to expand health insurance coverage for Americans.

Social Security Act of 1935

Massive legislation that created direct federal benefits for American citizens in the form of cash payments to the elderly. The act also provided for unemployment insurance and worker's compensation for injured workers.

Medicare

The federal program that provides health insurance coverage for people older than 65. Medicare Part A covers hospital costs; Part B covers part of the cost of ambulatory care; Part C is a managed care alternative; and Part D provides a benefit for the partial expense of prescription drugs.

Employer-sponsored insurance (ESI)

Insurance plans for which the employer pays part of the premium for the benefit of the employee and sometimes their family members. The primary way Americans obtain health insurance.



THE IMPORTANCE OF THE SOCIAL SECURITY ACT

The federal government's role also dramatically changed during the time between the two world wars. As the malaise of the Great Depression gripped the US economy, people looked to government policy makers for solutions. One piece of legislation that forever changed the nature of the contract the American people had with their government was the **Social Security Act of 1935**.

As the Roosevelt administration prepared the legislation, drafters considered including provisions for national health insurance. Advisers close to Roosevelt, specifically Dr. Harvey Cushing, voiced opposition to that concept, parroting the American Medical Association. Thus, national health insurance never made it into even the draft of the Social Security legislation (Blumenthal and Morone 2010).

The importance of the Social Security Act, however, rests in its sweeping scope of old-age benefits for workers, benefits for victims of industrial accidents, unemployment insurance, aid for dependent children, and aid for the blind and the physically disabled. Implementation of some of these programs came through the states with federal financial support. Some, such as the direct benefits for retired workers, came directly from the federal government. For the first time, the federal government would provide benefits directly to individual citizens, in the form of Social Security payments.

The act in its entirety, especially the direct payments to retired workers, established a broad precedent for the federal government's direct involvement in the lives of individuals, most particularly for the enactment of both **Medicare** and **Medicaid** some 30 years later. (Medicare and Medicaid will be discussed in depth later.) The Social Security Act provided the bedrock for what would become the pantheon of federal social programs, including healthcare, that directly affect the lives and well-being of individual citizens.

Insurance became an attractive and popular negotiated benefit during World War II. The federal government imposed wage and price controls to avoid, for example, the makers of airplanes from raiding the employees of those companies making armaments. Thus, as wages were frozen, employers searched for alternative mechanisms to recruit and retain their labor force. Health insurance became that recruitment tool. This led to significant growth in **employer-sponsored insurance (ESI)**, which became the primary mechanism by which individual employees acquired insurance to cover the costs of their care.

World War II also was a time when the federal government became more directly involved in providing health insurance. Congress enacted medical coverage for women and children dependent on members of the armed services and expanded coverage for all military personnel (Starr 1983).

As the first half of the twentieth century ended, the stage was set for a new era in American society, and a new era for healthcare. The Social Security Act (see box) provided

direct benefits for the American people. The concept of health insurance was born. War forced employers to embrace the concept of health insurance as an additional benefit for employees, and the federal government took an active role in providing insurance for a particular class of citizens. Combined, these developments served as the foundation for an era of unprecedented growth in all elements that together form what we today call the American healthcare system.

THE POST-WAR ERA TO THE EARLY 1970s

The post-World War II era was a period of profound growth in most aspects of American life, including healthcare. While many think of the 1950s as a relatively tranquil time in American history, often using the phrase “peace and prosperity in our time,” it was in fact an era of unprecedented growth and the injection of new dynamics into American life (Halberstam 1993). With respect to health services delivery, this growth manifested itself in multiple ways.

HOSPITALS AND HILL-BURTON

When President Truman proposed a universal healthcare plan in early 1945 (see box), Republicans in Congress found an alternative in legislation to expand the availability of hospitals. Authored by Senators Lister Hill, a Democrat from Alabama, and Harold Burton, a Republican from Ohio, the plan rested in a Senate committee until it became a watered-down substitute to the Truman plan (Perlstadt 1995). The heart of the act authorized \$75 million annually for five years to build new hospitals or expand existing facilities. The legislation’s funding distribution formula especially helped rural and poorer states where hospitals were rare or nonexistent. It also set a policy goal of creating 4.5 beds per 1,000 people. Hospitals that accepted **Hill-Burton** funding were then obligated to provide a “reasonable” amount of care for indigent patients who could not afford to pay the full cost of care. Because of this provision, Hill-Burton became the first federal legislation aimed at providing healthcare services for the uninsured (Perlstadt 1995). Hill-Burton was also significant in that it relied on the concept of federal–state cost sharing, a concept that would be used in subsequent health-related initiatives.

The Hill-Burton Act had a long run, beginning in 1946, including significant amendments to include long-term care facilities, rehabilitation centers, and certain outpatient facilities. When funding for the act was terminated in 1975, Hill-Burton had underwritten the bulwark of modern US healthcare infrastructure. It had provided \$3.7 billion in federal funding, with \$9.1 billion in matched funding from state and local governments. During that time, state and local governments added more than 410,000 hospital beds to the system in more than 10,000 projects. Since 1980, Hill-Burton hospitals and other facilities have provided more than \$6 billion in uncompensated care for eligible patients (HRSA 2016).

