Citizen-Patient Power:

Health Care 'Consumers' and the Politics of Reform

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PREFACE AND ACKNOWLEDGEMENTS

Long has been the journey, from project inception to present completion. Over the last several years, many have had a hand in subtly shaping the course and substance of this dissertation, and many others besides managed to keep me halfway sane throughout the writing process. There are many people I will inadvertently exclude, but I shall try nonetheless to offer gratitude to as many as space (and memory) will allow.

Heartfelt thanks first go out to my advisor, James Morone. His passion for the politics of health care inspired me to offer my own contribution on the topic. He has, moreover, been by my side through thick and (often) thin, urging me on when my energy flagged, and doing all in his power to ensure successful completion of this endeavor. All he received in return were divers verbal expressions of gratitude, and the occasional weather forecast. Despite the present protests of spell check, we both know 'divers' to be a legitimate term.

I would not be writing this, or anything, for that matter, if it weren't for my parents. Through the years, their faith in my abilities has been an invaluable source of strength. I learned from them that one should never give up, no matter the obstacles. The completion of this dissertation is a testament to their unwavering support.

Also instrumental as a source of motivation, and inspiration, was my dearest Amy. She has helped fortify me throughout this lengthy process, and rarely passed up an opportunity to (helpfully) ask after the status of this dissertation. At last, I do believe I

can give her the definitive answer to her queries—the answer she sought all along…it is finished!

The hand of Jeremy Johnson is visible in many corners of this dissertation. He (somehow) managed to plow through each chapter, offering suggestions, and transmitting its key points to certain curious parties. The time spent these past two years writing dissertations together has almost been…dare I say it? Fun! Almost…

Quite fruitful indeed were the (oft) intellectual chats over coffee with good friends Tony dell'Aera and Juliette Rogers. When my pen threatened to run dry, or the printer cartridge ran low (figuratively speaking), they managed to put me back in a proper frame of mind—one more conducive to relevant intellectual tasks. The example of Emily Dietsch always made me want to be a better writer. Last but certainly not least, the staff of Blue State Coffee, moreover, is to be thanked for aiding in timely injections of caffeine.

During the course of completing this project, I lost two grandmothers who were very dear to me. The constant support offered by my grandmothers Kelm and Ehlke made this work possible. It is to them that I dedicate this piece.

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Chapter 1—INTRODUCTION and THEORETICAL FRAMEWORK

"I made my decision about what to do about prostate cancer in 2000....The statistics, as of the time I made the decision, are absolutely accurate and I stand by them....I said, 82 percent chance of survival in the United States in 2000, 44 percent chance of survival in England. [Actually] it's a 43 percent chance of survival in England back in 2000."[1]

This was the sentiment expressed by one-time front-running Republican presidential candidate Rudy Giuliani at a campaign stop in New Hampshire on 6 November 2007. The remark was much-commented upon by the media, divers campaign watchers and, perhaps most of all, the health policy commentariat. It seemed a compelling argument, if true. The only problem, it seemed, was that it was, at best, factually ambiguous and, at worst, downright dishonest.

Giuliani was hardly the only presidential candidate to put forth exaggerations and distortions during the course of the campaign. As the general election campaign approached its close, the two parties' nominees artificially inflated the amount most Americans would save in health spending if their respective plans were to be enacted. The McCain campaign, for instance, tended to emphasize the amount of the refundable

[1] Michael Dobbs, "The Fact Checker: Four Pinocchios for Recidivist Rudy," *Washington Post*, 7 November 2007, [online: http://blog.washingtonpost.com/fact-checker/2007/11/four_pinocchios_for_rudy_the_r.html], accessed 13 November 2007.

tax credit (cited as being 'effective cash') the candidate offered citizens.[1] The Obama campaign similarly stressed the economy of their plan, which would purportedly save health care purchasers 'as much as $2,500.'[2]

Conservation of citizens' hard-earned money was not the only area in which the two candidates' health plans exhibited a certain amount of resemblance. Both parties also avowed a concern for the continuation, if not expansion, of patients' choice of doctor and/or health insurance plan. Patient 'empowerment' begins in the introduction to the Obama-Biden plan, which seeks to reassure doubters by claiming that "…patients [would] be able to make health care decisions with their doctors, instead of being blocked by insurance company bureaucrats."[3] The McCain campaign also trumpeted the capacity of its health reform plan to foster choice (as well as expanding coverage), suggesting that "American families—not government bureaucrats or insurance companies—should choose the coverage that best fits their unique needs."[4] Republican and Democratic leaders, moreover, were not the only political figures singing the praises of the patient empowerment ideal.

I. State Serving Patients: Rise of the Empowered Citizen-Patient

"We want…patients more involved in their own health care with more choice and

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[1] "Straight Talk on Health System Reform," John McCain.com (campaign website), http://www.johnmccain.com/content/default.aspx?guid=8475c713-a541-4b97-a2aa-800e35da37bb, accessed 23 October 2008.
[2] "Health Care: Barack Obama and Joe Biden's Plan," Barack Obama.com, http://www.barackobama.com/issues/healthcare/, accessed 23 October 2008.
[3] *ibid.*
[4] Johnmccain.com

more control than ever before."[5] The preceding line could have been lifted verbatim from one of the two campaign websites cited above. Instead, they are to be found on the official website of the British Labour Party, and constitute a small portion of a recent party conference speech delivered by Labour leader, and British prime minister, Gordon Brown. Despite sharing few systemic characteristics to the health care edifice constructed over time in the United States, the British National Health Service has nonetheless been marked in recent years by strikingly similar calls for specific sorts of reform. This, moreover, is not the first time that impulses for change have coursed through both systems at similar periods, and in similar ways. Accounting for the near-simultaneity of (similarly-themed) health care system change across two very different systems is part of the riddle I seek to crack over the course of pages that follow.

At the heart of Anglo-American health reform, particularly that occurring over the course of the past two decades, has been the elevation of patient choice and associated freedoms, often above other important values. Long after the advent (and some might even say failure) of the market experiment in health reform, scholars and policymakers on both sides of the Atlantic continued to choice and systemic flexibility as desirable values. More broadly, such elites tended to speak the populist language of patient empowerment. This veritable movement has taken various forms, including a long-discussed 'Patient Bill of Rights' in the United States, and an 'NHS Constitution', in the United Kingdom.

There are multiple ways to interpret the recent stress on active patient participation in health care. One interpretation is decidedly cynical: political figures have

[5] "Gordon Brown Speaks to Conference," labour.org, http://www.labour.org.uk/gordon_brown_conference. accessed 23 October 2008.

shown enthusiasm for patient empowerment insofar as democratization shifts risk, and accountability, from the State to the individual patient. After all, the flip side of the empowerment coin is individual responsibility—the burden on the patient to seek out the most appropriate care given the resources at his or her disposal. While the British (or American) leaders could hardly remove themselves entirely from the field of health care, it could seek to score political points by appealing to the abstract ideal of patient democracy, while offloading further responsibility for any negative experience back on to the individual citizen cum patient.

In privatizing services, state and local governments across the United States have offloaded risk onto private firms.[6] Within commercial enterprises themselves, business leaders have shifted the burden of health care spending from employers to employees. Governments have, to some extent, been engaging in similar behavior, even while attempting to offer greater choice and flexibility in the process (and thus maintaining positive electoral performance). Even if patient democracy looks far better on paper than it translates into practice, it is impressions, and not necessarily facts, that drive voting behavior.

On the other hand, national political leaders could be embracing patient empowerment out of genuine faith in the potency of decentralized democracy, and the efficacy of expanding the democratic ideal to venues far removed from electoral contests. As early as 1988, British observers noted the "considerable interest" with which "consumerism, decentralization, and the extension of local democracy" was being viewed

[6] Jacob Hacker, *The Great Risk Shift: The Assault on American Jobs, Families, Health Care, and Retirement and How You Can Fight Back* (New York: Oxford University Press, 2006), ix.

by officials in local government and within the National Health Service, and the "exciting possibilities" these trends appeared to offer.[7]

A related argument holds that policymakers, having attempted numerous state-driven devices to improve the quality (and lower the cost) of care, are now attempting one of the few policy avenues that remain—decentralization of decision-making. Just as "the population at large has become increasingly able to voice its views regarding public service inadequacies," it has often had all the more reason to do so in recent decades.[8] While euphoria greeted the expansion of welfare programs in the United States (and United Kingdom) between the 1940s and 1960s, this soon gave way to frustration, as high expectations failed to be realized, and a global economic downturn prevented full funding of most such programs.[9] Having failed to spend each health dollar (or pound) in the most efficient manner, states are now striving to hand at least a few cents, and the purchasing decisions that go with them, back to the patient. Patient democracy, seen through this analytic lens, arose to a position of ascendance out of an utter lack of acceptable, time-tested policy alternatives.

The idea of endowing patients with greater power in the health care sector as a pragmatic measure in dire times fits particularly well within the context of the evolutionary nature of American social programs. Over the past century, after all, development of the American health care system has been highly improvisation and incremental, with government generally making small changes around the margins to

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[7] Robin Hambleton, "Consumerism, Decentralization, and Local Democracy," *Public Administration*, Vol. 66, No. 2 (1988), 125.
[8] Hambleton, 128.
[9] Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 380.

address perceived contemporary needs. Crucial developments have tended to be not the result of deliberate policy choices, but have instead constituted unanticipated consequences of decisions public and private.[10]

American political leaders and other health care stakeholders have drawn upon themes of patient empowerment and citizen choice as a means of making change in the health sector more palatable to the broad body of citizen-patients. While the information revolution has increased the quantity of information available to patients, and changes in the policy landscape have expanded the range of choice, in few cases does this represent an actual increase in the clout of the citizen-patient. Furthermore, I argue that the patient empowerment movement in the United Kingdom has served the function of legitimizing big-bang reform, and blunting any resultant political backlash against two parties committed to using health care as a means of winning votes.

II. The Recent Anglo-American Health Care Dialogue

Throughout the bulk of the twentieth century, and into the twenty-first, would-be health care reformers have held up the health care systems of other nations as potential models to guide the way forward. Perhaps predictably, this has led opponents of paint efforts to radically alter American health care as 'foreign,' and somehow un-American.[11]

The specific charge issued by Giuliani at the start of this chapter—namely, that British health care arrangements constitute 'socialized medicine,' is hardly a new one. As most major health reform packages in the United States have been put forward by

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[10] Michael D. Reagan, *The Accidental System: Health Care Policy in America* (Boulder, CO: Westview Press, 1999), 19.
[11] Robert Cunningham III and Robert Cunningham, Jr., *The Blues: A History of the Blue Cross and Blue Shield System* (Dekalb, IL: Northern Illinois University Press, 1997), 35-36.

those on the left of the American political spectrum, the 'socialist' taint has been a powerful tool in the arsenal of (mainly conservative) defenders of the health care status quo.[12] Despite characterizations by opponents, contemporary health care reformers, and almost without exception, envision a continued (prominent) role for the market in American medicine.[13]

Indeed, health reform in the United States over the past several decades has generally taken the form of 'managed competition,' in which the State role in health care is largely limited to that of referee supervising private providers and payers.[14] Tellingly, the same Clinton-era reforms that drew vehement opposition from Republicans in Congress, small businesses, and insurers were based on principles that had guided a rightwing British prime minister, Margaret Thatcher, toward overhaul of that country's popular National Health Service (NHS). While American health care reformers on the political Left have borrowed heavily from European systems, British proponents of change have looked to the United States as a model—despite the widespread feeling on this side of the Atlantic Ocean that the nation's health care has, if ever it did function properly, simply stopped working.

In the years since the imposition of the first round of Thatcherite health reform in 1990, certain sectors of the British populace have begun to note the irony—that a seemingly bankrupt health care system has been drawn upon to alter a native system that

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[12] See, particularly, Jill Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance* (New York: Oxford University Press, 2005), 31-33.
[13] Quadagno, 207.
[14] Cunningham and Cunningham, 242-244.

nearly all would agree embodies considerable virtues.[15] A recent column in the left-leaning *Guardian* recently found fit to take up this theme.[16] The web site was deluged with responses from readers on both sides of the Atlantic. While the piece itself could be printed in just a bit over a single page, the comments appearing thereafter continued on numerous pages—a particularly impressive level of output, considering each was no greater than a few lines to a paragraph in length.[17]

The situation on both sides of the Atlantic is not exactly comparable, though. It is true that British health care reformers from the political right and center have drawn on American concepts to structure change, drawing charges from opponents that they are thus imposing foreign inefficiency on the NHS. To an extent, however, this is a mirror image of the American health care debate, in which leftist reforms inspired, in part, by European single-payer systems are opposed by forces on the right, which fear the import of foreign mediocrity to the 'high-quality' care options available in the United States.[18] The parallels break down a bit, however, when one considers that left-wing critics of British reform efforts are effectively reduced to mourning a long-lost, ideal-type NHS that has changed much since the opening of the 1990 Thatcher reforms.[19]

American critics of reform, however, arguably have a far easier task before them. Though the 2008 presidential campaign appears to be highlighting widespread popular

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[15] See, for instance, Anatole Kaletsky, "Gordon Brown's Sacred Cows Loom into View," *The Times of London*, 6 February 2003, 20.
[16] Suemas Milne, "Only Dogma and Corporate Capture Can Explain This," *Guardian*, 18 October 2007, 33. The printed online version of this opinion piece contained at least 54 pages of reader comments.
[17] British respondents were generally concerned about the continued seepage of American ideas (and corporate culture) into the very core of the NHS. Many Americans offered warnings of just the sorts of negative outcomes that could precipitate.
[18] Quadagno, 31.
[19] See, for instance, John Gray, "We Trusted This Country. Look How It Treats Us," *Guardian*, 10 February 2008, 33.

discontent over the present shape of the health care system, opponents of change know this is not the first time the constellations have appeared aligned in favor of change. A similar thirst for radical reform appeared to gather pace in the early 1990's, after all, giving rise to the first major presidential health care overhaul plan since at least the Johnson administration, if not the days of Truman.[20] As numerous social scientists have shown, dramatic change is difficult to achieve in the American political system, and requires a very unique set of favorable circumstances.[21] The failure of the 1994 Clinton Health Security Plan confirmed that thesis. Reformers were only partly redeemed when the marketplace accomplished some of the very changes sought by proponents of the Clinton plan.[22]

If the American political system is, in both design and practice, geared toward conservatism and only the most incremental of change, the British political system seems, by comparison, built for the exclusive purpose of fostering continual change.[23] Though the two nations are today often lumped together as the 'Anglo-Saxon countries,' their respective governing arrangements deliver far different outcomes in comparable situations.[24] The presence of a traditional diplomatic 'special relationship,' moreover, has not stopped politicians (and presidential aspirants) like Rudolph Giuliani from effectively demonizing the bold changes that issue forth from the British political system.

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[20] Quadagno, 184-185.
[21] To see why this is the case, one can go back to Louis Hartz's *The Liberal Tradition in America* and, indeed, all the way back to the works of Alexis de Tocqueville.
[22] Mary Ruggie, *Realignments in the Welfare State: Health Policy in the United States, Britain, and Canada* (New York: Columbia University Press, 1996), 215.
[23] R. Kent Weaver and Bert A. Rockman, *Do Institutions Matter? Government Capabilities in the United States and Abroad* (Washington, DC: Brookings Institution Press, 1993), 371.
[24] A new work, Walter Russell Mead's *God and Gold* (2007), seeks to show how the Anglo-Saxon powers are unique among the countries of the world, and how their ideas and ideals have, in large part, shaped the parameters of the modern world system.

The British parliamentary system of government, combined with its first-past-the-post electoral system, often breeds large government majorities. A strong tradition of party discipline, moreover, ensures that much of the government program, whether conservative or radical, is passed.[25] On a legislative level, then, it was a relatively simple task to pass health care reform in 1990, as it was to bring the NHS into being in 1946. That is not to say that radical changes face not a single obstacle. The obstacles, where they exist, are simply not to be found in parliament. In the case of health care and other public services, would-be reformer members of government must contend not with conservative parliamentarians, but champions of the status quo within the cabinet. Health reformers within government must thus be concerned by the reception granted to reform suggestions by NHS employees—doctors, nurses, and other such figures. Even if greeted with a chilly response on the part of these front-line workers, however, government reformers are still likely to enact change—the question, in such a case, is whether reform can be effectively implemented.

Since 1990, numerous rounds of reform have been passed, and implemented, at all levels of the NHS. Public opinion, nonetheless, remains ambivalent. Partly as a result of the tempo of reform, the British public is generally uncertain as to what to make of NHS reform.[26] To the extent that they are seen to resemble American arrangements, some Britons have voiced strong disapproval. Momentum for further fundamental reform nonetheless remains. This leads one to question just why reform proposals

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[25] Ironically, increased partisanship has, according to a recent column in the *Economist*, transformed the U.S. Congress into a veritable parliament—particularly in terms of party discipline. Slim legislative majorities, however, and divided government ensure that the policy status quo is rarely threatened. ("Lexington," 17-23 November 2007).

[26] "Confusion Over Health Bodies," (British) Local Government Association: FirstOnline, (online: http://www.lga.gov.uk/lga/core/page.do?pageId=727497), accessed 29 October 2008.

issuing forth from a seemingly failed health care system (that of the United States) have been pushed by successive governments of both the political Right and Left. Moreover, why have similar reform proposals been unveiled on both sides of the Atlantic, within health care systems that could hardly be more different? Furthermore, why have two nations sharing a common political culture hatched these highly divergent schemes of health care? Are governing arrangements the exclusive variables producing this rather counterintuitive outcome, or are there other forces at work? Given early divergence of health care structures, moreover, why has the lexicon of patient choice and empowerment become lingua franca in both countries and, indeed, beyond?

