



Meeting the 1950s Consumer Ideal in Health Care

Christy Chapin

The story of how private health interests allied to defeat president Harry Truman's proposal for federally financed universal care is well known. Additionally, scholars have demonstrated how conservatives and private health interests promoted the superiority of voluntary or private insurance in order to thwart such government programs. In this article, I advance these findings by demonstrating how politics and culture interacted to shape market institutions around a specific model of "private" health insurance that empowered insurance companies to become not only the primary financiers, but also the main supervisors and coordinators of health care.

During the first decades of the twentieth century, professional regulatory power enabled the American Medical Association (AMA) to thwart development and modernization in the health care market. State credentialing laws gave the AMA authority to have a physician's license revoked. Furthermore, doctors without AMA membership were generally denied hospital admitting privileges. The AMA used this power to frustrate health care financing experiments, including doctor groups or any form of insurance, whether managed by consumer groups, unions, or even physicians themselves. As America entered World War II, organized physicians continued to cling to solo practice and individual-patient financing as the best means of protecting themselves from corporate organization or lay supervision.

However, increasing threats of federal intervention in health care finally compelled AMA leaders to approve medical insurance. When World War II wage freezes and federal tax policy began encouraging businesses to purchase workers' medical benefits, insurance companies were the only

Christy Chapin <cf9b@virginia.edu> is a graduate student in history at the University of Virginia.

© Business History Conference, 2009. All rights reserved.

URL: <http://www.thebhc.org/publications/BEHonline/2009/chapin.pdf>.

organizations with the necessary financial reserves to fund health services for national employee groups.¹ Therefore, as private health interests allied to defeat Harry Truman's proposal for universal health care, they attempted to demonstrate the private market's superiority over government programs by promoting a specific model of voluntary insurance—policies financed by insurance companies.²

Commercial insurance companies assuaged physician fears about lay supervision by avoiding direct funding relationships with doctors. Commercial insurers transferred indemnity payments to subscribers and left them to settle their final bill with the physician. Under this system, physicians had the freedom to charge patients what they believed their services were worth. Nonprofit Blue Shield plans established an important precedent, however, when they created direct financing relationships with physicians and required them to accept fee schedule payments. The AMA allowed this direct third-party financing because constituent medical societies either established or, at a minimum, supervised Blue Shield programs.³

However, insurance companies also remained wary about third-party-funded health insurance. Underwriters worried about the high costs associated with moral hazard, because patients could request unnecessary care and physician autonomy precluded accountability to insurers. Doctors had little incentive to limit patient services and procedures because a distant corporation paid the bills. Commercial underwriters initially argued that due to moral hazard, health insurance should be

¹ For studies of government-funded welfare benefits delivered through private institutions see Christopher Howard, *The Hidden Welfare State* (Princeton, N.J., 1997); Jacob Hacker, *The Divided Welfare State* (New York, 2002); Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton, N.J., 2003); and Marie Gottschalk, *The Shadow Welfare State* (New York, 2000).

² For traditional narratives about the battle around Truman's plan see Monte M. Poen, *Harry Truman Versus the Medical Lobby: The Genesis of Medicare* (Columbia, Mo., 1979); Richard Harris, *A Sacred Trust: The Story of America's Most Powerful Lobby—Organized Medicine* (Baltimore, Md., 1969); Paul Starr, *The Social Transformation of American Medicine* (New York, 1982), 275-89.

³ In my dissertation, I demonstrate how insurers gained their market position for political reasons, through the AMA's state-empowered ability to prevent institutional development in health financing, and through federal policies that encouraged businesses to purchase employee benefits. Insurers did not gain their role through competitive market processes that sought to lower transaction costs. R. H. Coase, *The Nature of the Firm*, 2d ed. (New York, 1991); Oliver Williamson, *Economic Organization: Firms, Markets, and Policy Control* (New York, 1986). The 1954 Tax Revenue Act formalized the long-standing IRS (Internal Revenue Service) rule that permitted businesses to write off contributions toward employee benefits.

offered only to cover catastrophic costs, and they heavily marketed Major Medical policies to fill this role. Indeed, consumers were accustomed to purchasing automobile insurance on this model: subscriber received remuneration for damages only after paying a large deductible.