Medicaid

A joint federal–state program that provides insurance coverage for those who cannot afford it. The federal government funds 50 to 75 percent of the costs and controls the broad parameters of the program, which is otherwise administered by the states. The formula that allocates the federal funds is inverse to the relative wealth of the state, meaning that poorer states receive more while richer states receive less.

Hill-Burton Act

Bipartisan legislation aimed at funding the growth of community hospitals in the United States.

INVESTING IN SCIENCE

The post-War era also was a time when the United States invested billions in health-related science, significantly increasing funding to the National Institutes of Health (NIH). During the 1950s and 1960s, appropriations to the NIH grew from \$52.7 million in 1950 to \$291.8 million in 1959 to more than \$1.1 billion a decade later (NIH n.d.). As a result, scientists and public health providers all but eradicated smallpox; introduced and widely disseminated an effective vaccine for polio; discovered new diseases; deployed new methods of imaging and diagnosis; and deployed new therapies. A small sample of discovery during this period includes the use of diagnostic ultrasound (1953); kidney transplant (1953); the antibiotic tetracycline (1955); the cardiac pacemaker (1958); hip replacement (1962); the first oral vaccine for polio (1962); and liver and lung transplants (1963). Science was advancing knowledge about human anatomy and physiology at an astounding rate, finding new ways to diagnose “new” diseases and developing new methods of treatment and prevention (Stevens 1999).

EXPANSION OF MEDICAL EDUCATION

During this same time, the number of medical schools, medical students, and related research also exploded. Much of the NIH funding mentioned previously was allocated to medical schools for advanced research related to disease causation and treatment. Likewise, the federal government invested in health education facilities. Opposition by the American Medical Association, attempting to protect the markets for existing medical practitioners, stalled federal engagement in the issue of direct aid for the expansion of medical education throughout the 1950s. In 1963, however, Congress passed the Health Education Facilities Act that started a stream of funding to open 54 more medical schools (44 allopathic and 10 osteopathic), before federal appropriations ended in 1980 (Cooper 2003). To further address the perceived shortage of doctors, in addition to new students enrolling in the new medical schools, enrollments in existing schools went from an average of 90 per class to 149. Subsequently, by 1980 there were 18,200 students matriculating in medical school compared to 8,250 in 1956 (Cooper 2003).

PROLIFERATION OF PRIVATE INSURANCE COVERAGE

In 1954, Congress codified what had been an existing practice: permitting employers to deduct from their tax liability the cost of employees’ health insurance premiums. Even though employer-sponsored health insurance had expanded dramatically during World War II, the tax treatment of the premiums paid by employers was uncertain. For the most part, employers relied on a series of private rulings from the Internal Revenue Service permitting

them to deduct the cost of premiums for employees' health coverage from their federal income tax. With the passage of the Revenue Act of 1954, however, federal law embedded favorable tax treatment for employers providing health insurance for employees. To this day that deduction remains in place as an incentive for employer-sponsored insurance (ESI). Likewise, the predominant way individuals have secured healthcare coverage has been through their employers. Despite this incentive, however, the ever-increasing cost of coverage has caused some employers to re-examine the value of this benefit. Over time, the percentage of Americans receiving health insurance coverage through their employer has diminished from 64.4 percent in 1994 to 58.3 percent in 2012 (Fronstin 2013). The growth in ESI, however, from the end of World War II to the early 1990s was noteworthy, providing the essential underpinning of the US system of financing healthcare (Blumenthal 2006). Exhibit 1.1 provides a snapshot of the history of growth in ESI.

IMPLEMENTATION OF MEDICARE AND MEDICAID

Universal healthcare coverage has been a policy goal for many people since early in the twentieth century. President Theodore Roosevelt first issued a call for social insurance when he observed that many people could not afford the costs of medical services (Starr 1983).