III. Bringing the Citizen-Patient Back In

It is these questions that this dissertation seeks to answer. Several recent works have offered comparisons (and contrasts) between the American and British health care systems, and to these works and authors I am highly indebted. Moreover, some have explored the similar market dynamics driving the systems in recent years, a theme I will also treat at some length. I strive to take the analysis further, however, by showing how a group I will call 'citizen-patients' has helped determine the shape of the respective health care systems from the start, and how the interaction of this important, but often overlooked, stakeholder population with other key players to yield oft unique, but occasionally similar outcomes, within the contexts of the United States and United Kingdom.

Who are citizen-patients? They can be just about anyone within a given polity. Each and every one of us can (and most have) find/found ourselves in the position of

patient when ill or injured. This broad interest grouping is thus highly fluid over time, with the composition changing as some fall ill, and others recover. It is less stable than most political constituencies. Nonetheless, the way the potential body of patients relates to, and is treated by the state and other key players in the health sector can have significant bearing on the structuring and arrangement of care.

Citizen-patients have played an active role in shaping the British health care system, with involvement commencing at an early date. The so-called friendly societies catering to British workers were effectively early patient advocacy groups. Composed mainly of those in the fast-expanding laboring class, these societies were run by individuals who drove hard bargains with the medical profession on behalf of their citizen-patient constituency.[27] Friendly societies contracted with physicians during much of the nineteenth century and into the twentieth. In an era in which medical science had advanced little since the Middle Ages, and a visit to a hospital could prove risky at best, physicians desperate for the guaranteed business entered into occasionally-exploitative working relationships with the societies.

The friendly societies established an early tradition of (indirect) 'consumer' intervention in determining the shape of health care arrangements in Britain. Physicians pressured into accepting low wages eventually came to view the State as potential agent of salvation from the societies.[28] Thus facing consumer pressures, if not dominance, the

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[27] Anders Brandstrom, "Sick, Not Dead: The Health of British Workingmen During the Mortality Decline" (Book Review), *Journal of Social History*, Vol. 32, Issue 2 (Winter 1998), online: http://findarticles.com/p/articles/mi_m2005/is_/ai_53449354 Accessed 29 October 2008.

[28] Jane Lewis, "Providers, 'Consumers', the State and the Delivery of Health Care Services in Twentieth-Century Britain," in Andrew Wear, ed., *Medicine in Society: Historical Essays* (Cambridge, UK: Cambridge University Press, 1992), 327.

medical profession came to rely on the state to intervene on its behalf.[29] This the state did, though largely for reasons of partisan political gain and reformist sentiment.

Liberal Party leaders hoped to generally improve the still very precarious plight of workers, and opted to do so by extending a package of government-sponsored insurance schemes. The reforms would simultaneously benefit physicians and workers, as more of the latter could henceforth (consistently) afford care, while physicians went from working for the Friendly Societies, to offering services to the local Insurance Committee. The Insurance Committees, in turn, proved more merciful supervisors than many of the societies had ever been.

Hollingsworth further argues (if implicitly) that the higher costs endemic to the American health care system can be partly traced back to a corresponding lack of early 'consumer' involvement.[30] As Starr (1983) and others have documented, the American system evolved within the context of steadily increasing hegemony on the part of the medical profession. Disorganized citizen-patients were unable to establish their power as consumers during the formative period of American health politics. As a result, they—we--have had to endure considerably higher health care costs over the years—costs which spiral ever upward in the present era.[31]

This particular thesis, while compelling, tells only part of the story. Early consumer involvement in health politics can hardly account for dramatically higher costs and continued private provision of care centuries later—at least not entirely. Other variables are clearly at work. The continuing role of citizen-patient groups over time has

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[29] J. Rogers Hollingsworth, *A Political Economy of Medicine: Great Britain and the United States* (Baltimore, MD: Johns Hopkins University Press, 1986), 20-21.
[30] Hollingsworth, 3-4.
[31] Starr, 81-82, 379.

played a decisive role in determining the power, perceived and actual, of the other stakeholder groups in national health politics. Moreover, the precise way in which State agents have interacted with, and related to, citizen-patients has further influenced the present shape of health care systems in various nations.

The logic of markets adds a further wrinkle to this picture. In the ideal market the consumer is reigning monarch. Quasi-market mechanisms have recently been employed in many types of health care systems. They have been grafted onto systems containing prior provision for consumer influence, as well as those in which other stakeholders, including the medical profession, State, or third-party payers, have traditionally held sway. Predictably, given the diversity of system arrangements, market mechanisms take many forms in each country.

IV. Traversing the Intellectual Terrain

Many alternative narratives have been offered by scholars to explain differential health system outcomes across the different nations. Some of these explanations have tended to subsume health care under the broader rubric of social welfare provision, while others deal with health care systems on their own terms. Moreover, while some scholars have attempted to account for health care system difference across a wide range of nations, others have taken a more narrow focus, choosing to take on one or two cases. Indeed, some have gone even further by simply hypothesizing American difference as constituting yet another manifestation of its supposed political uniqueness.

Employing a broad lens, a recent generation of social scientists have sought not only to examine the ‘ingredients’ that go into creating a single nation’s welfare system,

but the larger international trends seen to be engendering similar policy responses across states. Welfare State convergence (or divergence) is hardly an unplumbed area of intellectual inquiry. Theorists going all the way back to Marx (and perhaps even earlier) foresaw increasingly similar trajectories among industrial nations. A later generation, including, notably, Williamson and Fleming (1977) of scholars applied this overarching idea to the welfare states that took shape in such countries.[32]

While divergence of welfare state outcomes has been stressed by many scholars, it is convergence in health policy that scholars have sought to explain. In a 2003 dissertation, Paula Blomvquist of Columbia University examined perceived policy convergence among two broader groups of European health care systems—tax-based (as in the British case), and those adhering to the social insurance model (along the lines of the German system).[33] Establishing that convergence has, indeed, occurred in health policy across the continent, the author goes on to suggest that this development owes largely to the powerful influence of a group of pro-market health economists, who knew just how to shape and present their ideas so as to grab, and hold, the attention of policymakers.[34]

Giaimo (2003) compares the health care systems of three States: Germany, the United Kingdom, and United States. She shows how market ideals were grafted onto each of the three systems, for better and, often, worse. Despite the varying origins of

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[32] John B. Williamson and Jeanne J. Fleming, "Convergence Theory and the Social Welfare Sector: A Cross-National Analysis," *International Journal of Comparative Sociology*, Vol. 18, No. ¾, Sep-Dec. 1977, 242.
[33] Paula Blomqvist, *Ideas and Policy Convergence: Health Care Reforms in the Netherlands and Sweden* (PhD dissertation, Columbia University, 2002).
[34] *ibid.*

these respective national health care systems, all had come to incorporate market principles by the concluding decades of the twentieth century.[35]

Taking on health care alone, rather than the broader array of state welfare schemes, Tuohy (1999) sets forth a multi-dimensional construct in explaining differential outcomes in national health care provision. Observers wishing to account for divergent paths in health care system development should, in her view, first determine the relative power of various actors within the system—the logic of the national 'structural' universe. They must then examine the means by which actors in a given society reach agreements, and work together—the (often unstated) institutional arrangements present on the national stage.[36]

It is the combination of these two logics and, indeed, their interaction, which she argues most affects the shape of a given nation's health care system. Hence a state with a broadly collegial style of national decision-making, but one in which the medical profession is given broad leeway, will come to possess a different health care system than one in which the profession similarly reigns, but in which the market ideal is followed when it comes to arriving at political settlements. It is differential mixes of these 'logics' that account for contrasting health policy outcomes in Canada, the United Kingdom, and United States.[37]

Immergut (1992) is, like Tuohy, interested in the role of interest groups and patterns of representation in the formation of health policy. National Health Insurance is

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[35] Susan Giaimo, *Markets and Medicine: The Politics of Health Care Reform in Britain, Germany, and the United States* (Ann Arbor, MI: University of Michigan, 2002).
[36] Carol Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (New York: Oxford University Press, 1999), 7-9.
[37] Tuohy, 8.

enacted in some countries, while being spurned in others on account of the nature of national governing institutions which, in turn, determine which interest groups tend to predominate, and which find their agenda perennially ignored.[38] "Specific institutional configurations," Immergut notes, "establish strategic contexts for political contests that that determine those interests that can be effectively expressed, and which ones will prevail over others."[39] Working from this guiding assumption, she then proceeds to track progress toward some form of NHI. I follow similar developments in this paper, though I am more interested in recent reform episodes, than the initial formation of national health care systems.

Other social scientists like Skocpol and Hacker have shown how policy can create interest groups, groups that invariable spawn new policy or, at the very least, shape the course of existing policy 'streams.'[40] Hacker, in particular, ties the rise, and relative strength, of the interests thus developed, to policy trajectory. Hence, on of the chief reasons it is so difficult to enact (public) reform in the American health care arena is the substantial growth over time in the power and influence of the vast system of private, employer-based health coverage, and the oft-inappropriate tactics of would-be reformers.[41] With the rise of private insurance in the 1940s and, especially, the 1950s, policy space was successfully conquered, living little room for a state-led NHI regime. On these points, Quadagno (2005) generally concurs, adding that the passage of an NHI

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[38] Ellen M. Immergut, *Health Politics: Interests and Institutions in Western Europe* (New York: Cambridge University Press, 1992), x-xiii.
[39] Immergut, 5.
[40] Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, MA: Harvard University Press, 1992), 531.
[41] Jacob Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* (Princeton, NJ: Princeton University Press, 1999), 172-174.

regime would require neutralization of traditional adversaries, and a system of tightly-organized national campaigning.[42]

Policy, and the spirit of policy more broadly, clearly influences which interests will take shape and prove particularly prominent in a certain political setting. Cultural predispositions also play a role, serving as another force shaping policy and thus, in turn, the character of the universe of national interests. The political manipulation of national cultural biases also plays a role in policy formation, as well which policy course is traveled, from the many concocted by national elites.

Still other scholars, among them Starr (1983) and Light (various), stress the relative position of distinct interest groups in a society—or lack thereof. The presence of a labor-led party of the Left has long been seen as a veritable pre-requisite of an expansive welfare state, and health care system. Hence the relative weakness of organized labor in the United States, and the strength of the medical profession, is seen to contribute to its hybrid system.[43] The corresponding strength of the medical profession, moreover, has further served to inoculate the American polity against the formation of a universalistic state-run health care system.[44] Not only have unions been weak relative to their European counterparts throughout modern American history, but there exists nothing precisely resembling a social democratic party. Indeed, the further left of the two main parties, the Democratic Party, has been compromised in the field of major reform on account of a decidedly conservative southern wing that long held dominance.

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[42] Quadagno, 212-213.
[43] Immergut, 232-233.
[44] The relative weakness of the British medical sector has, of course, had the opposite effect.

The prominence of organized labor in Britain, and its (very) close historical ties to the aptly-named Labour Party, has been set forth as one of the key determinants driving the rise, and, indeed, longevity, of the National Health Service. Whereas the Democrats were long led by a faction opposed to any scheme involving further centralization of government operations, even British Conservatives were long 'governed' by a paternalist Tory establishment that did not find state intervention in social policy anathema. The key constituencies, and resultant ideological positions, of the two main British parties created a climate conducive to radical reform by the conclusion of World War II hostilities. Conversely, the lack of a similarly close connection between organized labor and American political parties, and the relative strength of the American medical profession, have together been cited as a factor explaining the lack of NHI in the United States.[45]

War itself has long been put forward as another key ingredient of state-building. Skocpol (1992) shows how the earliest American 'welfare' provisions took the form of veterans' pensions in the wake of the Civil War.[46] Wartime powers assumed by governments, moreover, are frequently carried over into peacetime. Social welfare policies are often thus direct results of (perceived) wartime exigencies. Aside from the actual 'policy footprint' war can leave behind, it can also foster a sense of national solidarity, particularly if the very survival of the nation is seen to be at stake. Wartime solidarity can then be harnessed by policymakers in the immediate wake of armed conflict to create or expand state-sponsored measures seen to ameliorate the condition of at least a portion of a now-united populace. The social policy footprint left by wartime

[45] Quadagno, 13-14.
[46] Skocpol, 65-66.

does not always prove particularly lasting, however—Skocpol chronicles how Civil War pensions soon became the subject of controversy, and were eventually scrapped?[47]

In addition to war and the presence (or lack) of sympathetic interest groups or organizations, the political structure of a given nation has also been cited as a factor that can define the parameters of debate over social policy, as well as the stream of legislation produced. The literature on 'veto points' stresses the number of institutional hurdles would-be reformers must surpass if change is to be enacted within the context of national political systems.[48] For a given policy to succeed, it must satisfy a variety of different political figures and bodies. In such an atmosphere, it is far easier for inertia to reign, than for comprehensive reform to progress all the way from bill to law. There are many points at which reform proposals can be 'vetoed'—long before they reach the president's desk.

If the American system seems to present innumerable hurdles for would-be policy reformers, the British system can be seen as nearly opposite. At the most basic level, Britain retains a parliamentary system of government, in which the merged legislature-executive can more easily (and with greater frequency) produce large-scale political change. The first-past-the-post electoral system (seen also in the American system, but without the crucial parliamentary piece of the equation, moreover, ensures that governments often enjoy the parliamentary majorities necessary to push through favored legislation, of any sort.[49]

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[47] Skocpol, 309-310.
[48] See, for instance, Markus M. L. Crepaz and Ann W. Moser, "The Impact of Collective and Competitive Veto Points on Public Expenditures in the Global Age," *Comparative Political Studies*, Vol. 37, No. 3 (April 2004), 259-285.
[49] Richard Rose, *The Problem of Party Government* (New York: Free Press, 1975), 115.

Of course, this argument possesses its share of weaknesses. At key junctures in American political history, incrementalism has given way to big-bang policy change. Indeed, an oft-cited example involves health care and, more specifically, the passage Medicare and Medicaid. Indeed, the entire Great Society program of the 1960's shows the extent to which a powerful president, supported by like party control of Congress, can preside over significant political change. The American political system has proven quite capable of supporting the formation of large government programs—and in the area of health care—at certain points in its history. Morone (1998 and 2004) points to several potential catalysts for broad state-building projects—the dual strains of moralism that pervade American society, as well as occasional appeals to return 'power to the people' in an impulse he calls the Democratic Wish.[50]

Political culture is yet another variable, or contributing factor, cited when it comes to the specific shape of national health care systems, and of welfare provision generally. Those continental European states with more collectively-oriented political values have, perhaps unsurprisingly, spawned generous state-sponsored health care systems, and have tended to feature broad welfare state 'umbrellas' protecting citizens against the vicissitudes of life.[51] The relationship between culture and welfare generosity is hardly transitive, however—though many states with a broadly collectivist political culture can boast robust systems of social welfare provisions, not all states with a more individualistic ethos exhibit the opposite qualities. While 'collectivist' France features a

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[50] James A. Morone, *The Democratic Wish: Popular Participation and the Limits of American Government* (New Haven, CT: Yale University Press, 1998) and James A. Morone, *Hellfire Nation: The Politics of Sin in American History* (New Haven, CT: Yale University Press, 2003).

[51] For a graphical (symbolic) representation of this state of affairs see, for instance, Beatrix Rebecca Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (Chapel Hill, NC: UNC Press, 2001), cover.

generous system of health and welfare benefits, across the English Channel politically liberal Britain is home to one of the most universalistic health care systems anywhere in the world.[52]

Culture is also a problematic variable insofar as it is often difficult to separate from other, associated variables. For example, states containing societies that value solidarity over solitary success tend to also give rise to powerful labor unions.[53] As noted above, the presence of strong unions and associated parties of the Left have also been cited as a key variable driving welfare state development and elaboration.[54] One is thus left to wonder whether the prior, or more immediate, variable is actually driving the development of national health and welfare systems.

Institutional structure, political systems, war, and culture have all thus far been offered as competing variables fuelling health and welfare system development. Few scholars have attempted to explain such a broad phenomenon through just one of these variables in isolation. Nonetheless, most have tended to direct much of their focus to one, or perhaps two, of the variables (or variants thereof) in their quest to identify the factors that must be present if a certain type of health care system is to arise.

I intend to argue that these four forces, acting in concert, can go far in explaining not only the vast difference between the American and British health care systems, but why similar reforms came to possess peculiar resonance across the two systems at around the same point in time. Differences in institutional structure, political systems, and

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[52] For more on the French system, see *Differential Diagnoses*
[53] Sven Steinmo, "American Exceptionalism Reconsidered: Culture or Institutions?" in Lawrence C. Dodd and Calvin C. Jillson, eds., *The Dynamics of American Politics: Approaches & Interpretations* (Boulder, CO: Westview Press, 1994), 117-120.
[54] Quadagno, 13.

wartime experience initially created vastly different outcomes in the development of health care systems on both sides of the Atlantic. After system founding and maturation, however, the two systems began to converge—at least in terms of the types of reforms that were attempted.

Globalization and the ease of idea transmission explain why similar concepts have come to appear on the public policy agenda of U.S. and U.K. alike. But why has improved communication over the past several decades not led to further convergence, at somewhat earlier points in time? Moreover, just what lies behind the contemporary trans-Atlantic concern with the imperative of safeguarding the rights of the patient? The question becomes not why broadly similar reform ideas have been mentioned by both British and American scholars and policymakers, but why these shared ideals have gained so much traction, and why the resemblance of specific reform proposals is so striking. Having briefly surveyed the field of scholarship in health care reform, I will now outline the broad characteristics of the British and American systems, before delving into greater detail in the chapters that follow.

V. Getting a Lay of the Land: The American and British Systems in Broad Strokes

Establishing the starting date of the modern British health care system seems, on the face of it, a simple enterprise. After all, the historical record contains not only the day the NHS Act came into force (June 5, 1948), but the precise points at which the legislation was first proposed (1946), and then passed. Given a second glance, however, this mirage of simplicity swiftly fades.