The inherent inefficiencies of third-party financing were so widely understood that policymakers, reformers, and health care observers questioned the ability of this model to provide reasonably priced insurance products to mass markets.⁴ Indeed, as health insurance spread during the late 1940s, the costs of medical care began to outpace all other categories of spending in the Consumer Price Index (CPI).

An untenable consumer ideal compounded cost problems. Health care reformers argued that the private market would never be able to mass produce reasonably priced, generous, insurance policies, and that only a universal, federal program could deliver comprehensive coverage at a low cost. By branding the private market a failure unless all Americans could cheaply purchase insurance to cover every conceivable health cost, reformers helped shape consumer desires. In a postwar Keynesian context in which policymakers sought to encourage consumption, even Republicans were somewhat receptive to this message.⁵

Certainly, the consumer ideal was not wholly cut from political cloth; political debates mixed with changing cultural conceptions about what

⁴ For example, see Margaret McKiever to Margaret C. Klem, "Statements on Voluntary Health Insurance Made at Hearings on S. 1606," 31 May 1946, Record Group (RG) 47, Social Security Administration, box 3, National Archives, College Park, Md.; I. S. Falk, " 'Old-Age and Survivors Hospitalization Insurance,' The Need for the Program," 25 June 1951, RG 47, Social Security Administration, box 38; Jerry Voorhis, "Money Spent Unwisely," March 1955, *Committee for the Nation's Health Information Letter*, Michael Davis Papers, reel 1, New York Academy of Medicine. Oscar Ewing, secretary of the Federal Security Agency under Truman, confidently predicted that private insurance would never cover more than half of U.S. citizens. U.S. Federal Security Agency, *The National Health, A Ten-Year Program: A Report to the President* (Washington, D.C., 1948), 7. Indeed, concerns about efficient health market organization date back to the 1932 report of the Committee on Costs of Medical Care's (CCMC). The CCMC recommended that physicians form groups around hospitals and underwrite their own insurance plans. However, the AMA rejected the majority report, because organized physicians feared that such plans would eventually permit either lay or government domination of doctor groups. See Lewis E. Weeks and Howard J. Berman, *Shapers of American Health Care Policy* (Ann Arbor, 1985), chap. 2.

⁵ Lizabeth Cohen, *A Consumer's Republic* (New York, 2003), chap. 3. Cohen demonstrates how both Democrats and Republicans supported public-private policies that encouraged citizens to consume, even though Republicans had a less expansive view of federal power than did many Democrats. Also see Alan Brinkley, *The End of Reform* (New York, 1995).

citizens needed to obtain the “good life.” Americans sought not only material products, but also intangibles such as free time and environmental beauty.⁶ In the case of health care, they wanted access to the latest therapeutic innovations. What *Time* magazine labeled the “revolution in U.S. medicine”—scientific advances that included radiation therapies, penicillin, sulfa drugs, and antibiotics—made medical services much more valuable than those physicians had offered their patients in previous decades.⁷ Moreover, the large presence of nonprofits in health insurance encouraged ideas about equity and generosity. Blue Cross, which underwrote hospital coverage as a parallel to Blue Shield’s coverage for physician services, had long championed a nonprofit ethos that promoted uniformly priced policies for all subscribers and generous, first-dollar service benefits. Because employers partially subsidized health benefits, labor leaders bargained for gold-plated health packages that included first- and last-dollar insurance for workers and their dependents. Americans’ increasing affluence combined with these factors to create a consumer ideal for expensive health financing products that covered a broad-range of medical services.

In order to make generous medical coverage widely available, moderate Republicans and Democrats offered “compromise” health care reform proposals throughout the 1950s. If these legislators hoped to avoid a universal, federally managed program, then they needed to prove that insurance was not just a high-end specialty product for the healthy and wealthy. These proposals demonstrate how most policymakers recognized that third-party financing of health care contained inherent cost problems. Scholars have overlooked how this understanding led private health interests to continue to face a threatening political environment well after the defeat of Truman’s reform program.⁸

⁶ Samuel P. Hays, *Beauty, Health and Permanence* (New York, 1987). Hays discusses how the postwar rise of affluence and urbanization led to a search for environmental well-being as part of the consumer movement. Susan Sessions Rugh, *Are We There Yet? The Golden Age of American Family Vacations* (Lawrence, Kansas, 2008).