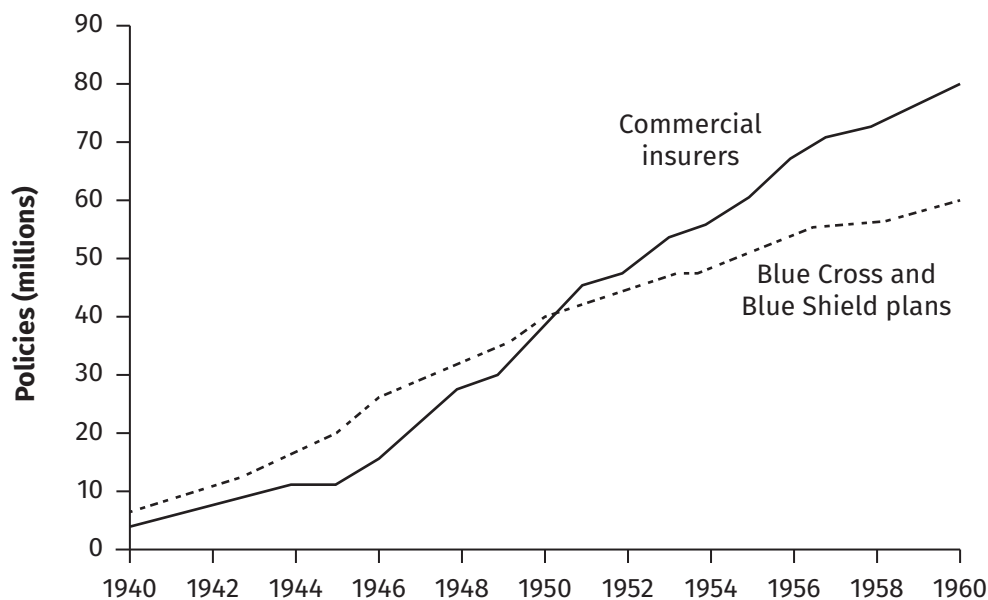


EXHIBIT 1.1
Enrollment in
Private Insurance in
the United States,
1940–1960

Source: Reprinted from Blumenthal (2006).

Likewise, as discussed earlier, President Franklin Roosevelt ruminated about creating national health insurance in 1934 and 1935. In 1946, President Truman also proposed creating national health insurance—again to no avail (Blumenthal and Morone 2010).

Each of these efforts cited the need for coverage or support because the costs of healthcare services were simply too great to bear for too many people. Invariably, assistance for the poor, elderly, and disabled was at the forefront in making the case for national health insurance. Moreover, while the proposals took several different forms, virtually all failed in the final analysis because healthcare policy was too complicated to explain or because the costs of the proposals were too great (Blumenthal and Morone 2010). Frequently, there were political considerations, such as when the Republican-controlled Congress of the Truman era passed Hill-Burton, in part to blunt the Truman administration's argument about the need for national healthcare coverage.

The recognition that costs were becoming too much to bear for some frequently was rooted in concern for the elderly. Specifically, in 1960, providing assistance with the cost of medical services for the part of the population that was both elderly and poor was the motivating factor behind legislation called “Medical Assistance for the Aged Act,” also known as Kerr-Mills for its two sponsors, Sen. Robert Kerr (D-OK) and Rep. Wilbur Mills (D-AR). This legislation included two important policy decisions. First, the bill created medical assistance for a newly classified group of people, the indigent elderly. The second critical concept, borrowing from Hill-Burton, was the implementation of a matching grant mechanism based on the relative wealth of the state. These concepts became the foundation for what would later become Medicaid (Moore 2005).

In 1964, the political landscape changed. In the wake of the November 1963 assassination of President John Kennedy, his successor Lyndon Johnson rode to victory on an enormous wave of popular support. The Democrats, in addition to controlling the presidency, controlled both houses of Congress by large margins. If ever there were an alignment of political constellations to move the healthcare coverage needle another step closer to universal coverage, this was the time. It was in this political climate that President Johnson and close congressional ally Wilbur Mills (D-AR), chairman (in those days it was “chairman,” not “chairperson”) of the House Ways and Means Committee, drove through the passage of Medicare and Medicaid. Like all things political, it was necessary to compromise on a number of provisions.

There were, in fact, three separate proposals grounded in different philosophies. One was a **social insurance** proposal mandating coverage for senior citizens. Social insurance takes its name from the concept that it protects individuals from hazards associated with conditions such as old age or unemployment. Coverage is for a particular class of people, paid for by employers and employees as mandated by the government. In other words, everyone pays for a benefit intended for a designated group of people. In this proposal, coverage would include hospitalization charges and physician costs only for inpatient care. In attempting to gain support for the bill, however, the sponsors limited coverage to those older than age 65.

Social insurance

A system of compulsory payments made by everyone to the government to provide assistance to a designated sub-set of the population for a specific service or set of services. Medicare Part A is a good example: Every employee and employer contributes to the Medicare Trust Fund through a taxing mechanism. Those funds are used to provide hospitalization benefits to everyone older than age 65.

A second proposal emanated from the concept of public assistance, meaning the government would provide coverage only to those who enrolled. The proposal called for coverage only of outpatient physician services. Tax revenues from all taxpayers would subsidize enrollees' premium payments to fund the program.

The third proposal came from the American Medical Association and was called Eldercare. This proposal would have expanded the then-existing Federal-State Medical Assistance for the Aged Program—the Kerr-Mills legislation referenced earlier—that provided a measure of support for the poorest members of the older-than-65 population.