Though the NHS, which stands as the prime actor in British health care politics was born in the late-1940's, it did not spontaneously spring into existence. On the contrary, the public body was years, indeed, decades in the making. Antecedents can be found in historically distant State and even Church intervention in health care. From an early date, local governments provided (albeit rudimentary, and occasionally barbaric) care to the poorest within their respective jurisdictions.[55] Local governing authorities, moreover, were entrusted with a wide public health function, one that they continue to possess even to this day.

A further layer was added to the foundation of pre-NHS health care with the passage of the National Health Insurance Act of 1911. At that point, the national government took on the responsibility of providing workingmens' insurance, effectively broadening their involvement in the provision of health care from the very poorest, to the burgeoning (and slightly better off) laboring classes. Crucial to this development, as well as its limitations, were the unique political constellations of the period.

The year 1911 thus constitutes a key signpost along the road to the NHS. The idea of the existence of such a road, however, should not lead the reader to conclude that said path followed a straight, or uninterrupted, trajectory. Under the national health insurance (NHI), not even the dependents of workers were afforded coverage, much less the rest of the British populace.[56] Moreover, many medical professionals, specialists (or consultants, in British medical parlance) continued to ply their trade, almost entirely free of State involvement of any form. Even general practitioners (GPs) continued to see

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[55] Lynn A. Botelho, *Old Age and the English Poor Law, 1500-1700* (Woodbridge, UK: Boydell Press, 2004), 11.
[56] Hollingsworth, 24.

patients outside of the NHI scheme, though the latter regime did have the salutary effect of ensuring a more stable (and higher) income.

While the British health care system remained largely in stasis throughout the bulk of the interwar period, the 1920's and 1930's did witness a broadening political and intellectual debate regarding the state and quality of medical care nationwide. Major academic and government-commissioned studies, chief among them the Dawson Report of 1923, called for further centralization of health services, with some recommending something that would look quite similar to the NHS.[57] The interwar political climate was, however, not terribly conducive to any broad expansion of government authority, or investment. Many of the governments of the era were Conservative and, perhaps more importantly, it was not believed the country could afford ambitious schemes during the course of economic depression.[58]

The next major signpost on the road to the NHS was the Emergency Medical Service, formed in the years immediately leading up to World War II. London, faced with the prospect of massive civilian casualties arising from aerial bombing raids, appropriated a fair number of the better hospitals around the country, hiring the specialists whose work was based in the respective institutions. The EMS had the dual effect of establishing the precedent of specialists working under State guidance, if not

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[57] John Carrier and Ian Kendall, *Health and the National Health Service* (London: Continuum International Publishing Group, 1998), 41.
[58] Virginia Berridge, "Health and Medicine," in F.M.L. Thompson, ed., *The Cambridge Social History of Britain, 1750-1950* (Cambridge, UK: Cambridge University Press, 1993), 226-227.

outright control, while making officials aware of some of the inadequacies of the still largely private health care system.[59]

While an increasingly coherent health care system was forming during the early twentieth century, it is the year 1948 that marks the definitive start of the modern British system. It was in that year that the NHS was established through the passage of a massive piece of legislation in 1946. The British portion of this narrative will thus largely concern events occurring during, and after, 1948. When it comes to the American side of this study, it is rather more difficult to establish a definitive date at which point the modern health care system can be said to have come into existence.

Any year employed as the advent of modern American health care will, inherently, be somewhat arbitrary. Unlike the NHS Act in Britain, there is no single piece of legislation, passed at a single moment in time, which brought the current 'system' into being. Stepping back even further, it is unclear whether a coherent health care system can be said to exist at present, or, for that matter, at any other time in recent American history.[60] Rather than being characterized by a single nationwide government (or private) health service, American health care is comprised of diverse forms of health provision, private and public. Moreover, these individual forms of health provision arose gradually starting at different points in time. Employee-based, private indemnity plans arose largely in response to first wartime price and output controls, then tax incentives passed in the immediate postwar era. Contemporary judicial rulings legitimizing health

[59] Brian Abel-Smith, *The Hospitals, 1800-1948: A Study in Social Administration in England and Wales* (Cambridge, MA: Harvard University Press, 1964), 440.
[60] Reagan, 17.

benefits as a bargaining chip in negotiations between labor and business effectively locked the employer-based system into place.[61]

Nonetheless, such forms of provision do not characterize the entire American health care mélange. As noted above, a fair proportion of Americans receive health benefits by way of two large government programs, Medicare and Medicaid. These programs were passed by Congress in the mid-1960s, following years—nay, decades—of attempts to create broad public health coverage. American veterans, moreover, receive care through the public Veterans' Affairs (VA) organization, which is one of the most efficient sectors of the national health care 'system.' A case could thus be made for locating the 'foundation' of the modern American health care system in the 1960's, as the system then contained many of the key components (both public and private) that would collectively provide health care to Americans in subsequent decades.

Acknowledging that the precise origins of the modern American health care system is something of a moving target, however, I choose to use the mid-1940's, and the passage of the tax incentives that would go so far to popularize employer-provided health plans, as a starting point. While it would be another two decades before the large public programs came into being, by the immediate postwar period the incipient American health care system did contain many of the features that characterize the contemporary system. Moreover, even post-1965, the 'system' continued to develop and, indeed, change. By the mid-1990's, managed care was becoming increasingly common across the national health care landscape. However, it would be foolish to place the start of the modern system at this late date. Placing the foundation of the modern system in the mid-

[61] Joseph A. Califano, *America's Health Care Revolution: Who Lives? Who Dies? Who Pays?* (New York: Random House, 1986), 44.

1940's has the added advantage of providing a certain parallelism with the British experience.

Health care in America is delivered via an elaborate patchwork of public programs, and private institutions. The 'system', if, indeed, one can be said to exist, is the result of nearly a century of deliberate political machinations, combined with a substantial accumulation unanticipated consequences arising from prior actions. The sum of these factors has produced health care arrangements that collectively resemble few, if any, systems found elsewhere across the globe.

Health care in the United States is, for many, employment-based. That is, a fair number of working Americans have traditionally received health benefits through their employer.[62] Employers, in turn, either finance their own set of benefits, and/or contract with any number of private insurers who offer health care packages. The latter range from Blue Cross/Blue Shield plans, offered by representatives of the medical profession, to health maintenance organizations (HMOs), insurers that seek to lower costs through, among other devices, unifying all care within a single network of providers—and many permutations in between.

Operating beside this collection of largely employment-based private coverage provisions is a large public health care system. Though it serves a minority of the population, albeit a fairly substantial proportion of the citizenry at large, the public component of the American health care system is, in fact, larger than all other health care

[62] Though the number continues to decrease over time, as major employers and smaller businesses alike seek to cut operating costs by reducing amounts spent on employee health plans.

systems around the world, including many that are wholly state-run.[63] The American state provides health care funding for many of the poor, mainly under the Medicaid program. Many American children are covered through a separate program, SCHIP, in which the individual states administer programs jointly funded with the federal government. Significantly, for a rapidly ageing society, the public Medicare program provides care for the elderly. The public role in American health care is thus hardly insignificant.

That said, if one could picture a spectrum of health care systems, ranging from those that mainly rely on the private sector, to those that are entirely supported by the State, America clearly fits rather far toward the former end of said spectrum. Equally distant toward the opposite end would stand the British health care system, characterized almost wholly by its uniquely universalist National Health Service (NHS). This state of affairs represents a political riddle. After all, the United States and United Kingdom are close cousins when it comes to their respective political cultures. Economically, moreover, the two are after conceptualized as an Anglo-American entity, to the 'right' of most states across the European continent and, indeed, around the world.

Yet the health care systems of the two States, which comprise a fair portion of their respective welfare states generally, could hardly be more different. As I intend to show, the contrast between the two has much to do with the historical circumstances surrounding system foundation, which can be said to occur at roughly the same time—during the 1930's and 1940's, even allowing for some prior relevant developments. In both cases, World War II and its impact on the two from a socioeconomic standpoint

[63] John S. Akin, *Financing Health Services: An Agenda for Reform* (Washington, DC: World Bank Publications, 1987), 14.

proved a vital formative factor in the development of health care systems on both sides of the Atlantic. The war, and other events, however, tended to have contrasting effects on the health care provisions that would be developed in the two states.

Not surprisingly, considering this divergence at birth, the British and American health care systems swiftly developed an entirely different set of strengths and weaknesses, with the latter calling for equally contrasting solutions. As the decades wore on, however, issues such as efficiency and poor value for money, began to bedevil both.[64] By the 1980s through the present, we are thus presented with a second riddle—despite the existence of two very different health care systems, the two have nonetheless been the target of some of the same types of reform and, indeed, reformers. As the twenty-first century opened, change had, for several decades, proven one of the few constants in the health care systems of both the United States and United Kingdom. Despite dramatically different trajectories over the course of decades, the two appeared, in some ways, to be approaching certain points of convergence.

Faced with years of under-funding and several sensational incidents of sub-par care, British leaders of the late 1980s and 1990s sought to subject the NHS to fundamental reform. The Thatcher and Major governments of this period of reform, moreover, were dedicated to increasing the role of the market in British society, and correspondingly rolling back the influence of government. Putting forward the bare outlines of reform in 1989, the Thatcher government presided over the passage of the landmark NHS and Community Care Act in 1990. It was then left to the government of

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[64] Milt Fredenheim, "Study Finds Inefficiency in Health Care," *New York Times*, 11 June 2002 (online: http://query.nytimes.com/gst/fullpage.html?res=9E01EFDC1E3DF932A25755C0A9649C8B63&sec=health), accessed 30 October 2008.

her successor, John Major, to implement the ambitious reform program.[65] This reform episode would be marked by periodic fits and starts of activity, but can be seen to continue in some form or another through the present day.

In the United States, something quite different occurred. There elite fears of rising health care costs (and national expenditures), joined with feelings of insecurity among members of the middle class concerned about retaining sufficient health benefits, drove government to respond. The Clinton administration thus spent months engineering an elaborate reform plan, largely behind the scenes. Unveiling the Health Security Act in 1994, members of the administration was initially optimistic about its eventual passage. As it turned out, however, an alliance comprised largely of small business groups and health insurers managed to defeat the program.[66] It thus seemed health reform would not be accomplished.

But that was not the end of the story. In the absence of government action, key actors in the health care sector took the initiative to enact reform. Anticipating that managed care would prove irresistible to employers seeking cost cuts, health providers rushed to sign on to various HMO-like plans. Insurers, in turn, expanded their managed care offerings to head off future government 'meddling' in the insurance market. At first, the directors of such plans were able to leverage savings from provider groups, who would accept lower payments in exchange for retaining a prominent position in an increasingly competitive market. As that market became saturated, however, and it became clear that insurers relied on providers, and perhaps needed them more than

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[65] Earl Aaron Reitan, *The Thatcher Revolution: Margaret Thatcher, John Major, Tony Blair, and the Transformation of Modern Britain, 1979-2001* (London: Rowman & Littlefield, 2003), 224.
[66] Quadagno, 11.

provider groups needed insurers, physicians and hospitals (re-gained) the upper hand. The prices they charged thus rose, and the plateau in health care costs during the 1990s proved decidedly short-lived.[67] The self-disciplining of the American market in health care brought only temporary savings, and a brief window during which the pace of health spending growth slowed. Despite the brevity of this phase, the perfecting of market mechanisms remained an important part of the arsenal called upon by crusaders for health system reform.

VI. Markets Ascendant

Proponents of market-based solutions in health care have tended to play on the Anglo-American devotion to individual freedom. They thus emphasize the supposed freedom on the part of any would-be patient to choose the nature of health care, or care plan, they receive.[68] To market purists, the only alternative is 'socialized medicine,' a term connoting drearily impersonal rigidity. This is, of course, a false dichotomy. After all, citizen-patients can NEVER be truly empowered to select appropriate care, as they would a carton of milk at the corner store. When even the definition of 'appropriate care' cannot be firmly established in any given case, patients are never in a position to act as ideal-type consumers. Decision-making in health care must be aggregated in some

[67] Joseph White, "Markets and Medical Care, the United States, 1993-2005, *The Milbank Quarterly* Vol. 85, No. 3 (2007), 395-448.
[68] Timothy Jost, *Health Care at Risk: A Critique of the Consumer-Driven Movement* (Durham, NC: Duke University Press, 2007), 31.

fashion, with the relevant value judgments made by members of some body or another—whether the state, medical professionals, or employers.[69]

Nonetheless, certain proponents of market-based health care regimes present the prevailing health care debate as one featuring champions of choice, on the one hand, and those who would dictate individual action at every turn, on the other. The aforementioned market purists also imply that the sum of individual (market-guided) decision-making would automatically render the most efficient allocation of resources, along the lines of Adam Smith's Invisible Hand. The first step to the most effective health care reform along the lines of this narrative would seem to be the freeing of health care consumer's hand, and the granting of autonomy to individual citizen-patients.

Governments on both sides of the Atlantic seem to have internalized this belief. "Patient choice" (and empowerment) is on the lips of many American and British policymakers. In recent political history, the Blair government was rhetorically dedicated to this phenomenon. In the name of allowing citizen-patients to make informed decisions, the British government set a series of minimum standards, and targets they expected medical professionals and institutions to meet.

Ironically, however, the more choices health care 'consumers' are offered, the less satisfied they seem to be.[70] Some of these very citizen-patients scoff at the very notion that they should be viewed as 'consumers' guided exclusively by the set of incentives and signals provided by the medical market. Thus one online posting responding to piece *criticizing* market reforms in health care pushes the author (who employs the language of

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[69] Helge Kjersem M.D., "Retrenchment and Values in a Health Organization," in Uffe Juul Jensen et al, *Changing Values in Medical and Health Care Decisionmaking* (New York: John Wiley & Sons, 1990), 23.
[70] David Mechanic, *The Truth About Health Care: Why Reform is not Working in America* (New Brunswick, NJ: Rutgers University Press, 2006), 127.

the market) to go further, (rhetorically) asking, "Consumers? Surely you mean patients[?]"[71]

Moreover, in many parts of the U.K. (and U.S.) choice in providers, for instance, is simply impossible to obtain, and therefore conceptually irrelevant. There are areas of both countries in which there is only one main provider.[72] Of course, citizen-patient choice is constrained by other factors, even across areas in which multiple medical providers are (theoretically) available. Despite the difficulties and deficiencies associated with the imposition of market-like principles in health care, however, such a course still holds much appeal to political leaders on both sides of the Atlantic. Why should this be the case? Why have market ideas in the American context, the efficacy of which are dubious at best, not been scrapped by international health policy elites, but exported around the world.

To some extent, the answer is to be found in the political advantages that may accrue to would-be market reformers. After all, the execution of difficult decisions involving health personnel and facilities on the part of governments can quite easily come back to haunt said decision-makers at the ballot box. Change large-scale and small is more politically palatable if it can somehow be traced to the vagaries of the (faceless, impersonal) marketplace, and not individual political figures. Populations endowed with a liberal political culture (such as exist across the U.S. and U.K.) could, perhaps, prove more accepting of local hospital closures if they are justified by the exigencies of 'the market.'

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[71] Milne, 18 October 2007.
[72] Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford, UK: Radcliffe Publishing, 2007), 163.

Available evidence suggests, however, that this is not the case. Activists and, indeed, politicians alike have proven quite vocal in the face of threatened British hospital closures, despite the fact these have partly been justified on the grounds of overall efficiency. Similar furor has arisen in response to American hospital closures, despite the emphasis on free markets within that country's health care system.

VII. The Way Forward: The Politics of Mixed Health Care Systems

Just as there are several points at which one could start any comparison of the British and American health care systems, there are also more than a few ways to structure such a study. One of the means by which to do so would be by examining the way each of the major actors in the respective systems are arrayed, and, indeed defined. Viewed broadly, health care is an enterprise that largely affects three key groups: patients, providers of care, and the State. Studying the identity of these three actors, and the nature of their relationship, can offer considerable insight as to the true nature of the health care systems they collectively inhabit. Such a perspective can also help one get to the heart of just what sets a given system apart from another.

In the American health care arena, patients are largely grouped according to their employer, or employment status.[73] Patients' care is, in many cases, funded by their ultimate superiors in the workplace. Providers of care, i.e. the medical profession, mainly operate in private practices, and have traditionally viewed one of their chief imperatives as the maintenance of professional autonomy. The American state plays a limited, though not insignificant role in the overall system. The federal government directly

[73] Kant Patel and Mark E. Rushefsky, *Health Politics and Policy in America* (New York: M.E. Sharpe, 1999), 16.

funds care for many poor and older Americans, and state government bodies preside over the licensing of physicians. Otherwise, many patients and providers operate independent of the State. Providers have historically had a moderately antagonistic relationship with government, particularly in times when further regulation appeared probable.[74]

This view of health care, through the lens of three key participant groups, provides some important insights. The emphasis placed on professional autonomy by many American health care providers partly explains the lack of traction on the part of efforts to institute state-led NHI. It also points up a cruel irony: in seeking to escape infringement on professional prerogative by the state, the medical profession has steadily fallen under the control of cost-conscious insurers and other corporate interests. The identification of health benefits with employment status is one reason job security (and anxiety) is such a major concern for many American citizens. Meanwhile, the long tradition of limited state participation in health care makes it difficult to establish a precedent of broad public intervention in this sector.

Owing to differing configurations within the overarching system, the concerns and calculations of the major constituent groups comprising the British health care system are significantly different. In a system in which patients are simply 'classified' as any citizen of the British state, concerns about health care are mainly directed toward politicians, and are thus entirely decoupled from the issue of job security. This makes these British patient-voters particularly receptive to claims on the part of government or opposition that the other major party would 'kill' (or 'save') the NHS. In 1997, part of Labour's appeal (and perhaps a large part) was focused around its claim that 'only 24

[74] Hacker (1999), 86.

hours remained to save the NHS', an explicit linkage of Labour's fortunes with that of the health service.