⁷ “What the Doctor Ordered,” *Time*, 18 Aug. 1952; URL: <http://www.time.com/time/magazine/article/0,9171,816710,00.html>. Organized physicians helped fuel this consumer conception by trumpeting the advances of modern medicine as one reason that the government should not intervene in the market.

⁸ For traditional accounts that stress the willingness of Eisenhower-era politicians to accommodate private interests see Hacker, *Divided Welfare State*, 237-43; Starr, *The Social Transformation of American Medicine*, 335-47; Odin W. Anderson, *Health Services as a Growth Enterprise*, 2d ed. (Ann Arbor, 1990), 145-59. For the traditional narrative that costs became a political concern after Medicare’s passage, see Rashi Fein, *Medical Care, Medical Costs: The Search for a Health Insurance Policy*, 2nd ed. (Cambridge, Mass., 1989); Karen Davis et al.,

President Dwight Eisenhower proposed reinsurance legislation to compensate insurance companies for losses incurred from underwriting poor health risks such as the chronically ill or elderly. Insurance companies and physicians rationally feared that such a system would allow the federal government to become the ultimate underwriter and supervisor of health plans. Other legislators offered proposals to reorganize the private market around nonprofits or group practices that paid physicians with fixed salaries. The AMA, the Health Insurance Association of America (HIAA, which represented commercial insurers), and the Blue Shield Association allied to defeat such proposals.⁹

In order to prove the superiority of the existing market over government programs that attempted to rearrange the status quo, insurers and physicians sought to fulfill the consumer ideal constructed at the intersection of political debates and cultural conceptions. They therefore overcame their mutual suspicions and radically expanded health insurance. Between 1945 and 1965, the percentage of U.S. citizens with some type of health insurance coverage grew from less than 30 percent to almost 80 percent.¹⁰ The quality of coverage also improved vastly. During the 1940s, most health insurance subscribers had minimal benefits that partially covered hospital bills. Between 1950 and 1960, the number of persons with protection for out-of-hospital doctor services grew from 22 million to 88 million.¹¹ Ironically, the Major Medical policies that commercial insurers designed to reeducate consumers on the limits of insurance were simply layered over basic packages to create comprehensive first- and last-dollar protection.

As the campaign to provide the elderly with health benefits through Social Security heated up with the 1957 Forand bill, Blue Shield and HIAA members attempted to expand private insurance to cover the aged ahead of the government. Using state enabling laws, commercial firms pooled

Health Care Cost Containment (Baltimore, Md., 1990). Although some scholars blame technological advances for persistent increases in health costs, such analyses make technology a determining force, separate from the needs of businesses, providers, and patients. See for example David Mechanic, *The Growth of Bureaucratic Medicine* (New York, 1976); Sherry Glied, "Health Care Costs: On the Rise Again," *Journal of Economic Perspectives* 17, no. 2 (Spring 2003): 125-48. For a discussion of the importance of health care markets in relation to the efficient use of technology, see Victor Fuchs, *The Health Economy* (Boston, 1986), 29-31, 107.

⁹ While Blue Cross regularly lobbied the Eisenhower administration to support proposals that favored nonprofit coverage of the elderly and indigent, Blue Shield leaders fought such reforms. Blue Shield had to maintain a political alliance with the AMA in order to continue funding physicians' services.

¹⁰ *Source Book of Health Insurance Data* (New York, 1966), 10.

¹¹ *Source Book of Health Insurance Data* (New York, 1962), 10-11.

their resources to create experimental programs that marketed and sold policies to the elderly. Additionally, insurers increasingly allowed individuals with employee benefits to retain their policies upon retirement.¹² In three short years between 1958 and 1961, the number of elderly citizens with some form of health insurance more than doubled.¹³ Blue Shield and HIAA leaders also encouraged constituent plans and firms to extend policies to individual subscribers who presented greater underwriting risks than relatively healthy employee groups. While only about 10 percent of twenty-first century consumers buy insurance outside of employer-provided group coverage, individual purchasers made up about 30 percent of commercial insurance policyholders by the end of the 1950s.¹⁴

The political bargain to expand benefits shaped the economic institutions through which these transactions occurred. As insurance structured a larger portion of the health market, insurance companies and physicians constructed interlocking institutional mechanisms to negotiate their increasingly intimate financial relationships.