While each of the three proposals competed with the other two, Mills combined them all under one bill to the extent possible. Medicare Part A was born from the first proposal, the social insurance concept. The second proposal—the public assistance option—became the foundation for Medicare Part B. And the third proposal became what we now know as Medicaid, a program funded by both the federal and state governments to provide health services for the indigent. None of this, of course, had much to do with anticipated future needs and expenditures. It had everything to do with political compromise (Myers 2000).

In the end, the Social Security Act of 1935 provided the legal vehicle for the 1965 passage of Medicare and Medicaid. Title XVIII of the Act is Medicare, while Medicaid has its legal nexus in Title XIX. Medicare and Medicaid were major expansions of the role the federal government plays in people's lives. As noted earlier, the Social Security Act set the policy precedent of the federal government providing a direct benefit to US citizens. Medicare and Medicaid represented expansions on that concept and provided two additional steps on the road to health coverage for all Americans.

Today, Medicare consumes 15 percent of the federal budget, while Medicaid commands 9 percent (Cubanski and Neuman 2018). Combined, they represent 37 percent of **national health expenditures** (NHE), which is everything Americans spend on healthcare (CMS 2016). These programs have become essential ingredients in the American healthcare system, and the long-term sustainability of each has been, and continues to be, a source of political debate. On average, Medicaid represents 25.6 percent of all state budgets, the largest single category of spending (NASBO 2015). Chapters 2 and 11 will address these programs in detail.

National health expenditures

An economic indicator showing the aggregate amount the United States spends on healthcare each year, frequently expressed as a percentage of the gross domestic product.

THE SUM OF POST-WAR EFFORTS

What might you expect to be the result if you (a) have more hospital beds, (b) more doctors with more areas of specialization, (c) improved diagnostic methods, (d) improved treatment methods, and (e) more widely available insurance? The result, of course, is the delivery of more and better (technologically speaking) healthcare to more people in more places than ever before. Not surprisingly, this translated into astronomical healthcare inflation. Both the cost of care in absolute dollar terms as well as the proportion of gross domestic product (GDP) dedicated to healthcare grew at exponential rates during the 1950s and 1960s.

Expenditures per capita expanded from \$147 in 1960 to \$356 in 1970 to \$1,112 in 1980 (Kaiser Family Foundation 2014). Medical inflation generally ranged from about 7 percent in 1960 to more than 14 percent in 1975 (CMS n.d.). These astounding increases presented policy makers with a renewed impetus to “do something” about healthcare costs.

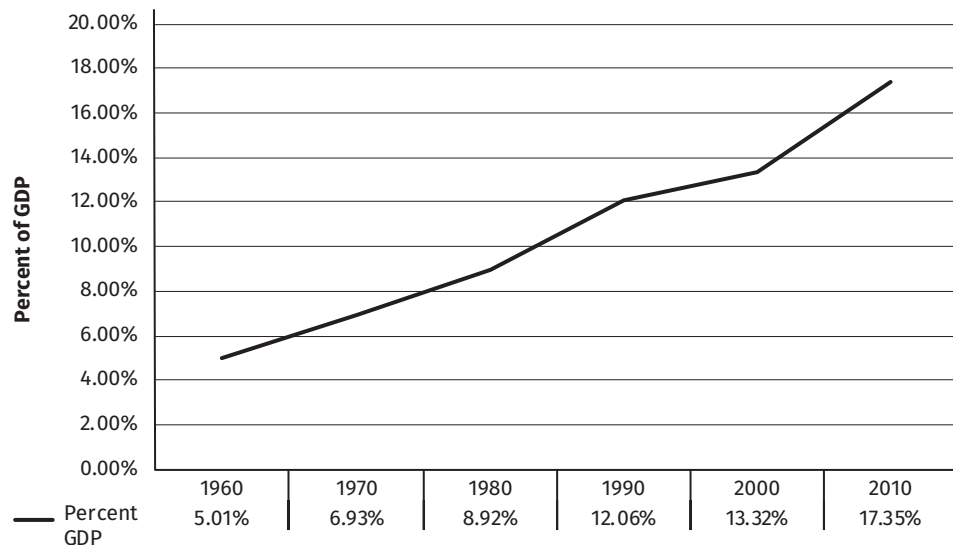
Exhibit 1.2 demonstrates the growth of NHE as a percentage of GDP. NHE includes all healthcare services spending from whatever source, so the graph includes Medicare, Medicaid, commercial insurance, private pay, over-the-counter purchases, and more. Every dollar of healthcare expenditure is included, so you can see the dramatic increase from 1960 onward.

This rampant inflation grabbed the attention of policy makers in the early 1970s, and it has remained a source of concern (and a political issue) ever since. While costs had previously been a motivator to provide coverage for various groups of citizens, overall costs in the system now became a separate, more general source of concern: How long could the country sustain medical inflation at these rates? Thus was born multiple initiatives to curb costs.