The effective fait accompli of state intervention in health care ensures that the provider community is hardly concerned about further public encroachment on professional prerogatives. Indeed, decades of operating under the auspices of the NHS have led providers to identify their professional interests with those of the health service generally. Under the system as it has traditionally been configured, physicians have enjoyed a fair degree of autonomy, as well as a fairly secure and, indeed, generous income. Thus compensated for their cooperation, the medical community as a whole has been transformed from one of the chief roadblocks to health service formation, to some of the staunchest NHS defenders.

The British state finds itself both empowered and constrained within the broader health care arena. To a large extent, the state IS the health care system, with wide powers to shape and exercise effective control over its divers parts and subsidiary systems. On the other hand, the organization has, as large government bureaucracies are wont to do, taken on a logic and direction of its own. Moreover, the substantial responsibilities taken on by the national government in health care makes it vulnerable to charges of incompetence as a result of any failing within the system upon which the media, opposition, or the broader public happens to capitalize. Successive government ministers (including the system's founder, Aneurin Bevan) have lamented the fact (expressed

through many variations in wording) that a single ‘spilled bedpan’ can carry serious political repercussions.[75]

As noted above, comprehensive control of health care has alternately proven a source of empowerment and consternation for successive British governments. Two relatively recent examples illustrate the dual consequences of the state role in British health care. Faced with the continued underfunding of the NHS, Prime Minister Tony Blair pledged in 1999 to raise British health care spending to the European Union (EU) average over the course of the following ten years. Because the private sector role in health care is small, with the state responsible for the bulk of health expenditures, he could make this pledge with a considerable amount of credibility, provided political will in this area proved enduring.

Several years later, the Blair government unveiled a program to institute a comprehensive information technology (IT) program across the NHS. Though the program was soon slowed by a series of practical ‘kinks’, it continues to work its way through the system at present. More significant than its status, or even practical success, is the fact that the government felt that it could impose such a bold program on the NHS in the first place.

Such ambitious goals as substantially changing the proportion of GDP that is dedicated to health care, or comprehensively automating medical recordkeeping through the application of IT would be well nigh unimaginable within the context of the American health care system. Successive presidential administrations have, in fact, attempted to place indirect pressure on health care expenditures which, in direct contrast

[75] Neil Carter et al, *How Organizations Measure Success: The Use of Performance Indicators in Government* (London: Routledge, 1995), 103.

to the British case, is perceived to occupy far too large a segment of GDP. Such limited efforts have, at best, temporarily slowed the annual growth rate of health care spending. Moreover, government action in this area has, in the main, been limited to tax and other incentives toward moving persons into HMO plans. These are hardly the sort of direct measures that a British prime minister could expect to impose on the national health care system, through government control over the NHS. Nonetheless, comprehensive state control of health care can have certain deleterious effects on the functioning of the system overall.

Intra-governmental rivalry has been one consequence of the all-encompassing state role in British health care. While the Ministry of Health has generally regarded the NHS as a part of its political bailiwick, successive treasury ministers have had other ideas. Indeed, this state of affairs has led to some of the health service's most enduring problems, chief among them being underfunding and, to some extent, policy drift, if not outright paralysis.[76] While obviously difficult to measure or quantify the results in any meaningful way, it is undoubtedly true that the health service has, throughout its history, been subjugated by the broader political programs or imperatives of successive governments.

Perhaps the greatest consequence of carving out such a pervasive role for the state in health care has been that the system has become a thoroughly politicized creature. Of course, health care is, by its very nature, a political arena, though it often lies at, or near, the very center of national politics in those states that wield comprehensive control over the system. The NHS occupies such a vast territory within the British polity that it is next

[76] Klein, 150.

to impossible for governments to ignore. This can, of course, prove something of a mixed blessing.

It is hardly unheard of for governments to present grandiose pledges concerning the health system for the sake of political gain, and then failing to follow through, for any number of reasons. Since the 1980's (or perhaps a tad earlier), successive governments have felt compelled to present ever more elaborate plans for NHS reform. The near-constant state of system flux that has been the result is hardly conducive to stability or, for that matter, high morale among personnel. Since it presents such a large target, the NHS has long served as an effective testing ground for broad governing philosophies, from 'Thatcherism' to 'Blairism,' or the 'Third Way.'

Powerful state influence in health care has thus led to inertia, and the subservience of the health care system to politics. If the problem in the British case is that the state has, perhaps, bitten off more than it can chew, the reverse is true in the American case. Successive presidential administrations have, in the main, had little impact on the overall shape of the health care system, if only because the state role is so thoroughly circumscribed. American political leaders thus have few effective levers by which to enact change across the system.[77]

British patients have hardly presented a united front in the battle to maintain and improve the quality and accessibility of health care in that country. This is in large part due to the fact that this constituency is quite large and diverse. As I noted above when introducing the tripartite analytical framework of health care systems, patients in the United Kingdom can be defined as the entire citizenry. Indeed, even visiting foreigners

[77] Leiyu Shi and Douglas A. Singh, *Delivering Health Care in America: A Systems Approach* (New York: Jones & Bartlett, 2003), 535-536.

have long been entitled to treatment in NHS facilities. It is thus little wonder that this impossibly expansive constituency has not been effectively organized to lobby for health care policy change.

Once again, the United States here presents a stark contrast. Though organizations like AARP provide some representation on the matter of health care for older citizens, patients are, in the main, fractured along lines of employment. This has the effect of limiting organization potential and, indeed, the unified concerns of any hypothetical patient groups rarely seem to enter into the calculations of American political leaders.

After six decades of evolution, the British and American health care systems have, in some ways, become mirror images of each other. The American system started as an almost strictly private and fractured entity, with many different organizations and, indeed, classes of healers, offering some form of care. During the course of the nineteenth, and particularly the twentieth century, physicians established a well-developed professional ethic, one that had the effect of limiting competition among practitioners while defending against external (read: government) intervention. Faced with a powerful American Medical Association (AMA), the American state remained sidelined when it came to the health care arena.

This private, professionally-led system was not, however, to prove lasting. Dramatic political shifts (and, specifically a larger northern Democratic presence in the U.S. Congress) created a public consensus around public assistance to certain vulnerable sectors of the population in the field of health care. The twin policy outcomes were Medicare and Medicaid, two massive government programs. While together they

constituted significant state intervention in health care, the public health care programs nonetheless 'nested' comfortably within the still-largely private American health care system. Private insurers retained a significant (and lucrative) role within the context of the programs, while physicians soon found that they were effectively able to pass on charges to the government, with few questions asked. Doctors continued to charge for service provided, rather than being compensated for the number of patients they treated. Continuation of fee-for-service payment schemes combined with a new state willingness to contribute substantial funding to the health care of certain 'deserving' groups within society had the effect of dramatically accelerating the growth in health care expenditures.

The 'modern' British health care system started life as a largely public enterprise. As noted above, the NHS, a political creation, left much decision-making power in the hands of political leaders. Physicians did manage to retain a certain degree of autonomy within the context of the NHS, though many nonetheless found themselves effectively employed by the state. Throughout the first forty years of the NHS, the private sector had a minimal presence in British health care, with only a tiny fraction of the populace opting to avail itself of (private) insurance coverage.

This preponderant public presence would begin to decrease in scope a bit by the 1980's and 1990's. Whereas the American public sector can be seen to have 'nested' within a mainly private system of health care delivery, the private sector in Britain was assigned a growing role within a still largely-public NHS. More significantly, market mechanisms were 'nested' within the mainly non-market driven NHS. Not only were support services contracted out to competing private entities, but doctors were encouraged to 'shop around' for the best specialist services for their patients. The

hospitals in which the specialists were based were, in turn, allowed to compete against each other for GP contracts, as well as being granted a greater degree of independence.

By the start of the twenty-first century, it appeared that at some point in the not-too-distant future most actual delivery of health services would be in private hands, while the state's role, though still substantial, would be largely limited to basic funding and regulation. The role of markets, it was envisioned, would, if anything, expand. Though the American and British systems started out as archetypes of public and private sector-driven health care delivery mechanisms, both are becoming increasingly mixed, with markets playing something of an enhanced role within the context of both systems. In both cases, the seeming contrast between public and private delivery of services has, in recent years, been blurred, if not entirely reconciled. It is this outcome that the proceeding chapters will seek to explain.

This study will compare and contrast the politics of health care found in the United States and United Kingdom, respectively. It will set out the trajectories of the two systems, and trace the complex interplay of private and public actors. Finally, I seek to show how two otherwise contrasting health care systems were nonetheless exposed to similar market forces, based partly (if not largely) on the power of common policy ideas. The narrative that follows will proceed in largely chronological fashion. I will start by examining the context of the foundation of the modern health care systems of, first, the United States, and then the United Kingdom. This section will be followed by two more chapters providing a view of the maturation of the systems in question. I will then provide s survey of the reform experience in both countries, and conclude the paper by highlighting the common themes and conclusions arising from the study.

In this study I incorporate a broadly least-similar systems design. While the two countries I will be examining, the United States and United Kingdom, share much in common, their respective national health care systems do not. By analyzing the ways in which the role of the citizen-patient has evolved across two very different policy landscapes over time, I hope to learn a considerable amount about the aforementioned under-examined political actor.

CHAPTER 2—The Fledgling American Health Care System, 1910-1950

German workingmens' insurance was inaugurated in 1883. Britain's National Health Service first saw the light of day in 1948. In both of the aforementioned states, there is a precise point at which the cornerstones of the respective national health care systems can be said to have been laid. This is not the case when it comes to the United States, in which a hybrid public-private system of health provision arose over the course of decades, if not centuries. With several minor exceptions, there was very little government (federal or state) involvement in the finance or dispensing of health services until well into the twentieth century.

Today, despite a sizable state component, many such services are purchased out of private pockets or, in many cases, those of private insurers. Despite this unique outcome, the United States at one time witnessed a strenuous debate over the merits of national health insurance. Indeed, at one point during the mid-1910s, such a system was seen by some (including much of the professional medical community) as inevitable.[1] My purpose in this chapter is twofold—I will show how this moment in the country's history represented something of a birthing period of the modern American health care

[1] Alan Derickson, *Health Security for All: Dreams of Universal Health Care in America* (Baltimore: Johns Hopkins University Press, 2005), 9.

system, while also explaining just how national health insurance went from a foregone conclusion to dead letter, all within the space of a few years.

Key to this early narrative on the politics of health care are two groups which would eventually find themselves on opposing sides in the debate over compulsory health coverage—the American Association for Labor Legislation (AALL) and the American Medical Association (AMA). The AALL, composed of prominent, socially-aware Progressive reformers, would disappear from the political scene by around 1940.[1] The AMA would, of course, live to fight another day, offering continued resistance to public insurance schemes whenever they arose.

I. Agenda-setting and the Politics of Health

The health insurance debate of the 1910's and 1920's effectively marked the start of a national dialogue on care for the infirm, and means for covering the rising costs it entailed. Up to that point, the provision of health care had largely been a local concern, with involvement from the individual states limited to the mental health sector.[2] There was, as yet, next to no federal role in health. The AALL and its interlocutors in the debate over national health insurance elevated health care to the realm of nationwide public policy, and brought attention to the rapidly rising costs associated with medical care, and the strain this placed on those with limited incomes as well as the economy at large.

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[1] Theda Skocpol, "Is the Time Finally Ripe? Health Insurance Reforms in the 1990s," *Journal of Health Politics, Policy, and Law*, Vol. 18, No. 3 (Fall 1993), 537.
[2] Ronald L. Numbers, *Almost Persuaded: American Phyusicians and Compulsory Health Insurance, 1912-1920* (Baltimore: Johns Hopkins University Press, 1978): 7-8.

No significant legislation concerning health insurance would be signed into law by the time this first chapter in the ongoing debate came to a close in the early 1920s. Indeed, the AALL could claim only one (symbolic) victory—the passage of a compulsory insurance bill by the New York state Senate.[3] Any initial cause for optimism was, however, swiftly dashed as the lower house of the legislature managed to keep a similar bill bottled up in committee.[4] The significance of this initial discourse on health care does not, therefore, lay in the copious legislation it bequeathed. Instead, this chapter in American history was important for the issues and ideas that received inclusion on the public agenda for the first time. Debate parameters defined in this era would, moreover, help to determine the course of future efforts to reform the American health care system.

Assuming this period did, in fact, witness the advent of themes that would continually reemerge in debates over health care down to the present, the next logical question is why determining such a 'date of birth' matters. The answer is that one cannot begin to understand the present contours of the American health care system nor, indeed, the future possibilities for change if left unacquainted with the origins of the current dialogue on health. Subsequent episodes of (attempted) reform make little sense if the first moments of debate in the 1910s-20s are left unexamined. The 1930s witnessed crushing economic Depression and the rise of Blue Cross—events that would both contribute to the future dominance of private health insurance.[5] However, the nation would approach the brink of radical reform when President Truman championed the

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[3] In response to this major setback, AALL secretary John Andrews claimed to have been "startled to learn from the Chairman of the [NY state legislature's] Rules Committee that legislation such as the provision for…workmen's health insurance is contrary to the principles of Republicanism." (Papers and Letters of the American Association for Labor Legislation, Reel 61. New York: AALL, 1919).
[4] "strangled in the Rules Committee" was how Andrews chose to characterize this state of affairs. (*ibid.*).
[5] Lawrence D. Weiss, *Private Medicine and Public Health: Profit, Politics, and Prejudice in the American Health Care Enterprise* (Boulder, CO: Westview Press, 1997), 86.

cause of national health insurance in the late 1940s. Studies of these critical periods alone, however, would not effectively capture the mosaic that is the American health care system, nor the terms of the ongoing debate over insurance.

This chapter will not touch on all the aspects of the extraordinarily complex American health care system. Instead, I will be focusing on several aspects of the health 'market.' On the demand side, I am interested in the means through which health services are financed and, more specifically, the role of insurance on this front. On the supply side, I will be examining the increasingly prominent role of the organized medical profession, largely through the guise of the American Medical Association and its state and local subsidiaries. Managing medical supply and demand is a critical public policy issue continually faced by governments the world over. I argue that the first time this issue attained entry on the public agenda in the United States was during the 1910's-1920's, through the efforts of such figures as John Andrews and the American Association for Labor Legislation.

In the end, the promise-nay, dream-of national health insurance proved illusory. The failure of the Progressive-era health care reformers had a decisive impact on the overall strength of citizen-patients within the American health care sphere. The corresponding success of the AMA in its fight against the AALL emboldened organized medicine, and help assure continued consolidation of professional control of health care in the United States. Moreover, the experience of the AALL would inform the political calculations of President Franklin Roosevelt who, wary to follow in the footsteps of those

failed reformers of yore, made the fateful decision to exclude national health insurance from the policy territory covered by the landmark Social Security Act of 1935.[6]

II. The Advent of Modern Health Politics

Though it seemed by 1917 that the time had come for some form of state-managed health insurance scheme, a variety of factors converged to militate against the passage of such a system. The issue came to the fore just as professional medicine was consolidating institutionally under a newly-empowered American Medical Association (AMA), and opposition to national health insurance proved a useful unifying force for those intent on strengthening the organization, or their role within it, further.[7] At the same time, a pattern emerged that would doom many a future national insurance scheme, as opponents of the plan managed to successfully tie the proposed system to a foreign menace. Pointing up the fact that one of the inspirations of the plan was, in fact, the German health care system, the opposition was able to establish a connection between America's chief nemesis in the Great War and national health insurance. While German associations would doom national health insurance at that particular historical moment, connections with (Soviet) socialism would play the role in later iterations of this debate. The idea of 'foreignness,' first tied to national health insurance during the late Progressive era, would remain attached to similar proposals for decades to come.[8]

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[6] Raymond Richards, *Closing the Door to Destitution* (State College, PA: Pennsylvania University Press, 1990), 145-146.
[7] Numbers shows how physicians like New York's James Rooney effectively rode the issue to power within the profession. (Numbers 92)
[8] Quadagno, 20.

By the turn of the twentieth century, the United States nor, for that matter, any other nation, could claim the presence of anything remotely resembling a national health care system. Some would (plausibly) argue that that maze of institutions interests congregating around the field of health care today hardly constitutes a system, though that is a debate for another time, place, and paper. In 1900, the first professionally-accredited medical schools in the United States were only a few decades old. Medicine as a profession was still in the process of consolidation, and professional norms and practices were still of rather recent vintage. Doctors and other medical practitioners were finally winning the war against folk 'medicine', but they weren't nearly the force in society (nor, indeed, politics) they would eventually become.[9]

Health care had yet to become the giant industry it would comprise by the end of the century. Far less money was spent on medicine as a proportion of the American economy as a whole—and, indeed, the American medical profession was still struggling with the 'scourge' of quasi-scientific patent medicine. At the same time, however, even the relatively small macro-level costs involved could prove downright disastrous to the bulk of workers and their families. Illness was, in this period, one of the major causes of destitution in the United States and, not surprisingly, the burden of health care costs was particularly acute for those with lower incomes.[10] The issue of covering health care costs could not only be conceived as a means of improving public bodily wellbeing, then, but also one of maintaining (or establishing) something resembling income security. In his comparative look at the earliest debates on health insurance in the United States and

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[9] Starr, 79-109.
[10] Daniel Fox, *Health Policies, Health Politics: The British and American Experience 1911-1965* (Princeton, NJ: Princeton University Press, 1986), 4-5.

Britain, Daniel Fox shows how the terms of said debate in the U.S. oscillated between the issue of public health and poverty reduction.[11] Clearly the specter of illness not only loomed large as a mortal threat to ones very physical wellbeing, but to the weight of ones billfold as well.