With health costs soaring well above all other goods categories in the CPI, insurers gradually introduced doctor controls. Hospitals and local medical societies created utilization review committees to ascertain if physicians properly treated insured patients. Insurers began requiring doctors to receive authorization before admitting patients to the hospital.¹⁵ Significantly, commercial firms began to copy Blue Shield payment methods by creating direct financing relationships with physicians instead of merely sending indemnity fees to subscribers.¹⁶ These direct funding

¹² Health Insurance Association of America, "Report of the Special Committee on Continuance of Coverage," June 1960, box 18, Orville Francis Grahame Collection, University of Iowa Special Collections and University Archives.

¹³ Health Insurance Association of America, "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen," Dec. 1961, box 22, Grahame Collection. The number of persons over 65 who owned some type of health insurance increased from 2.3 million to 4.75 million between 1958 and 1961.

¹⁴ *Source Book of Health Insurance Data* (New York, 1963), 13. Scholars highlighting the fact that the nonprofits, Blue Cross and Blue Shield, underwrote a larger proportion of high-risk subscribers than did commercial firms, tend to overlook how commercial companies also engaged in "nonprofit" activities to fulfill a political goal.

¹⁵ The finding that private interests established cost control mechanisms before Medicare contradicts standard health care accounts.

¹⁶ By 1965, approximately 30% of physicians accepted direct payment from commercial insurance companies. Although the AMA initially attempted to prevent these direct financing relationships, physicians found it easier and less expensive to collect fees directly from insurers, rather than individual patients.

linkages became crucial to the development of cost controls and physician regulation. Insurance companies still lacked the power to supervise physicians' work directly; however, the situation was analogous to the use of a fence. Before the passage of Medicare, insurers constructed a fence around doctors, but mostly left the gate open. After Medicare's passage, they began to close the gate more often.

The radical expansion of health insurance also altered the political concerns of HIAA and Blue Shield leaders and undermined their alliance with the AMA. After evaluating their financial experience with insurance for the elderly, underwriters became more receptive to federally financed benefits for the aged. While the HIAA and Blue Shield formally maintained allegiance to the AMA's campaign to defeat Medicare, insurance leaders failed to mount intense opposition to the legislation.

By designating insurers as the financial intermediaries between the federal government and physicians, Medicare further entrenched insurance companies in their position as the primary financiers and coordinators of health care. At its inception and as it developed, Medicare adopted the institutional underpinnings, including cost containment measures, that insurance companies created during the 1950s and early 1960s. In the decades after Medicare's passage, insurers and federal administrators further increased their oversight of physician decision-making in an attempt to rein in costs.

By 1970, political debates, federal legislation, and the drive to fulfill a consumer ideal of generous coverage pushed health care to develop around a high-cost corporate model. Under this system, physicians acted as highly professional "managers" whose interests continued to be at odds with those of third-party financiers: insurance companies.¹⁷ Between 1945 and 1970, federal policy and debates shaped medical operations and

¹⁷ For discussions of how the health system became corporate, see Starr, *Social Transformation of American Medicine*; David Dranove, *The Economic Evolution of American Health Care: From Marcus Welby to Managed Care* (Princeton, N.J., 2000); Anderson, *Health Services as a Growth Enterprise*. My work emphasizes how the corporate model was shaped in the public realm. Principal-agent literature examines how managers, who Alfred D. Chandler, Jr., found so important to U.S. business structure, often have goals that differ from those of stockholders and financiers. See Alfred D. Chandler, Jr., *The Visible Hand* (Cambridge, Mass., 1977); Daniel Raff and Peter Temin, "Business History and the Economic Theory," in *Inside the Business Enterprise: The Use and Transformation of Information*, ed. Peter Temin (Chicago, 1991); Roger Clarke and Tony McGuinness, eds., *The Economics of the Firm* (Oxford, England, 1987); and John W. Pratt and Richard J. Zeckhauser, eds., *Principals and Agents: The Structure of Business* (Boston, 1985). Also see Olivier Zunz, *Making American Corporate, 1870-1920* (Chicago, 1992).

insurance product design, thus positioning insurance companies at the center of a unique public-private system.¹⁸

¹⁸ Douglass C. North, *Institutions, Institutional Change, and Economic Performance* (New York, 1990); Paul A. David, "Why are Institutions the 'Carriers of History'? Path Dependency and the Evolution of Conventions, Organizations, and Institutions," *Structural Change and Economic Dynamics* 5, no. 2 (Dec. 1994): 205-20.