1970s TO THE AFFORDABLE CARE ACT

Earlier, we mentioned President Truman’s effort in 1946 to pass National Health Insurance. He was not the only US president to address this issue, but his proposal was the most expansive before the Affordable Care Act of 2010. During his term (1953–1961), President Eisenhower never tried to institute universal coverage; however, he maintained compassion

EXHIBIT 1.2
National Health
Expenditures as a
Percentage of GDP



Source: Adapted from CMS (n.d.).

for those confronting excessive healthcare costs. President Kennedy (1961–1963) wanted to expand the availability of healthcare services for more people, particularly in the form of Medicare. President Johnson (1963–1969) successfully sought coverage for the aged and the poor in Medicare and Medicaid, as discussed earlier. President Nixon (1969–1974) proposed mandates for employers and individuals to purchase insurance. And President Clinton (1993–2001) proposed universal coverage through “managed competition” of healthcare markets (Blumenthal and Morone 2010).

RESPONDING TO RAMPANT INFLATION: 1970s–1990s

Despite policy makers’ concerns about the dramatic increases in healthcare costs, they could not seem to control them. Medicare and Medicaid did not address the issue of national healthcare expenditures, but rather focused on ameliorating the impact of the cost of care on specific population groups, the elderly and the poor—and have become major contributors to national healthcare expenditures. Indeed, these two government programs have been among the leading causes of healthcare cost increases (CMS n.d.; Kaiser Family Foundation 2014).

As costs exploded throughout the 1970s and beyond, presidents and Congress have struggled, mostly without success, to tame the beast of medical inflation. President Nixon not only proposed insurance mandates, but also suggested the creation and expansion of **health maintenance organizations** (HMOs) as a way of managing costs while providing access to primary care. HMOs were ostensibly a way to limit aggregate spending in the system by restricting access to high-cost specialty care. Insurance companies paid providers a set fee, in advance, to provide care for individuals enrolled in the HMO. These HMOs engaged the primary care physician as a “gatekeeper” for the patient. (HMOs, along with their spinoff **managed care organizations** (MCOs), will be discussed in detail in chapter 11.) Simply stated, HMO patients could not access specialty care—at least specialty care that would be paid for by their insurance—without the prior referral of their physician. Likewise, some HMOs limited the number of primary care physicians available, so consumers were suddenly limited in their ability to choose their medical care. Consumers began to object to these limits, crescendoing in the late 1990s into a widespread and intense consumer backlash that moved the federal and state governments to pass a wide variety of patient protection acts (Sultz and Young 2014).

Health maintenance organization (HMO)

A healthcare providing organization that generally has a closed panel (limited number) of physicians (and other providers, including hospitals) that agrees to provide all the medical and hospital care an individual may need, for a fixed, predetermined fee.

Managed care organization (MCO)

A general term applied to a variety of organizations that provide services intended to reduce healthcare costs by managing access to care.

RESPONDING TO RAMPANT INFLATION: 1990s–2010

The next major push to realign the healthcare system and how it delivered services came during President Clinton’s first term. Before his election, Clinton’s political team had taken note of a US Senate special election campaign in Pennsylvania in 1991. Harris Wofford, a Democrat and the state’s insurance commissioner, defeated a much better funded, popular

Republican former governor and former US Attorney General, Richard Thornburgh. Wofford's signature line in the campaign: "If criminals have a right to a lawyer, I think working Americans should have the right to a doctor" (Johnson and Broder 1997, 60). It was a stunning upset that captured the attention of the Democratic party leadership as well as the man who would soon become president.

It also captured the attention of the George H. W. Bush administration, which before Wofford's win had been withholding its plan for healthcare reform. Because of Wofford's victory, however, and in an effort to upstage the Democrats as the 1992 presidential campaign took shape, President Bush and his team unveiled a Comprehensive Health Reform Program featuring tax credits and vouchers (Blumenthal and Morone 2010).

Yet after President Bush announced the plan in his 1992 State of the Union address, he never acted on it. Wofford's win moved healthcare access to the forefront of the presidential election of 1992. Governor Clinton campaigned on sweeping reform of the healthcare system, and after winning promised to have a healthcare reform proposal before Congress as one of his first initiatives (Blumenthal and Morone 2010; Johnson and Broder 1997).

Clinton appointed his wife, attorney Hillary Rodham Clinton, to chair the task force charged with developing a comprehensive reform of the American healthcare delivery system. The ultimate product was an initiative to encourage competition among health insurers, called managed competition. It was a massive upheaval of the insurance markets. Critics derided the proposal as a government takeover of healthcare. After months of debate, the beleaguered plan was withdrawn in the face of overwhelming opposition complicated by other issues on the political agenda (Johnson and Broder 1997).

After eight years in office, the Clinton administration gave way in 2001 to the presidency of George W. Bush without achieving the signature reform on which it had staked so much. The new administration, committed to leaner, less intrusive government, would not venture so far with regard to healthcare reform.

DEMOGRAPHIC CHANGES

Besides the intense political debate about rising healthcare costs and what to do about them, two significant demographic changes in the American population were creating an increasing demand for long-term care and chronic disease management.