Just as the nature of the substantive debate over health coverage would change considerably over the space of years and decades, prevailing opinion over the proper way to enact change in the system would also evolve over time. The American Association for Labor Legislation embodies the latter phenomenon quite nicely. Established as an organization dedicated to the (mere) study of issues touching on the wellbeing of the laboring population, the group would quickly be transformed into one actively involved in lobbying efforts and, indeed, drafting legislation.

III. The Politics of Good Intentions: The AALL and Compulsory Insurance

The papers and correspondence of the American Association for Labor Legislation (hereafter AALL) contain an approving transcription of a 1917 quote from then-Treasury Secretary William McAdoo. National health insurance, according to this Wilson administration official, could be the next step in American social progress.[12] At the time, such a system constituted a major plank of the AALL program, viewed by the

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[11] *ibid.*

[12] Secretary McAdoo stated (July 1918), "In my opinion, there is no doubt about the principle of social insurance. We have substituted the justice of insurance for the charity of pensions in the army and we shall undoubtedly come to a consideration of the whole field of social problems to which the principle of insurance can be applied. Workmen's compensation has already prepared the way…Insurance against sickness, old age, and unemployment, as they have it in England and other European countries, may be the next social step for the United States." (reported in AALL Papers and Correspondence, Reel 63).

organization leadership as a crucial element in the overall improvement in the plight of American laborers.

The AALL was established in 1906, the result of a series of meetings between leading reformers today collectively grouped under the banner of Progressivism. Its leading light would swiftly become the dynamic and prolific John Andrews, though it also counted among its board members such national luminaries as Louis Brandeis, Jane Addams of Chicago's Hull House, and Princeton political science professor (and future President) Woodrow Wilson. The Executive Committee was comprised of such prominent experts and industry leaders as University of Wisconsin economist John R. Commons, and a future foe of national health insurance, Prudential statistician Frederick L. Hoffman.[13] The organization was one of many Progressive-era groups seeking the amelioration of social ills, largely through the application of rational analysis and 'scientific' premises.

As the name of the group makes clear, the AALL was largely concerned with the interests and well-being of workers and not the American citizenry at large. As Fox points out, however, the organization justified their focus on this particular sector of the population by referring to the productivity increases, and thus (national) economic gain that could come from improved worker wellbeing. Reformers hoped to achieve the aforementioned outcome through a generous package of proposed labor-friendly legislation. The organization thus dedicated itself to enhancing workplace safety, studying the effects of common pollutants and harmful substances (including,

[13] Member listing found in the AALL 1912 'Outline of Work' (Reel 61).

interestingly enough in view of future events, anthrax), as well as lobbying for workingmens health coverage.[14]

Workingmens insurance is a slightly more accurate term to describe the AALL program in health coverage than 'national health insurance,' which is something of a misnomer in this case. The AALL planned envisioned a series of local insurance funds, supervised by the government of the state in which they were located. As mentioned elsewhere in this paper, contributions would come from employers, employees, and the state. Fees for various medical procedures were to be established by a physician union, and approved by the physician director of a state insurance bureau, and arbitration boards in cases of disagreement were to include representatives from all concerned parties.[15] Given the prominent role played by state-level groups, it should come as no surprise that the AALL focused its efforts on passing state, rather than federal legislation embodying the aforementioned tenets. Those states that, for cultural or institutional (or both) reasons were perhaps more predisposed to pass health insurance were targeted by the organization. This is why efforts to pass bills in such a state as New York attained great importance within the context of the overall cause.

By the time of the founding of the AALL, the banner of Progressivism had been waving for over three decades. The movement was made up of numerous disparate groups, but all were more or less united by an unswerving conviction that adherence to scientific rationalism was the way of the future and, indeed, would solve any problem to

[14] The group also dedicated itself to treating such minutiae as sanitation in U.S. postal facilities. (Reel 63).
[15] "Memorandum re: Necessary Standards of Sickness Insurance," Undated, and "Proposed Sickness Insurance Standards (1914), AALL Papers.

which it was applied. Progressives came from roughly similar backgrounds—many were members of academia or social policy practitioners, and their activities appealed to the rising American middle class. While their agenda was ambitious, and their leaders energetic, their political fortunes were decidedly mixed. Progressive groups like the AALL often exhibited a certain amount of political naïveté, at times seeming to hope the inevitability of social 'progress' would serve to obliterate any significant opposition, or all that needed to be done was to illuminate the benefits of science, and all would be convinced (and thus converted).

The AALL resembles many other Progressive groups in its goals and tactics. In some respects, however, it would appear unique. Though Wilson, Brandeis, and Addams leant their names and, by extension, their reputations to the organization, it was, throughout much of its history, largely the creature of a single reformer, John Andrews. In terms of internal organization, the AALL was, in some ways, quite weak. Though several state branches were extant for a time, the group was largely limited to a single national office, located in New York (and not, significantly, Washington, DC). The organization offered several benefits to its members, including annual conferences and a journal, the American Labor Legislation Review. Membership peaked in the late 1910's (during the period when the group was most active in lobbying for health insurance), but quickly dropped during the course of the 1920's. By the late 1930's, the organization was a mere shadow of its former self, and within a few years it would disappear from the

scene entirely.[16] The cause of national health insurance would then be championed by reforming members of the (Franklin D.) Roosevelt administration.

A cartoon appearing in the pages of the AALL's Labor Legislation Review depicts a brawny laborer hefting an umbrella encompassing not only himself, but his entire family.[17] Such artwork accurately chronicles the ambitions of the group with regard to workingmens' insurance. While their proposals (inevitably) underwent numerous revisions once unveiled before various political bodies and constituencies. Nonetheless, certain unifying themes stand out—coverage was to be accorded to all laborers earning under a certain level of income, with contributions coming from the workers themselves, employers, and the state. Successive plans also called for the establishment of State Health Boards to effectively govern the system. Many of the AALL proposals also allowed for free choice of medical practitioner, while according physicians key roles in the management of the system.

So far as Progressive groups go, the AALL came to the table at a relatively late date. While founded not long after the turn of the century, it would only reach its prime in the late 1910's and early 1920's. By the late thirties, moreover, it would be reduced to but a shadow of its former self. The timing of the group's founding and, indeed, existence, would be cited by such scholars as sociologist Paul Starr as a leading cause of its limited success and eventual demise. Starr notes that the AALL had the misfortune of coming into its own just as the reformist zeal of the Progressive era was fast receding. It

[16] A fine chronology of the group can be found in the index to the collection of AALL Papers and Correspondence.

[17] The cartoon is reproduced at the start of the second half of Theda Skocpol's *Protecting Soldiers and Mothers* to symbolize the paternalist nature of such organizations as the AALL (in contrast to such maternal groups as the Womens Christian Temperance Union [WCTU]). It is not my purpose to simply reiterate that point here, but to merely suggest that health insurance was viewed by some as a means of strengthening traditional families, and therefore the very fabric of American society of the time.

should thus come as little surprise that the organization's pet cause, national health insurance, came to naught in the end.[18]

This explanation, however, leaves many questions unanswered. It is doubtful such prominent individuals as Wilson and Brandeis would lend their name to just any cause, particularly if it appeared doomed to failure. More importantly, while the political climate of a period can count for quite a bit, powerful political leadership can, at times, push and pull policy in wholly unpredictable directions. There is no guarantee, moreover, that national health insurance would have been implemented had the AALL been around to champion the cause from an earlier date.

IV. 'Made in Germany': Alien Associations and Medical Institutionalization

All of this is not to say that timing was not a factor in the direction the debate on health insurance eventually took. Timing turned out to be critical in the disappearance of state-financed health from the political agenda, though not simply because the issue was raised when Progressive fortunes as a whole were beginning to flag. The chief chronological variable in the sudden death of national health insurance as an idea(l) in the United States was the onset of World War I and, more specifically, the enemies against which America found itself pitted in said conflict.

Timing was also crucial in another way. The debate over national health insurance happened to transpire just as the medical profession was consolidating to form a powerful bloc in politics, and society at large. As Numbers shows, the American

[18] Starr, 243.

Medical Association, though founded in the first half of the nineteenth century was, for many years, largely ineffectual.[19] The loose organization of the group, coupled with the continuing competition from folk practitioners and patent medicine, ensured physicians would enjoy little in the way of social prestige for about the first hundred years following American independence. Starr quite eloquently sketches the broad, gently sloping arc that represents the fortunes of professional medicine.

By the turn of the twentieth century, however, a radical reorganization of the AMA infused the heretofore moribund collective with a new vitality and sense of purpose (Numbers). New functional committees were formed within the larger organization, and part of this trend was the formation of the Committee on Social Insurance. The latter was charged with studying the issue of national health insurance. The level of cooperation between committee physicians and AALL reformers is neatly symbolized by the fact that the former met in the same building that housed the AALL's New York headquarters.[20] The newfound power and influence of organized medicine thus initially appeared to be channeled toward consideration of plans for compulsory insurance along the lines envisioned by Progressive reformers.

Though the rapidly increasing stature of the AMA ensured the AALL would have an effective and credible counterpart with which to negotiate on the matter of national health insurance, the new state of affairs would soon prove a mixed blessing. So long as leading figures in the newly-empowered AMA proved decidedly amenable to the prospect of compulsory insurance, the idea took on ever greater resonance. Once

[19] Numbers, 27.
[20] Numbers, 36.

opponents of national health service came to the fore within the organization, however, its increased clout would prove devastating to the cause.

Even assuming the AMA could martial a host of new resources and institutional strength toward whichever stance it chose to take, there were still limits to the strength of the national organization. Specifically, individual leaders continued to differ at the national level, while state and local medical societies would, on occasion, diverge from the positions taken by their parent organization. In *Governing the Economy*, Peter Hall shows how it was, somewhat counterintuitively, the lack of institutional depth of organized labor, and not its strength at the national level that often foiled British attempts to institute a coherent industrial policy. Specifically, unions at the local level failed to fall in line behind the national (parent) confederation, preventing terms of any bargain from being enforced across the country.[21]

A weak, internally-divided AMA would similarly be unable to negotiate effectively on account of its professional constituency—indeed such an organization would not be capable of formulating a coherent position on national health insurance nor, for that matter, any other policy goal. Without the organization's participation, any national insurance program thus produced would likely lack legitimacy.

A roughly similar phenomenon existed during the debate over national health insurance. While a steadily strengthening national body of physicians came close to endorsing national insurance, state and local medical societies in such locales as New York (Brooklyn, specifically) and Buffalo at times refused to debate the issue and, indeed,

[21] Peter Hall, *Governing the Economy: The Politics of State Intervention in Britain and France* (New York: Oxford University Press, 1986). See especially pages 59-61.

formed subsidiary groups for the sole purpose of attacking politicians who appeared to champion the AALL cause.

Of course, the formation of such groups showed how little depth there was when it came to physician support for national health insurance. It also showed how internally-divided, and thus how ineffective, the national AMA organization remained. The open-mindedness of a few reformist leaders does not indicate general approval of said policy. From the start of the national debate on the issue, there was no considerable amount of enthusiasm for compulsory health insurance among physicians. Supposed acceptance of the measure was actually little more than resignation in the face of a trend that appeared more or less inevitable.

While the debate over health insurance revealed some rifts in national and local medical societies, the issue would generally prove galvanizing for the AMA. The issue was a means through which the group could flex its newly-attained political muscle, while mobilizing members, and thus leading to further strengthening of the organization. Though it would take several years, the AMA rallied behind the cause of keeping health financing out of public hands. It would continue to draw strength in years from continued opposition to any plan to involve the state comprehensively in the funding of health care. Indeed, the AMA would most effectively use the specter of national health insurance as a means of attracting (and retaining) members, as well as building coalitions with like minded groups and politicians. While it was unable to bring its full resource base to bear on the AALL episode in (attempted) health reform, this was the last such occasion in which the organization would prove reluctant to take a definitive stance on the issue.

Doctors were not the only opponents arrayed against the AALL in its efforts to institute compulsory health insurance. Predictably enough, private insurers were dead-set against the plan, despite the fact that the highly influential Prudential statistician (and industrial disease specialist) Frederick Hoffman was, for a time, a member of the AALL-led committee studying the issue of health insurance.[22] Though the motives behind medical opposition to the plan were complex and, indeed, were not shared by many members of the profession, insurer opposition could be traced to the fact that AALL proposals envisioned a system in which private health insurers would cease to operate, thus ensuring that the American private health insurance industry would be stillborn. Under the circumstances, it would thus seem startling if the industry failed to oppose the proposed legislation.

Though the prominent Prudential official Frederick Hoffman would initially appear open to the possibility of compulsory health insurance, he would swiftly turn into one of its most vehement foes. Private insurers generally expressed misgivings on the proposed legislative program from a relatively early point in the debate. A March 1916 report detailing "some activities of the American Association for Labor Legislation" contained the dire prediction that,

[22] Moreover, as in Britain during this period, private insurers did not, as yet, offer health benefits on a particularly broad scale.

"bitter opposition may be expected [to compulsory health coverage]…for certain insurance companies have formed a Federation with a large campaign fund, whose admitted purpose is war against all American social insurance legislation…"[23]

But why would private insurers oppose compulsory health insurance? After all, another thirty years or so would elapse before (private) insurance would cover a sizable proportion of the American populace. By the early twentieth century, however, insurers did provide profitable death or burial coverage, and AALL proposals threatened to curtail this area of activity.[24] Leading private insurers also envisioned future provision of health coverage, and did not wish to be prospectively sidelined through state intervention, even at such an early date.

AALL leaders, moreover, appear to have underestimated the threat posed by the insurance industry, just as they failed to appreciate the opposition they would encounter by certain sectors of the medical community. While reams of documents in the AALL Paper collection deal with the opposition of certain physicians to national health insurance, however, there is less evidence that the position of insurers were considered, or taken seriously. Though Hoffman was initially included on the committee studying the issue, his alliance with the organization would prove short-lived. By 1919 he was providing a catalogue of arguments against the adoption of compulsory, state-supervised health insurance to Connecticut officials who were, at the time, mulling such a plan.[25]

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[23] "Some Activities of the American Association for Labor Legislation (1915)," AALL Papers and Correspondence, 1916.
[24] Gordon, 13.
[25] These included evidence that social insurance had little effect on preserving income security, that health and mortality outcomes had not improved significantly, and, an early enunciation of the position taken by

While insurer opposition to the AALL agenda in health care was occasionally recognized by leaders of the organization, it was often dismissed as being "characteristically selfish" and directed toward the cause of maintaining the "profiteering element."[26] Perhaps aware that the industry needed to be seen to transcend greed in order to effectively oppose national health insurance, leading private insurers sought alliances with skeptics in the medical community. As legislative action appeared to progress in New York states, representatives of the insurance industry formed the New York League for Americanism.

The League for Americanism was instrumental in attaching the stigma of 'foreignness' to the concept of social insurance, a stigma that would adhere to many future plans to institute compulsory health insurance. As AALL literature reported, "peculiar conditions of propaganda invited by wartime prejudices enabled the opposition to poison the public mind…maliciously alleging [the New York legislation] was 'Made in Germany.'"[27]

In a letter to a leading official in the nursing arena, John Andrews was somewhat more direct, asserting that the "apparently inherent dislike of the medical profession for anything approaching practice in connection with insurance is being played upon by commercial insurance interests."[28] Andrews would then go on to detail how League literature was being distributed at medical society functions, while the League was reciprocating by distributing output from such organizations as the Kings County

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conservatives generations later—that such measures fostered dependency and moral decay. (AALL papers, reel 61).

[26] John Andrews, "Progress Toward Health Insurance," (AALL Papers), 1917.

[27] "1921 Report of Work" (AALL Papers).

[28] John Andrews, letter to Josephine Schatz, National Organization for Public Health Nursing, 8 November 1919. (AALL Papers).

(Brooklyn) Professional Guild, a group formed with the tacit approval of the local medical association to oppose state compulsory health insurance legislation.[29]

V. NHI: The Denouement

Faced with an opposition alliance drawn from the ranks of the insurance industry and medical profession, the denouement of this initial national debate over compulsory insurance was close at hand. In the same 'Report of Work' in which AALL leaders noted the 'poison[ing] of the public mind' on the issue, the organization appeared to concede defeat, stating that "the Association's officers…decided to await a more favorable time before again devoting so important a part of its modest resources to this legislative campaign."[30] For the AALL, however, such a favorable time was never to arrive. By the time compulsory health insurance was next seriously considered, the group was no longer in existence.

So what, then, compromised the AALL's mission to institute compulsory health insurance across the United States? Given the Association's campaign left nary a legacy, why should it be of interest to those studying the modern politics of health care? Clearly, timing played a role. The debate ended unfavorably for health insurance proponents partly because much of it happened to fall during and in the years immediately following America's involvement in World War I. Proposals for national health insurance, suffered from the fact that the most generous such program was offered to the citizens of the United States' arch nemesis in the conflict, Germany.

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[29] i*bid.*
[30]"1921 Report of Work" (AALL Papers).

While the foreign taint would continue to bedevil plans for state intervention in health insurance down to the present, such negative associations alone would likely not have been enough to bring the AALL program to a screeching halt. After all, the immediate (international) impetus for attempting the foundation of national health insurance in the United States were steps in that direction taken by America's ally in the World War, Great Britain. Instead, the timing of the health insurance debate was poor in another respect—this initial debate happened to occur just as the American Medical Association was coming into its own as a force on the national stage, following years, nay decades, of veritable dormancy. Indeed, the battle against national health insurance helped mobilize the profession, and increased the relevance of a growing AMA. Though physicians as a whole seem to have been ambivalent toward the AALL program, local and state medical societies and, eventually, the umbrella national organization, would prove powerful foes of national health insurance.