The "baby boom" generation was aging and changing the population pyramid. Born between 1946 and 1964, this extraordinarily large cohort has had an indelible effect on American wants, needs, tastes, and culture. Exhibit 1.3 depicts the age and gender distribution of the US population in 1900, 1950, and 2000. Notice the dramatic growth in the cohorts ages 65 and older over the years. Notice also the dramatic growth in the "85+" age category in 2000: More people were living longer lives (US Census Bureau 2002). Furthermore, economic mobility meant more families were living farther apart; sons and daughters

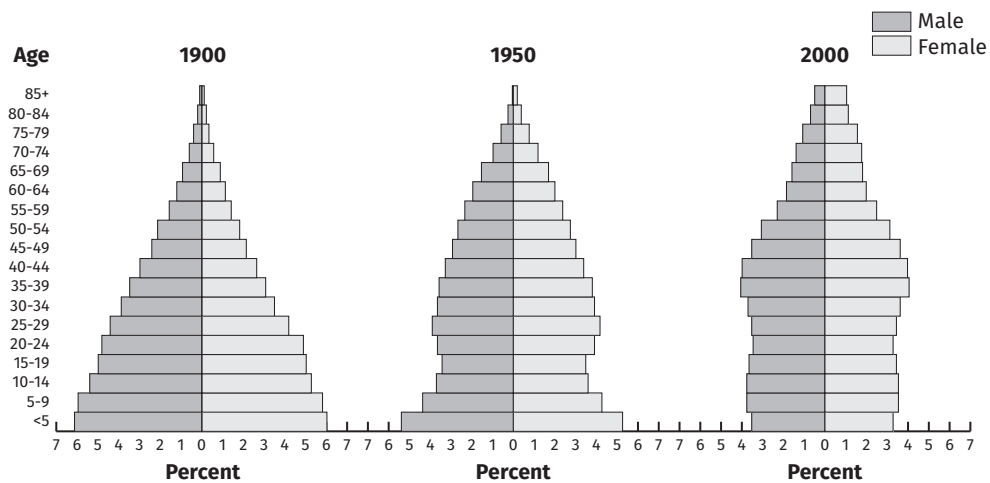


EXHIBIT 1.3
Age and Gender
Distribution of the
US Population in
1900, 1950, and
2000

Source: Reprinted from US Census Bureau (2002).

left home and moved to other regions of the country to pursue their own dreams, leaving aging relatives to seek help from strangers. “Nursing homes” started to change into “assisted living” and “long-term care” facilities to address the needs of an aging population whose families had dispersed to other parts of the United States.

The growth in the segment of the population of working age also created a greater demand for health insurance coverage. At the same time, there was massive growth in the biotechnology, medical device, and pharmaceutical industries. Money flowing into this “medical industrial complex,” combined with increased expenditures on health services by both government and private insurers, exacerbated the overall cost of healthcare coverage and forced employers to begin the process of reconsidering or scaling back the scope of their employee health plans (Rutkow 2010).

Another significant development during this era was the rise of for-profit hospital chains. Traditionally, hospitals had been not-for-profit charitable institutions that provided care for the very ill. As science advanced and improved hospitals’ quality of care and outcomes, the facilities began to charge for services. Increasingly, the hospital became a business. A number of entrepreneurs saw an opportunity to provide similar or better service at a lower cost. The for-profit chains were able to generate operational savings through economies of scale when purchasing goods and equipment. Thus, what had been a community service transitioned into a corporate enterprise (Stevens 1999).

The other significant trend that began during this time was hospital ownership of physician practices. Payment systems such as HMOs and preferred provider organizations had begun ratcheting down the number of specialty visits by requiring primary care providers to refer patients to specialists, in order to guarantee that insurers would cover these visits. As

this occurred with increasing frequency, hospitals began to acquire primary care practices in the hope of being on the receiving end of these referrals. In addition, hospitals found other ways to align physician practices to maximize referrals to specialists associated with *their* organizations. While this strategy had mixed results, it did presage a movement that would be central to the next wave of re-alignment in the healthcare system (Stevens 1999).

In terms of health policy during this time, President George W. Bush's initial priority was the enactment of tax cuts, which he largely achieved. The Bush administration eventually proposed—and Congress passed—the Medicare Modernization Act of 2003 (MMA). MMA provided the Medicare population a wholly new benefit: prescription drugs. Commonly known as “Part D,” the MMA was at that point the largest single change to Medicare in its 48-year history. Yet the act was controversial, in part because it did not fully pay for medications for seniors, instead creating a “donut hole” gap in coverage. Still, this was a sea change in extending the breadth of Medicare benefits to a new coverage area (Blumenthal and Morone 2010).

Like most of the health policy initiatives targeted at a particular population, the Medicare Modernization Act did little to offset the overall level of medical inflation. While it provided a measure of protection to older Americans against the impact of what was then the fastest growing cost in the healthcare market, prescription drugs, the MMA did not offer comprehensive initiatives with regard to overall costs. By the time President Obama took office in 2009, healthcare costs were a stunning 16 percent of the gross domestic product (CMS n.d.).

AFFORDABLE CARE ACT TO 2018

Affordable Care Act

Also known as the Patient Protection and Affordable Care Act, legislation that was promulgated by the Obama Administration to bring the United States one step closer to “universal coverage,” or insurance that covers everyone in the country.

President Obama signed the **Affordable Care Act** (ACA) into law on March 10, 2010, after a bitterly partisan political fight. Chapter 2 includes a more detailed discussion of the ACA and its key provisions, but note here that it represented another expansion of government into the healthcare system. As such, it ignited a heated and protracted debate.

From its introduction, controversy engulfed the ACA that ultimately became intensely partisan. Republicans decried the government “take over” of health care; government interference in the doctor-patient relationship, and the creation of “death panels” intended to control the rising cost of Medicare. There were no “death panels,” and the administration countered with the argument that the legislation would insure more people, improve quality of care and bend the cost curve (Dawes, 2016). Ultimately, legislation designated as the Patient Protection and Affordable Care Act (PPACA or ACA) passed on a straight party line vote in both houses of Congress. Indeed, in the Senate, the Democrat leadership invoked special rules that prevented Republicans from filibustering, further adding to the partisan acrimony.

Because, unlike Medicare and Medicaid, the ACA lacked bipartisan support, the Republican members of Congress have never fully embraced the law. Between 2010 and

2016, the House of Representatives recorded more than 50 votes to repeal the ACA. Largely these were symbolic measures with no practical effect beyond demonstrating the lack of political cohesion underlying the act.

Meanwhile, as the policy debate raged about the prospect of universal healthcare—or anything remotely resembling universal healthcare—the healthcare system itself continued to change in the way it delivered services. Some of these changes were a byproduct of reform efforts, while others were natural extensions of clinical measures already in place.

CLINICAL INTEGRATION AND TEAM-BASED CARE

The development of **electronic health records (EHRs)** facilitated the sharing of patient data across multiple providers. As the traditional “medical chart” morphed from paper to electronic format, it became a database that could be viewed from remote locations by different kinds of providers. Thus, the record of a patient hospitalized for a heart attack could be accessed by his or her primary care provider to review any clinical indicators. The ability to share information in this fashion and act on it is referred to as **clinical integration**. The concept aims to reduce medical errors by coordinating care among multiple providers, eliminating the risk of patients visiting multiple clinicians who might prescribe contraindicated medications or therapy.

Concomitant with this concept is the idea of *team-based care*, which also began to see an upsurge at the turn of the twenty-first century. In the inpatient setting, for example, such a care team might include a surgeon, the attending physician, a pharmacist, a nurse, a social worker, and a nutritionist. In the ambulatory setting, team-based care might include a physician, nurse, social worker, and navigator all working together to care for a patient. This holistic approach implicitly recognizes the need to address multiple systems in a single patient while treating one particular illness or trauma.

PAYMENT AND STRUCTURAL CHANGES

Payment and reimbursement strategies also emerged at the beginning of the twenty-first century, spurred by new legislative and administrative policy. These initiatives include pay for performance, also referred to as P4P, and bundled payments. These will be explained in depth in chapter 11; in brief, they ask providers to accept more of the risk in financing patient care by incentivizing them to be more efficient and effective in their services.

In addition to changes in the way care was delivered and how it was paid for, the structure and governance of healthcare systems began to change quickly. Mergers and acquisitions continued at a record pace. Healthcare systems became less centralized in a single local hospital and increasingly transformed into large multihospital systems that also provided care in a growing number of ambulatory centers. Chapter 3 will discuss this evolution in more detail.

Electronic health record (EHR)

A digital record of the care provided to a patient by a healthcare organization, including the patient's up-to-date, real time health-related information. When the record can be shared among multiple providers, it is said to have *interoperability*. Also called *electronic medical record*.

Clinical integration

The coordinated delivery of patient care by a team across conditions, providers, settings, and time to achieve high-quality care. Best effectuated by a common (electronic) health record to keep all providers informed.

HIGH TECH AND HIGH TOUCH

Amid these structural and payment changes was another change: the way care quality was measured. While the actual delivery of care was becoming more individualized and high-tech, down to the level of the patient's DNA, providers were being asked to focus on the health of whole populations. Reimbursement schemes, such as the accountable care organizations created with the Affordable Care Act, called for providers to improve the health of communities, not merely individual patients. Payers started to penalize readmissions, for example, prompting healthcare systems to spend more time and resources to manage the care of each patient, offering closer and closer follow-up—an approach known as “high touch.” Delivering medical care designed to prevent inpatient admissions and improve a community's overall health status became increasingly important, and hospitals decided that using beds more efficiently was more valuable than having more of them.