Certain physicians alone did not bring about the demise of the Progressive dream of state-sponsored health insurance. An embittered insurance industry was crucial in building an alliance of opponents among medical officials and insurers. Together these individuals managed to demonize proponents of health insurance by questioning their patriotism, and quite effectively heaped scorn upon their proposals as having been 'made in Germany.' They were assisted in their efforts by the very weakness of the AALL itself, which seemed naïve to the threat posed by allied opponents (during a 1917 meeting, the president of the group warned members to 'get wise' to the arguments raised by opponents of national health insurance—a startling reminder of just how blind this

elite group happened to be to the political complications that faced any such legislation).[31]

Such alliances, and associations of health insurance with foreign enemies, would be replicated during succeeding iterations of the debate as the twentieth century progressed. Thus similar efforts to institute national health insurance in the late 1940's and early 1950's would be stymied partly by associations with socialism, and thus the Communist bloc and the threat it was then seen to pose. Even following the fall of the Berlin Wall, 'socialized medicine' remained a repellent term to many, and was employed with considerable success by those opposing the Clinton health plan of the mid-1990's.

Though the health insurance debate thus left little in the way of legislation, it is significant in the ideas and motifs it propelled onto the national agenda. The episode proved beyond a doubt that national health insurance was not inevitable in America, and that concerted action among interests opposed to such proposals could be effective. Moreover, it showed just what a successful offensive might look like—namely, it would include references to the foreign roots of the idea and, if possible, it would involve linking any proposed legislation with an enemy of the United States.

VI. Interwar Politics and the Rise of Private Health Insurance

Private insurance behemoths such as Prudential vehemently opposed national (public) health insurance, despite the fact that these corporations had, as yet, little real stake in the conflict. During the first two decades of the twentieth century, the closest

[31] "Minutes of the Social Insurance Committee Meeting," 29 March 1917 (AALL Papers).

many private insurers came to the health care 'market' was through offering policies largely covering funerals. There was, as yet, no 'health insurance' as Americans would come to know it. Nonetheless, private insurers were concerned about losing the funeral business, and could envision a time when they might be called upon to assist in the payment of the burgeoning costs relating to health care.

The first stirrings of modern health insurance arose in several areas, and sectors of the country. In an early example of managed care, the Kaiser Corporation in California commenced coordination, and payment assistance, of employee health care. Another groundbreaking development transpired at a school system in Dallas, Texas just prior to the onset of the Great Depression. There, in 1929, system employees pooled a portion of their income toward a package of care offered (and run by) one-time Dallas school superintendent and then-area hospital coordinator Justin Ford Kimball.[32] Thus was forerunner of so-called first Blue Cross plan. Such hospital-based insurance plans would gradually spread across the country in the several decades to come.[33]

Physicians concerned about the position within the discipline were initially reluctant to work under Blue Cross plans, as they did not feel they had enough of a voice in the governance of such schemes. While Blue Cross subscribers could thus expect to be reimbursed for hospital expenses, they were not compensated for expenses incurred when visiting the family doctor. This anomaly was eliminated with the birth of the first Blue Shield plan, in 1939. Blue Shield insurance plans contained terms similar to Blue Cross, only they were controlled by doctors, rather than hospitals. The origin of these plans is

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[32] According to the website of the Blue Cross Blue Shield Association (BCBSA), enrollment in 'the Blues' grew from just over one thousand in 1929, to three million in 1939, to some 94 million in 2006.

[33] Emily Friedman, "What Price Survival?: The Future of Blue Cross and Blue Shield," *Journal of the American Medical Association,* Vol. 279, no. 23 (June 17, 1998), 1863.

traced to certain mining concerns based in the Pacific Northwest which, just after the turn of the twentieth century, contracted with doctors to provide care at a given monthly rate.[34]

The position of 'the Blues' was cemented by preferential tax treatment at state and, eventually, federal level. Operators of such plans managed to have their organizations attain tax exemptions. This favored status was 'justified' by the fact that they were run on a not-for-profit basis, and because they offered insurance coverage to at least some sectors of the population who were refused by commercial, for-profit insurers.

At the same time, further efforts on the federal level to expand the public role in health care made limited headway. After the decline of the AALL and its drive to establish a system of comprehensive insurance based on the individual states, reformers waited for their next opportunity to raise the issue. This seemed to arrive with the accession of Franklin D. Roosevelt in the midst of the Great Depression. The administration swiftly drew up plans for broad federal recovery efforts to varied and wide sectors of the populace. Some administration figures, including Labor Secretary Frances Perkins, lobbied for the inclusion of national health insurance coverage within the larger program. Indeed, plans were drawn up for NHI as a subsidiary of the emergent social security regime.

At the very hint of health care reform, however, the AMA was swift to mobilize against any fundamental change to the system, taking the same stance it had during the AALL episode twenty years before. Roosevelt and others among his advisory staff soon nixed the proposal, operating under the (very plausible) assumption that such an effort

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[34] Gerard Markowitz and David Rosner, "Seeking Common Ground: A History of Labor and Blue Cross," *Journal of Health Policy, Politics, and Law*, Vol. 16, no. 4 (1991), 699.

could sink the entire raft of social programs—particularly the ambitious social security system of benefits. This second unsuccessful attempt to enact national health insurance left in its wake a dedicated group of would-be reformers—figures like Wilbur Cohen and Oscar(?) Ewing, who would work to ensure that health care remained on the American political agenda.

Executive inaction on health care did not prevent Congress from tackling the issue. In 1939, New York Senator Robert Wagner, Sr. spearheaded national health insurance legislation. Though it attracted immediate, ferocious opposition from the AMA and its allies, his proposed program was actually relatively moderate. It did not envision massive new federal bureaucracy, and complete federal control over the terms under which physicians practiced. Wagner and several Senate colleagues, including John Dingell (D-MI) and James Murray, also a Democrat from Michigan, attempted to obtain legislative action on similar bills annually over the next several years. Eschewing state-level reform efforts, the Wagner-Murray-Dingell legislative formulation contained federal provision of national health insurance along the lines of Social Security.[35]

In the absence of federal (or even state) intervention, then, a network of private bodies developed to offer would-be patients protection and assistance, in the event of ill health (and the costs arising from such a circumstance). This development was very much in contrast to the situation that had unfolded in the United Kingdom just prior to the enactment of National Health Insurance. There, government coverage was offered before corporate giants entered the health insurance market. Indeed, London intervened to shape the health care system around the moment of its (modern) inception, and before health

[35] Jaap Kooijman, *…and the Pursuit of National Health: The Incremental Strategy Toward National Health Insurance in the United States* (Amsterdam: Rodopi, 1999), 86-87.

care costs reached the astronomical levels associated with growing technological sophistication and proliferation of care options.[36] As Jacob Hacker has shown, the possibilities for government intervention in American health care decreased, as private provision of care and finance increased.[37] The national political universe became crowded with influential individuals and interest groups with a vested interest in retention of the *status quo*.

While the AMA and interest group allies tarred any AALL-sponsored national health insurance scheme through association with Germany, America's chief opponent in the Great War, organized medicine worked to prevent the advent of NHI during the interwar period by pointing up supposed deficiencies of the British health care system. The worst aspects of health care under British national health insurance appeared in the pages of the *Journal of the American Medical Association* (JAMA), where a column cataloguing medical misadventures ran for over a decade beginning in the mid-1920s.[38] There were undoubtedly shortcomings when it came to British NHI after 1911, as multiple reports, including several commissioned by leading luminaries of the British medical profession, could attest (cite).

Ironically, such systemic faults were, as many of the aforementioned reports indicated, related to a lack of national coordination and, indeed, the limited nature of the coverage offered under NHI. National Health Insurance in Britain between 1911 and 1941 was hardly a panacea, and in the end served to highlight more problems than it

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[36] It should, however, be noted that even after enactment of the (very incomplete) NHI program in 1911, high health care costs could easily send working class individuals and families into poverty.
[37] Jacob Hacker, "Yes We Can? The New Push for American Health Security," *Politics & Society*, Vol. 37, no. 3 (2009), 8-9.
[38] Nicholas Laham, *Why the United States Lacks a National Health Insurance Program* (Westport, CT: Greenwood Press, 1993), 16.

resolved. The NHS was an attempt to fulfill the need for national coordination of care that had been found wanting under NHI.

The AMA's efforts to discredit the British health care system reached a fever pitch with the foundation of the NHS, and the simultaneous efforts on the part of President Truman to enact national health insurance in the United States. Operating from a position of strength and professional unity—the AMA could count around 90% of practicing American physicians as members—organized medicine launched a National Education Campaign during the 1940s to prevent any significant new government intervention in health care.[39] Not surprisingly, the AMA portrayed the battle as one pitting citizen patients against a meddlesome State that could only offer mediocrity in medicine. Positing that "the Government" was intent on "dominat[ing] the medical affairs of every citizen", the AMA leadership ensured that administration efforts to pass national health insurance was associated with infringement on basic American freedoms.[40]

The political opposition to Truman's national health insurance proposal did not limit its efforts to rhetoric. While the Federal Security Agency (the forerunner to the present Department of Health and Human Services) and figures from other organizations sponsored programs across the country educating the populace on the virtues of NHI, an alliance of Republicans and southern Democrats went about investigating the administration. They charged administration officials with attempting to impose national health insurance through what amounted to mass-brainwashing.[41] In the period

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[39] *ibid.*, 14-15.
[40] *ibid.*, 15.
[41] Quadagno, 34.

immediately preceding Senator Joe McCarthy's notorious witch hunt, government officials expressing enthusiasm for national health insurance were fingered as crypto-communists.[42] This era was one in which a perceived link to Communism, however tenuous, was enough to ruin the careers of many worthy individuals, along with equally worthy causes.

In this way, national health insurance was presented as very much counter to national ideals. Left unmentioned was any hint that the interests of the medical profession could ever run counter to those of would-be patients. Perched atop a broad alliance of interest groups, the AMA was careful to portray its lobbying efforts as downright altruistic, conveniently failing to note what a mortal threat the profession perceived in NHI.

When professional representatives did state the obvious—that organized medicine opposed national health insurance for reasons of self-interest—they were careful to preserve the linkage between patient and physician interests. Hence one such figure explained the profession's opposition by stating in seemingly forthright fashion that "physicians do not want to work for the government. They want to work for the people, directly. They want to be responsible to the people, directly."[43] National health insurance, certain doctors claimed, would have the effect of decreasing the (democratic) accountability of the profession to the citizen-patients its members served.

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[42] Particularly instrumental in this pre-McCarthy crusade against suspected communists was Senator Dies of Texas. Though a Democrat, Dies used the House UnAmerican Affairs Committee, over which he presided, to defame New Dealers and their latter-day sympathizers (see Quadagno, 33-35).

[43] Jonathan Engel, *Doctors and Reformers: Discussion and Debate Over Health Policy, 1925-1950*, (Columbia, SC: University of South Carolina Press, 2002), 197.

The attitudes of American physician leaders contrasted considerably to those of British doctors in the years leading up to World War II. In both states, there was some recognition among key players that something needed to be done to modernize medical facilities, and improve access to health care broadly. The general acceptance of the range of prescriptions, however, varied. Prominent leaders in the British medical profession, with the backing of the BMA, put forward a state-sponsored plan that would expand coverage to at least 90% of the population—those that could not fully afford the increasingly expensive cost of care without assistance. The only significant difference of opinion between reformers on the political left and the medical profession was over how to provide, and pay for, care accruing to the remaining 10% of the population.

In the United States, on the other hand, the medical profession (as documented above) departed from health care reformers early on the matter of state-sponsored national health insurance. Indeed, American physician leaders did not even accept the notion of pre-paid insurance plans until the 1930s and 1940s. The justification offered for more generous, and stable financing of care for those who could not afford it was that most doctors already provided charity care, adjusting costs according to the individual patient's ability to pay. American physicians, moreover, were particularly keen to defend and preserve their professional prerogative to select their patients—a privilege they feared losing under a system of state health insurance.[44]

The prestige traditionally accorded to American doctors (1940-era polling suggests they barely trailed Supreme Court justices in terms of respectability), and their

[44] British physicians were similarly concerned about having patients forced on them, though this issue was not treated in earnest within the context of Parliament until the debate over the specific shape the NHS Act would take.

ubiquity in the lives of the nation's citizen-patients ensured their position on the matter of national health insurance gained considerable traction. At an elite level, the sheer breadth of the interest group alliance over which organized medicine presided also helps account for the widespread acceptance of this conservative point of view. Even thus buttressed, however, physicians and their allies could not have defeated national health insurance, were it not to the biases of the American political system in which they operated, as well as the overarching (liberal) political culture of the citizenry at large. As noted previously, the rise of a private health insurance infrastructure would, as the 1940s and 1950s progressed, effectively 'crowd out' public solutions.

In some ways, it would make sense from the perspective of policy progress to fast-forward from the conservative interwar period all the way to the liberal activism in health care under the Johnson administration in the mid 1960's. To do so, however, would lead one to miss the nuanced, but critical, ways in which federal policy choices shaped the American health care system during the 1930's through 1950's. During this period, the modern American health care system with foundations around the turn of the twentieth century, began to exhibit many of the characteristics that define it to this day.

The onset of American involvement in World War II led to the imposition of price and wage controls, deemed a necessary sacrifice in a time of large-scale conflict. Lacking the leverage furnished by differential wage offerings, employers increasingly sought to attract workers through the provision of benefit packages. Chief among the benefits comprising these incentive packages was corporate-financed health insurance. As large firms turned to the finance of health insurance, private health insurance companies blossomed. Hospital-based Blue Cross systems were soon joined by

commercial enterprises. In contrast to the state of affairs across the Atlantic, serious national attempts to achieve national health insurance followed the colonization of heath care finance by commercial insurance companies. The major insurers generally allied themselves with the AMA, forming a part of the massive interest alliance that opposed a greater public role in health care for the better part of a half century.

Insurers and physicians were, however, not natural allies. Indeed, as late as the mid-1930s, the AMA could muster only lukewarm support for private health insurance.[45] As the specter of national health insurance once again 'haunted' organized medicine and associated interests, however, the physicians' body was swift to make common cause with private insurers, as a (very effective, as it would turn out) means of heading off calls for comprehensive PUBLIC finance of health care. Four decades later, many physicians would have reason to regret the now-longstanding strategic alliance with insurers against the state, and the consequences it has had on professional autonomy.

Nonetheless, in the 1930s and into the 1940s organized medicine and insurance giants were effectively forced into each other's arms. Together they led the powerful interest group coalition that managed to defeat multiple attempts to carve out a more substantial government role in health care. They could not have been nearly as effective in their quest to preserve the private-public status quo, if it had not been for the liberal political culture of the United States, and the party politics in which the interests operated. An alliance of conservative southern Democrats and Republicans managed to block congressional and administration efforts to build support for national health insurance.

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[45] Engel, 64.

Because of the growing strength of the AMA-led interest coalition, presidents and congressional figures were increasingly hesitant to tackle the issue of health care reform. As noted previously, FDR feared offering a health reform program, lest it sink the larger social security package to which it would have been attached. Senator Wagner and allies, aware of the opposition they would inevitably face, crafted a moderate program of reform. Nonetheless, their efforts came to naught in the face of physician and insurer-led uproar.

To anticipate the events of future decades, this alliance was only overcome during the mid-1960s, when northeastern Democrats were able to overrule their southern colleagues, and build a majority in favor of health care reform. Within a few years, however, Republicans began to regain the ground lost during (and immediately following) the Kennedy era. The window of opportunity for reform during the postwar era was, therefore, quite narrow. Lacking the level of national solidarity arising from existential crisis, the United States instead witnessed a resurgence of classical liberalism in the guise of American conservatism, with its emphasis on individual rights, and fostering the private sector at the expense of the public. I will have much more to say about the latter era of health care reform (and lack thereof) in future chapters.

But first, I turn to the development of the British health care system. Whereas it is quite difficult to historically 'locate' the precise moment of foundation when it comes to the American health care system, we know when the modern British system came about—1948. In May of that year the NHS Act came into effect, and the National Health Service was formally established. On the 'Appointed Day', health care became free to millions at the point of delivery. Just about every hospital in England, Wales, and

Scotland was nationalized, and their respective staffs became state employees. Just as it took several decades for the American health care system to take a form vaguely recognizable to observers today, the NHS was also years in the making.

The following chapter will explain the set of historical circumstances that led to the creation of a comprehensive system of state-sponsored health care. It will show how the National Health Insurance Act of 1911 set the stage for later reforms, and the sort of political wrangling involved in the year or so leading up to passage of the NHS Act. Moreover, the next chapter will illustrate how the opposition of the medical profession was overcome, and the crucial role the representation of the concerns of citizen-patients played in this process.

CHAPTER 3—The Rise of the National Health Service

I. British Health Care Before 1948: NHS Antecedents

"The NHS did not start with a clean sheet of paper. It was a rationalization of what existed, conditioned by a need to cajole, not coerce, somewhat reactionary interest groups." –NHS historian, and former employee, Geoffrey Rivett

I. The Early British Health Care System

Information on the British health care system prior to 1946 is, relative to the material to be found on the National Health Service, quite limited. Statistics relating to health expenditure prior to the Second World War, for instance, can only be found in the most obscure of contemporary reference sources. Why should this be the case? For a start, there was hardly a single 'British health care system' prior to World War II.[1] Two institutions operating on the local level were key in the provision of care during this period—the voluntary hospital, financed by charitable donations, and municipal hospitals, an outgrowth of local institutions that had traditionally aided the poor. In London, there were several great teaching hospitals—institutions hundreds of years in the making, that cherished their independence as a mark of prestige. Quality of care across

[1] Klein, 2-4.

these disparate facilities was very uneven, and it was partly this lack of uniform salubriousness that led British leaders to conceive of a national health service.[1]

The unified, universal National Health Service combined several disparate strands of medical provision, bringing under one roof institutions that harked back to the nineteenth century and, in some cases, even earlier. In the acute sector, hospitals in the (local) public and private (charitable) sector were all nationalized, and governed by a new top-down system. Even the prestigious, centuries-old teaching hospitals situated in and around London were brought under this new nationwide system, though they were allowed to retain a relative measure of independence within the new system.[2] Hospitals that had just witnessed state control under the Emergency Medical Service were brought back into the public sector.