CONCLUSION

The next phase in the evolution of the US healthcare “system” is just beginning. As of this writing, in summer 2018, the Trump administration and the Republicans who control both houses of Congress have continued the healthcare debate, still focused on “repeal and replace” of the ACA. Once again, the notion of increasing market competition and reducing government involvement has moved to the top of the political agenda. It will be a significant challenge to repeal popular provisions of the ACA, such as ensuring coverage for those individuals with pre-existing medical conditions, or to eliminate coverage for those Americans who only recently received it. Time will tell whether the intensity of political engagement in the healthcare system is waxing or waning. The forces of “greater competition” argue that reducing government activity in the healthcare system is the path to true savings, while others maintain that greater free market influence will result in higher costs, poorer quality of care, and fewer Americans insured.

We began this chapter observing that throughout American history proponents of greater government engagement and supporters of free market mechanisms have debated their respective philosophies with varying degrees of success. Once again, Americans confront that philosophical choice. The outcome of the debate will influence how the US healthcare system delivers care, at what cost, and to whom. The public debate will address questions of equity: “How fairly is the care being distributed?” That same debate will also address questions of cost: “How much is enough?” And it will also address effectiveness: “How good is the care Americans receive?” Cost of care, quality of care, and access to care form the **iron triangle**. We will explore the inextricable linkage of these three concepts in the next chapter, and examine how public policy defines the US healthcare system.

Iron triangle

The interlocking relationships among the cost of care, its quality, and access to it.

MINI CASE STUDY

Bipartisan support for legislation is important to its long-term survival. Political scientists use the term “legitimacy” to refer to legislation that political actors from all parts of the spectrum support. In the context of Medicaid, Democrats were clearly in control of the presidency and both houses of Congress. President Johnson and his congressional allies developed the national agenda to include the extension of healthcare to segments of the population that could not afford to pay for medical services. In Congress, however, the Republicans eschewed the concept of government-funded healthcare in favor of private markets. On the Ways and Means Committee, Chairman Wilbur Mills, rather than leading efforts to defeat the Republican proposal to create premium-funded coverage, incorporated it as part of a larger legislative initiative. Thus was born Medicaid, as well as Part B of Medicare, a premium-based insurance covering ambulatory services for people older than age 65. It also created Medicare Part A, which is social insurance—that is, inpatient care funded through payroll taxes. By joining the two proposals together, Mills made it easier for Republicans to support Medicare and Medicaid, even if somewhat reluctantly. Consequently, the two systems have enjoyed a 50-year history of bipartisan support and have become a part of the fabric of American healthcare. (This is truer for Medicare than Medicaid, given the prevalence of older citizens to vote.)

Conversely, the Affordable Care Act passed in 2010 with votes exclusively from Democrats in both houses of Congress. While these majorities, along with President Obama’s signature, made the ACA the law of the land, what was then the minority party has never fully accepted the ACA. The Republicans mounted numerous repeal efforts and legal challenges, to no avail. These challenges have undermined the smooth implementation of the ACA. When the GOP next won control of Congress and the presidency, the assault on the ACA continued. In short, the act has never gained the “legitimacy” achieved by Medicare, remaining controversial and the target of vocal critics.

MINI CASE STUDY QUESTIONS

1. How did the bipartisan support for Medicare facilitate it becoming a critical part of the US healthcare system?
2. Provide a prognosis for the future of the ACA. What did you describe and why?
3. What might have happened had Wilbur Mills led the outright rejection of the Republican proposal?

POINTS TO REMEMBER

- The US healthcare system is the product of private market and public policy decisions made during the life of the country.

- Scientific development has been central to the types of healthcare services delivered by components of the healthcare system.
- “Germ theory” revolutionized the delivery of care in the United States.
- The Social Security Act fundamentally changed the social contract between the federal government and US citizens by establishing the precedent of federally sponsored services provided directly to individuals in the population.
- The federal government’s role in healthcare has grown during the course of history, but not consistently. Government engagement has waxed and waned over time.
- One example of federal government involvement in healthcare is the Hill-Burton Act, which supplied funding for the construction and expansion of hospitals.
- Medicare, Medicaid, and the Affordable Care Act are all examples of federal government engagement in the US healthcare delivery system.

CHALLENGE YOURSELF

1. Should the federal government’s role in the US healthcare system be greater than it is, or should it be less than it is? Explain why in either case.
2. Why is the “germ theory” of medicine still important today?
3. Other than generating a need for more long-term care facilities and organizations, what impact will the continuing aging of the population have on the healthcare system?

FOR YOUR CONSIDERATION

1. Research the trends regarding employer-sponsored insurance (ESI) from 1950 through 2000. What did you find? Explain how that trend might affect public policy as it relates to healthcare.
2. Research population trends. Look ahead 30 years, to when you will be in the prime of your career. What will the population graph look like then? Compare the number of people older than 65 to those between 18 and 64. What will this new population distribution mean for your career as a health services administrator?

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