Before skipping ahead to the arrangements brought into being through the 1946 passage of the National Health Service Act, it is important to examine prior developments in British medicine. The British health sector has a rather different profile than that found in the United States, and this affects its degree of internal unity and, therefore, its political efficacy vis a vis other important groups in society. Particularly powerful and enduring has been the split between hospital-based consultants, on the one hand, and GPs, who generally own their own practices.[3] I will first outline some of the salient aspects of the British hospital sector, before surveying the experience of general

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[1] Klein, 3.
[2] Robert Dingwall et al, *An Introduction to the Social History of Nursing* (New York: Routledge, 1988), 107.
[3] Juan Baeza, *Restructuring the Medical Profession: The Intraprofessional Relations of GPs and Hospital Consultants* (New York: McGraw-Hill, 2005), 2.

practitioners prior to 1946. I will then bring the groups together, and show how the health care sector related to political leaders in the run-up to the passage of the NHS Act, and in the years immediately thereafter.

II. The Early Hospital Sector

Central to understanding the British hospital system is the fundamental divide that long lay between prestigious 'voluntary' institutions, and those more workaday facilities run locally by the State. Voluntary hospitals were supported by concerned (wealthy) citizens and local subscriptions. Municipal hospitals, on the other hand, were administered by local (governing) authorities. Many were originally operated under the aegis of the Poor Law, the regime that structured what was then a parsimonious system of welfare provision.[4]

Voluntary hospitals had, since the eighteenth century, sustained themselves through continuous funding infusions from wealthy individuals or families, business, as well as the charitable giving of ordinary individuals.[5] Others were supported and, indeed, attached to local universities (these were the most prestigious institution of all—the teaching hospital). Many such hospitals also used their patients as an income stream, accepting fees from those able to pay for their care. Hospital employees led regular charity campaigns (so-called 'shroud-waving' events), often going door-to-door to seek

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[4] Alysa Levene et al., "The Development of Municipal General Hospitals in English County Boroughs in the 1930s," *Medical History*, Vol. 50, No. 1 (January 2006), 3-28.
[5] Martin Gorsky and John Mohan, "London's Voluntary Hospitals in the Interwar Period: Growth, Transformation, or Crisis," *Nonprofit and Voluntary Sector Quarterly*, Vol. 30, No. 2 (June 2001), 247-249.

the funding that would allow the institution to continue serving the surrounding community.[6]

Wealthy benefactors and local subscribers were not the only funding sources voluntary hospitals could call upon. While the facilities were much sought-after training grounds for ambitious medical professionals, who jumped at the chance to treat some of the poorest Britons for free, they did not serve all gratis. Wealthy patients also sought the luxury voluntary hospitals could offer, and paid for the privilege. As the British economy soured during the interwar period, voluntary hospitals increasingly sought to expand opportunities to charge patients, while neighborhood fund-raising (some would say 'begging') campaigns were also stepped up.[7]

To some inside and outside the medical profession, such desperate measures seemed below the dignity of those working for an important facility, and of such an elevated station in life. By the mid-20th century, many voluntary hospitals were in dire financial straits. Charitable donations decreased precipitously as all sectors of society suffered the depredations of the Great Depression. At the same time, hospital operating expenses rose, as medical technology improved (and the price of medical equipment rose).[8] As the science of medicine and the quality of care thus improved, more and more individuals from all walks of life sought out the new life-extending miracles hospitals

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[6] Geoffrey Rivett, *National Health Service History* (nhshistory.net). Online: http://www.nhshistory.net/intro1.htm#The_inheritance_of_the_NHS, accessed 8 November 2008.
[7] Klein, 2-3.
[8] Martin Gorsky and John Mohan, *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain, Past and Present* (London: Office of Health Economics and the Association of Chartered Accountants, 2001), 38-54.

seemed capable of providing. Even with the increase in proceeds from patient charges, voluntary hospitals were in an unenviable financial position as World War II approached.

The other major type of acute care facility was the local municipal hospital. Such institutions were financed and managed by local authorities, the basic unit of British local government. They were not nearly as prestigious as the voluntary hospitals and, indeed, were often inherited Poor Law facilities. In 1929 local authorities were empowered to take over hospitals serving the poor within the framework of the Poor Law of 1834, about which more appear a bit later in this chapter.[9] Just as there was considerable economic inequality across (and even within) local authorities, the hospitals governed by these jurisdictions were highly uneven in finance, and, therefore, quality.

While the voluntary hospitals treated many among the middle and, in some cases, upper classes, the municipal hospitals were often left with lower-class patients, as well as many of those suffering from chronic conditions, and thus in need of long-term care. Indeed, while some poorer patients were treated free of charge at voluntary hospitals, these institutions tended to export the less 'glamorous' or exotic cases to local municipal hospitals. As Rivett notes, many municipal hospitals were thus saddled with the reputation of 'dumping ground'—the St. Elsewheres of their day.[10] This often led to enmity between the voluntary and municipal hospitals, particularly when the latter competed for patients (mainly in acute care) from the voluntaries.[11] It was thus left to the

[9] Michael Moran, *Governing the Health Care State: A Comparative Study of the United Kingdom, United States, and Germany* (Manchester, UK: Manchester University Press, 1999), 28.
[10] Rivett, 2008.
[11] Levene et al.

NHS to soothe strained relationships between the different institutions, and to make them work together under a national care rubric.

III. Physicians in General Practice

Several different models of general practice were also unified within the context of the NHS. Physicians in private practice, whether entirely independent, or under contract with friendly societies and other such payers, were brought under the same institutional mechanisms as the many GPs who had previously served patients under the Poor Law medical system, and then (after 1911) under national workingman's insurance. Before delving into the early history of the National Health Service itself, I will explore historical developments that impacted the provision of primary care in the United Kingdom prior to the mid-20th century.

Prior to 1911, many British general practitioners (GPs) owned small, individualized practices, using proceeds from (paying) wealthier patients to finance charity care for those who could not afford it.[12] A fair proportion of GPs were under contract with so-called 'friendly societies.' These were groups representing the growing ranks of (mainly industrial) workers that financed and oversaw the provision of health care for this sector of the populace. As Hollingworth notes, the friendly societies exerted a powerful influence on behalf of British health care 'consumers,' driving down prices and largely determining the terms of care.[13] They were so effective when it came to determining—nay, dictating--the specific shape health care would take that many

[12] John Howie, "Research in General Practice: Perspectives and Themes," in Irvine Loudon et al., eds. *General Practice Under the NHS, 1948-1997* (New York: Oxford University Press, 1998), 146.
[13] Hollingsworth,

physicians felt enslaved under the onerous conditions set down contractually.[14] Across the profession, friendly society practice had the effect of lowering health care prices (and therefore) costs. They were thus opposed by the leaders of the medical profession, as were those physicians who worked for them.[15] By the early twentieth century, physicians were yearning for ways to minimize the influence of friendly societies. To many general practitioners, State intervention must have appeared preferable to continued dominance on the part of said groups.

The relationship between many GPs and hospital-based physicians was often a tense one. The latter often sought to monopolize hospital practice, and elevated themselves above the less prestigious community-based GP. This was not necessarily the same sort of intra-professional divide found in the United States—namely, that between specialists and generalists. To the contrary, many of the most respected hospital-based physicians were generalists. Those who chose to specialize were, particularly in this early period, considered inferior to those able to treat a wide range of conditions.[16] The salient divide in the medical profession was, instead, between those GPs who practiced in a community setting, and those 'consultants' who were based in the hospitals.

Physicians thus lacked unity and, indeed, many (particularly GPs) lacked a secure livelihood. While the aforementioned GPs formed the backbone of the British Medical Association (BMA), consultants were represented by the more prestigious Royal

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[14] Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Patients, 1720-1911* (Cambridge, UK: Cambridge University Press, 2002), 122.
[15] Howard M. Leichter, *A Comparative Approach to Policy Analysis: Health Care Policy in Four Nations* (Cambridge, UK: Cambridge University Press, 1979), 166-168.
[16] Hollingsworth, 30.

Colleges. While the BMA generally presented itself as a thorn in the side of successive governments on medical policy, the elites of the Royal Colleges often enjoyed a more cozy relationship with those in positions of political authority. No single peak organization therefore existed to propound a coherent case for the status quo.[17]

IV. Political Background

By 1911, the Liberal Party was seemingly near the height of its power. Under the leadership of H.H. Asquith, it had been in power for five years, and would remain in office for the better part of a decade to come. Few then could anticipate the precipitous decline in party fortunes that would accompany the 1917 power grab by the ambitious chancellor, David Lloyd George.[18] Even at that early date, however, the Liberals were increasingly under pressure from both the political right and left. It was through such progressive reforms as workmen's compensation and workingman's insurance, that Lloyd George and other leading lights of the Asquith government sought to placate the rising laboring class, many of whom would eventually (and predictably) find a political home in the Labour Party.[19]

Nonetheless, it was a Liberal government that would set the nation on the long road to a free, comprehensive National Health Service. How did the government manage to pass such legislation, an act that has eluded many a champion of the American Left? A good part of the explanation can be found in the fragmented nature of the interests that

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[17] Hollingsworth 19-21.
[18] Alfred F. Havighurst, *Britain in Transition: The Twentieth Century* (Chicago: University of Chicago Press, 1985), 137.
[19] Havighurst, 103-105.

could be expected to fight for the continuation of the status quo, and correspondingly, the relative strength of those who could be mobilized on the side of reform. The United Kingdom, one of the first countries to industrialize, already contained a strong network of labor unions, constituent groups that were well on their way to establishing what was, in effect, their own political party.

Sensing an opportunity to appeal to would-be constituents of the up-and-coming Labour Party, Lloyd George, in his capacity as Chancellor of the Exchequer (or treasury chief), hit upon the rather Bismarckian notion of effectively buying labor's support through the enactment of welfare measures.[20] The Welsh chancellor would be known throughout his lengthy public career as one who was eminently flexible as to the political means, as long as they served his political ends. His NHI scheme and related reforms offers an early example of this quality.[21]

The 1911 National Health Insurance legislation was part of a raft of reforms passed by the Asquith at the suggestion of the dominant Chancellor, David Lloyd George. This reform package also included workman's compensation, and other forms of insurance coverage—all targeted to manual laborers attempting to get by on a minimal income. Lloyd George propounded the legislation out of genuine concern for rectifying

[20] Bismarck attempted, with some success, to blunt the appeal of the political Left by leading his conservative government to effectively construct an early welfare state.
[21] L.C.B. Seaman, *Post-Victorian Britain, 1902-1951* (New York: Routledge, 1968), 150-152.

the plight of the poor, though he was also conscious of the political gains that would accrue to the government, and governing party.[22]

The medical community did not accept the NHI proposal without a fight. Nonetheless, physicians and their allies proved unable to prevent their passage. I previously noted that the medical profession was internally divided, and that this fractiousness extended to those organizations charged with representing its member's interests. This state of affairs tended to play into the government's hands in the case of the debate over national health insurance.

Leading members of the BMA remained implacably opposed to the reforms, naturally fearing government interference in professional affairs, and a dilution of the cherished autonomy enjoyed by members of the profession.[23] Nonetheless, a fair portion of the medical rank-and-file actually eventually favored NHI. They did so because while they feared overbearing government, they feared the intrusiveness of the Friendly Societies more.[24] Furthermore, many recognized that work under national health insurance would be remunerated at highly levels than those to which they had become accustomed.

Faced with what amounted to an insurgency on the part of its membership, the BMA leadership nonetheless remained committed to the position they had adopted from the very beginning of the debate. The firmness of BMA leaders, however, did not inspire

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[22] Peter Clarke, *Liberals and Social Democrats* (Cambridge, UK: Cambridge University Press, 1981), 113-120.
[23] Digby, 310-311..
[24] Geoffrey Russell Searle, *A New England?: Peace and War, 1886-1918* (New York: Oxford University Press, 2004), 386-389.

loyalty on the part of the rank-and-file. Thanks to a strong majority, as well as the ever strong party discipline found within the British system, the NHI legislation passed and, perhaps more importantly, enjoyed a successful roll-out.[25]

The BMA initially responded by calling for a physician strike as the NHI reforms were applied in 1913. In the days following the point at which the reforms were to go into effect, however, many physicians signed on to the program, leaving the upper echelons of the BMA organization looking weak, if not a tad foolish.[26] The bulk of physicians soon found the program to be much to their advantage. There would be occasional conflict between physicians and government over levels of compensation under the national health insurance regime, but relations between the two parties remained otherwise quite commodious.

Just how did the medical establishment go from a state of active protest to one of calm collaboration? The Asquith/Lloyd George government ensured goodwill among medical professionals by freeing physicians from reliance on contractual obligations to the so-called friendly societies. The friendly societies were superseded by 'approved societies, which were local bodies generally comprised of insurance company representatives as well as community members, which presided over the distribution of insurance payments at the local level. The prominent place in health care and, indeed, social policy generally, once occupied by the Friendly Societies was largely filled by the

[25] Searle, 389.
[26] John Carrier and Ian Kendall, *Health and the National Health Service* (London: Continuum, 1998), 64-65.

approved societies, which went on to become a powerful vested interest in their own right.[27]

At the same time, physicians maintained their independence from the government. Administering the medical benefit portion of the program was a quasi-private entity, the local Insurance Committee. Membership was split between consumer representatives, persons selected by local government, and area physician representatives.[28] Cash benefits distributing during periods of worker ailments and maternity were distributed through 'approved societies,' or private insurers. In this way, physicians were incorporated willingly within an overarching structure that gave no single interest overwhelming power, while allowing all major parties a place at the table.[29]

Having secured compromise from the major relevant interests involved, the Liberal government managed to forge a system of National Health Insurance three years before the outbreak of World War I commenced. Despite dramatic political developments associated with the war, as well as the scourge of the Great Depression, Lloyd George's NHI scheme continued to function. It endured during and after the formulation of several 'vague' proposals for more comprehensive health care reform during the course of the 1920s and 1930s.[30] Despite its longevity, however, the system had definite shortcomings, and it was partly these limitations that drove early (radical)

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[27] Bentley B. Gilbert, *British Social Policy, 1914-1939* (Ithaca, NY: Cornell University Press, 1970), 256-257).
[28] Michael Heller, "The National Insurance Acts 1911-1947, the Approved Societies, and the Prudential Assurance Company," *Twentieth Century British History*, Vol. 19, No. 1 (January 2008), 1-5.
[29] Hollingsworth 21-22
[30] Klein, 4-5.

reform proposals and, eventually, launched the idea of comprehensive, truly national (public) health care to the top of the political agenda.

Even as the war waged on, reformers within the government sought to further rationalize provision of health care across the nation by forming a centralized health ministry. Such a government body, it was hoped, would overcome the continued fragmentation within the health care system. After all, while many physicians worked under the new NHI scheme, other health care functions (particularly those relating to maternity) were supervised by the local authorities. Still other responsibilities in health care fell under the bailiwick of the Poor Law institutions, overseen by local Boards of Guardians.[31]

Despite the successes connected to NHI, which included greater access to health care on the part of many who had gone without, the British health care system as a whole remained a veritable crazy quilt—not unlike that found in the United States to the present day. In the name of greater efficiency and progressive rationality, reformers such as Lord Macdonald sought to combat the disorder that continued to prevail in health care.[32] Several plans were outlined, granting a new ministry of health some of the powers at the time enjoyed by local authorities and approved societies. What followed were several years of political skirmishing between authorities, societies, and advocates of an empowered health ministry. The end result was stalemate, and the government opted to

[31] Gilbert, 253.
[32] Geoffrey Rivett, "The Development of the London Hospital System, 1823-1982," in *National Health Service History*, online: http://www.nhshistory.net/.

largely preserve the status quo. The conclusion of war in 1919 was thus accompanied by policy stasis so far as the national health care system was concerned.[33]

The aftermath of World War I, and the idealism peace initially engendered, led political leaders, and others across society, to exhibit optimism about the potential for further large-scale social reform. From the post of chancellor, Lloyd George retained considerable control over the British economy as chief of a new wartime Ministry of Munitions. Toward the conclusion of the conflict, the ambitious minister climbed even higher, securing the prime ministerial dignity.

Upon accession to the top national political post, Lloyd George remained committed to reform and, indeed, envisioned dramatic expansion of NHI and, perhaps, a more comprehensive health care regime. Ideals, however, swiftly collided with economic reality. Wartime economic strength gave way to a rather serious downturn. The government thus found itself without the requisite funding for large-scale reform.[34] Initial expectations were thus swiftly dashed in the immediate postwar era. The most that could be achieved was a modest expansion in the national health insurance program.[35] As I will outline below, however, the NHI program was shown to have considerable shortcomings. Though it improved access to health care in limited fashion, it did little to improve the conditions under which doctors labored, and patients treated.

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[33] Gilbert, 264-267.
[34] Gilbert, 267.
[35] Anne Digby and Nick Bosanquet, "Doctors and Patients in an Era of National Health Insurance, 1913-1938," *Economic History Review*, Vol. 41, No. 1 (February 1988), 74-75.

During this entire period from 1911 through the 1920s, medical care was (unsurprisingly, perhaps) still quite archaic, and GPs were able to offer little in the way of comfort or basic protection to most of their patients. As British health historian Geoffrey Rivett notes, "Pain and suffering were accepted as part of life to be endured with stoicism," and that, partly as a result, "patients' expectations were not high."[36] Some would argue that this stoicism and, indeed, sense of resignation relating to health has remained a part of British medical culture, even up to the present day. In a period when few treatment options were available to most, it was particularly acute.

Moreover, the NHI system itself soon proved unequal to the task of providing medical care to ALL of those in greatest need. The program only covered workers, or those earning under a certain benchmark wage. Dependents of those eligible, including spouses and children, were not covered under the program. Additionally, national health insurance only covered primary physician care, and not hospital treatment.

National Health Insurance also did little to improve the poor conditions found in medical facilities of the period, outlined above. While the problem of coverage and access were thus partly treated, the issue of quality remained problematic. Concerns about quality could have been less salient in an earlier time, when relatively few individuals actually sought professional medical care—and fewer, still, endured hospital stays. By the 1920s and 1930s, however, this was beginning to change. More citizens, across a broader swath of the economic spectrum, were seeking care outside of the home.

[36] Rivett, nhshistory.net.

Expectations surrounding just what medical care of the time could offer patients were also beginning to rise.

Just what changed during the course of the interwar period, then, to make patients' expectations rise, and the pressure on government to respond to increase commensurately? First, medicine entered the modern era, becoming a true science. Entering a hospital was no longer a gamble, and demand for care thus rose dramatically. Furthermore, wealthier individuals were compelled to seek care in institutions formerly reserved largely for the poor, as they became more confident in the healing powers of the personnel and equipment to be found in such settings. Municipal hospitals, formerly the reserve of the poor and, indeed, often inherited from the old Poor Law public apparatus, saw some of their first middle, and even upper class patients during the interwar period.[37]

The appalling conditions with which they were faced led many in that sector of society to believe that hospitals could be better run by (national) government (or, for that matter, anyone else), rather than leaving the responsibility to (often cash-strapped) localities. Some assert that the shortcomings of NHI-era provision of care began to show up in early opinion polls, and that this is what initially piqued the interest of enterprising political figures. Others, however, stress the independent positive role adopted by key bureaucrats and, indeed, non-governmental reformers, in creating initial momentum toward system overhaul.

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[37] Lawrence Jacobs, *The Health of Nations: Public Opinion and the Making of American and British Health Policy* (Ithaca, NY: Cornell University Press, 1993), 52.

As the continued limitations of NHI became clear, governments of the day proceeded to solicit advice on how best to respond to what was increasingly being seen as a health care crisis. One of the first products of this search for solutions was the report published by a Royal Commission on the nation's health chaired by Lord Dawson, a longtime reformist bureaucrat. The report called for a (more) comprehensive government-directed national health service, though one somewhat more limited than that eventually hatched in 1948.

Under the so-called Dawson Report, hospitals were to be grouped and coordinated on a regional basis. Physicians would continue to be paid based on the number of patients they could claim, and would not become salaried state employees. Rather than leading a relatively isolated experience in private practice, Dawson and colleagues suggested that the general practitioner should play a far greater role in shaping and, indeed, ordering the broader health care system.[38] GPs were to group themselves under the rubric of local health centers, which would be hierarchically linked to larger secondary health centers. These secondary centers would, in turn, be connected with specific regional hospitals. While radical insofar as it envisioned a rather more rationalized system of (mainly hospital) care, the Dawson Report also contained conservative elements, particularly when it came to the relationship of physicians to the

[38] Jane Lewis, "Providers, 'Consumers', the State and the Delivery of Health-Care Services in Twentieth-Century Britain," in Andrew Wear, ed., *Medicine in Society: Historical Essays* (Cambridge, UK: Cambridge University Press, 1992), 331-332.

state. This is perhaps not surprising, considering it was approved by leading members of the medical profession itself.[39]

Despite (or perhaps because of) its radical, forward-looking agenda, the Dawson Report failed to leave much of a policy footprint. Nonetheless, the idea of greater hospital coordination and organization was not dropped by successive governments during the decade of the 1920's. Particularly forceful in his advocacy of hospital system rationalization was then-health minister Neville Chamberlain.[40] The future prime minister who would become best known for what many would later view as a meek, conservative foreign policy, called for dramatic action in the health care sector. He thus mooted the idea of creating a central health authority, which might one day coordinate all the health care needs in a given geographical area. Until that day, he advocated greater cooperation between voluntary hospitals and other care-giving institutions in the community.[41] Like the Dawson Report, however, Chamberlain's prescriptions for health care reform made little political headway. While political inaction remained the rule during this period, other members of the wider community were still debating alternative strategies to realize fundamental reform of the health care system.

The government could, for instance, continue to turn to the British medical profession for advice on future health care provision. In 1930, ten years after the release of the Dawson Report, a BMA commission published recommendations that ironically

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[39] Hollingsworth 45.
[40] David Dilks, *Neville Chamberlain, 1869-1929* (Cambridge, UK: Cambridge University Press, 2002), 106-107.
[41] Geoffrey Rivett, *The Development of the London Hospital System, 1832-1982* [online: http://www.nhshistory.net/inter_war.htm].

also called for greater State intervention in health care. At first, the BMA merely recommended expansion of the existing NHI regime. Later in the decade, however, another group led by leading BMA figures urged the establishment of a comprehensive health service, one that would cover at least 90% of the populace, leaving only a limited role for private health care provision.[42] Though dramatic in its scope, this proposal still did not match the ambitions of the Socialist Medical Association, the leftist advisory group that was charged with formulating the Labour Party's position on health care. This body pushed for a fully nationalized system of care, and incorporating salaried physicians. The latter point was one that remained anathema for a large number of physicians, and would present a stumbling block to future reform efforts.[43]

The position of the Socialist Medical Association vis a vis the Labour Party points up the extent to which the latter was comprised of an alliance of different groups, many of which performed specific tasks in service to the umbrella organization. Hence the Socialist Medical Association effectively wrote the section of the party platform dealing with health care. Labour unions represented perhaps the most important of the party's constituent parts. Unions, in addition to broadly representing laborers, also supplied foot soldiers within the context of Labour Party campaigns. When the party needed to rally the faithful, or effect grassroots action in support of issues of concern to the party, the unions were mobilized on its behalf. In exchange for party service, unions were granted dominant representation within the party governing apparatus. The domination of the Labour Party by its constituent unions could prove both political curse and blessing—

[42] Leichter, 178-179.
[43] Hollingsworth, 44.

while such organizations provided an effective grassroots backbone to the party, they also tended to radicalize party positions on a range of issues.

Despite a growing body of policy recommendations on health care, governments of the 1920s and 1930s generally lacked the funds and, indeed, the political will, to act on the matter. This began to change during the late-1930s, and particularly thereafter. One of the factors driving this shift from an initial state of complacency were growing signs of public dissatisfaction over the status quo, as registered in early public opinion polling.

As Jacobs notes, early public opinion data as well as government studies point to growing support across the populace for the state to take a greater role in health care. Respondents seemed to believe that hospitals could be better equipped, and run, under a national regime. Among those on the margins of the lower-middle class, and those ruined by the Depression, there was also a growing rebellion against means-tested medicine, and its associated stigma. They were therefore inclined to support a comprehensive system of state care, one that would provide medical treatment regardless of ability to pay—and without the stigma of welfare.[44]

Jacobs points to the extent to which public opinion seemed to converge around the idea of a national, state-run, comprehensive health care system, and, even more importantly, that certain government officials (particularly those sponsoring studies within the Health Ministry) were aware of this trend.[45] The will to respond on the part of national leaders, however, remained minimal during the immediate prewar period, as the

[44] Jacobs, 60-63.
[45] Jacobs, 75-76.

country girded for war with Nazi Germany. The development of a national (public) health care system was thus delayed—first by war preparations, and then by the devastation of war itself. The public imagination was reignited on the matter, however, by the 1942 publication of the Beveridge Report. Government, in turn, was moved to respond.[46]

Until the late-1930s and, especially, the early 1940s, disparate reform proposals were largely ignored by governments of the day.[47] I will now discuss the change in political circumstances that transformed academic arguments to government policy. The mere presence of ready-made policy alternatives is part of this story. However, the activation of survival instincts on the part of a Coalition government buffeted by war is, in the end, what brought the long-running dreams of reformers to fruition.

III. The Political Stage is Set, 1930s-1944.

As we have seen, the period from approximately 1911-1941 had witnessed two complementary trends in the field of British medical organization: an ever-increasing proportion of the medical community was brought into contact with the State, while the hospital sector underwent considerable centralization, with many previously stand-alone facilities combining in some measure with other facilities. Though the system remained rather haphazard in form, power over the system increasingly resided in three sectors: medical professionals, local authorities, and the national government. By the conclusion

[46] Jacobs, 111.
[47] Leichter, 178.

of World War II many could agree on the need for a unified health service.[48] What remained open to (fierce) debate is just how such a system would look, and who would hold the reins of power.

Between 1935 and 1945, no general elections were held in the United Kingdom. Throughout much of the 1930s, Union governments under allied Labour and Conservative political leaders ruled the realm.[49] The country, like many others around the world, was buffeted by the economic ruin associated with the Depression, and political leaders came together to combat extreme want, and the extremism it tended to engender. As the 1930's came to a close, economic crisis gave way to military crisis, and the parties thus remained uncomfortably fused. During World War II, this arrangement evolved into a formal all-party Coalition.[50] In the course of the war itself, it was thought elections would prove distracting, if not impracticable, during a period in which the State was engaged in a fight for its very existence. Wartime politicians formally pledged cooperation, even as policy differences began to drive the parties, and factions within parties, apart.

As World War II descended on continental Europe and threatened the British Isles, government officials prepared for the possibility of massive military and civilian casualties by effectively enlisting a large proportion of the medical community in the service of the state. Medical personnel thus continued what was becoming a tradition of cooperation with the state and, indeed, this tradition was expanded as hospital-based

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[48] Rob Baggott, *Health and Health Care in Britain* (London: MacMillan, 1994), 79.
[49] Philip Williamson, *National Crisis and National Government: British Politics, the Economy, and Foreign Policy* (Cambridge, UK: Cambridge University Press, 2003), 133.
[50] Mark Donnelly, *Britain in the Second World War* (London: Routledge, 1999), 4.

specialists were enlisted into this Emergency Medical Service.[51] This system had its share of weaknesses and hiccoughs, particularly in its early phases. Under its dictates, many doctors were forced to abandon lucrative practices to provide care where the state expected need could be greatest, with significant reductions in revenue the result. A certain proportion of hospital beds, moreover, were effectively claimed by the State to treat anticipated wartime casualties.

Invariably, such a large effort had its share of shortcomings. These kinks were, in good measure, ironed out once government and medical personnel agreed on a fair (and, in some cases, generous) rate of compensation.[52] The effects of the Emergency Medical Service for the future development of British health care should not be understated. While it should not be viewed as the direct precursor to the NHS, it was nonetheless one of several key developments that made a comprehensive postwar government-led health care system that much more conceivable.

Under the Emergency Medical Service, many physicians who had previously treated patients at their private practices, or in patients' homes, were compelled to provide hospital treatment. This exposed many physicians to the blatant shortcomings of the contemporary hospital system, and produced a desire on the part of some to work for its reform. Greater numbers of patients, moreover, found themselves in hospitals as they were forced to follow their respective physicians there for care. Understaffed, resource-poor hospitals thus saw a new influx of physicians, patients, and, indeed, government

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[51] Mark Harrison, *Medicine and Victory: British Military Medicine in the Second World War* (Oxford, UK: Oxford University Press, 2004), 32-33.
[52] Rosemary Stevens, *Medical Practice in Modern England* (New York: Transaction Publishers, 2003), 68-70.

officials—many of whom were appalled by what they found, and driven to lobby for fundamental change at the first politically expedient opportunity.[53]

In organizing the Emergency Medical Service, moreover, government leaders became painfully aware of the glaring deficiencies of the contemporary health care system. The task of coordinating hospital care across the country was made all the more difficult by the inconsistency across such facilities in terms of record-keeping. Coordination was thus a project that had to start from the ground up, as wartime officials worked to bring order to a system seemingly governed by entropy.

Just as many (primary care) physicians were exposed to state intervention in the wake of the passage of the 1911 NHI Act, a fair number of hospital-based physicians were thus familiarized with working with agents of the State under the Emergency Medical Service.[54] Ironically, the Emergency Medical Service would prove largely unnecessary. Though a fair swath of England, and London particularly, suffered under the depredations of Hitler's Luftwaffe, resultant casualties were far lower than the government had predicted in the immediate run-up to war.[55] The episode was nonetheless significant within the context of the State's role in the national health care system. Along with the National Health Insurance Act of 1911, the Emergency Medical Service of the late-1930's and early 1940's set a precedent of substantial government intervention in British health care. Indeed, the effectiveness of the Service led to calls for a postwar National Hospital Service, one which the government swiftly promised its

[53] Hollingsworth, 47-49.
[54] Stevens, 76.
[55] Harrison, 32.

citizenry.[56]

In addition to providing hospital-based physicians with experience in working with the State, World War II also had broader significance for the development of the British health care system. Many of the elements of a heavily-stratified society that had once been thoroughly segregated found itself thrown together under circumstances of considerable adversity. The same fears of widespread (mainly urban) casualties that led the government to establish the Emergency Medical Service also led to mass evacuations of women and children from London and other urban centers, into (an often more genteel) countryside. Well-off rural residents were, for the first time, brought into contact with some of poorest within society.[57] The war also had the effect of raising public expectations surrounding the sort of constructive role the State would play in the everyday lives of its citizens.

The maintenance of civilian morale was considered key to the successful prosecution of the war effort, particularly under conditions in which so many ordinary Britons fell victim to the German *blitzkrieg*. While reform proposals for the health sector abounded during the 1930s, as has been noted before, little was done to alter the system beyond piecemeal adjustments to eligibility standards for the NHI program. Though policy stasis had largely taken hold, then, in the years immediately preceding the war, government officials increasingly sensed the need to offer radical postwar reform as an incentive to remain strong in the face of seemingly unrelenting adversity. Politicians from both Conservative and Labour backgrounds called on the old Liberal reformer

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[56] Stevens, 67.
[57] Nick Timmins, *The Five Giants: A Biography of the Welfare State* (New York: HarperCollins, 2001), 31-33.

William Beveridge to draft a comprehensive program of further government intervention in the life of the citizenry—in short, a welfare state.

Though raised in an opulent environment, Beveridge became attuned to the needs of the poor when working as a social worker in some of the most poverty-ridden quarters of East London.[58] The ambitious social reformer worked closely with Lloyd George, first in association with the aforementioned Chancellor's unemployment insurance scheme, then supervising aspects of the wartime economy during World War I at the Ministry of Munitions. When he was tasked with the publication of a comprehensive report on social welfare provision planned for the immediate post-World War II period, Beveridge was a well-known figure in reformist circles. Soon he would become a national—nay, international—celebrity.

In a mere year and a half, in December 1942, the study was complete, and the resulting 'Beveridge Report' engendered jubilation across wide swaths of the population, while sending tremors through the corridors of power. The wartime Coalition government rolled out the document in grand style, ensuring not only national circulation, but dropping copies in Nazi-occupied portions of the European continent, as well as sending other copies for resale in the United States. Millions were inspired by Beveridge's call to slay the 'five giants' that had, to that point, stalked humanity—"physical Want, disease, ignorance, squalor, and idleness."[59]

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[58] E.P. Hennock, *The Origin of the Welfare State in England and Germany, 1850-1914: Social Policies Compared* (Cambridge, UK: Cambridge University Press, 2007), 298.
[59] Timmins, 24.

Beveridge's report served its intended purpose of rallying the public to the Coalition's side, and remaining committed to the war effort.[60] While it was replete with lofty language and expansive pledges, however, the Beveridge Report did not contain a detailed road map as to how such a program was to be implemented, particularly considering the fissures that were rapidly emerging within the increasingly awkward Coalition.[61] The Report gave new impetus to ongoing bureaucratic attempts to formulate a coherent response to Britain's broken health care system. Like generations of American reformers, civil servants in the Ministry of Health and Treasury were faced with the task of creating order out of disorder—of knitting together what was essentially a messy patchwork into a more uniform whole.

The Beveridge Report served to heighten expectations amongst the populace considerably. It seemed to pledge radical change in the immediate wake of the war, and some politicians, at least, acted on the assumption that they would be taken at their word. Reform proposals thus abounded during the period between 1942 and 1944. In the case of health care, however, policymakers did not start from a clean slate. As Klein (2007) notes, Health Ministry officials had been actively engaged in building a health care system.[62] They were assisted in this regard by members of the medical profession itself, who had steadily broadened their conception of a national health care system during the course of the 1930s. As in the case of the AMA during the AALL attempted reform episode, the British medical establishment initially supported government reforms—in

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[60] Stephen J. Lee, *Aspects of British Political History, 1914-1995* (London: Routledge, 1996), 177.
[61] David Morgan and Mary Evans, *The Battle for Britain: Citizenship and Ideology in the Second World War* (London: Routledge, 1993), 122.
[62] Klein, 5

the abstract. Medical community leaders likely hoped that a cooperative attitude would foster goodwill, and perhaps deter government from seeking large-scale reform in the first place.

As indicated above, Beveridge Report was no political Big Bang—at least not when it came to health reform. Bureaucratic and professional figures had been engaged in developing reform scenarios for several years when the report was published. If broad agreement seemed to exist on the imperative of health care reform, any tentative consensus broke down when it came to specific means.[63] Perhaps the most logical solution, dramatic expansion of the extant NHI plan, was a distinct possibility.[64] This route to reform would have received substantial support from the Approved Societies who administered NHI, and certain portions of the medical community. This would require minimal additional involvement on the part of the State, and would cause the least disruption to the status quo.

There was no single triggering mechanism that led bureaucrats to consider alternatives to the existing health care system. Instead, there was wide recognition—particularly among elite figures in the private and public sector alike—that the status quo was untenable. By the early 1940s the quantity of reform proposals reached critical mass, while immediate impetus was given to further specification of the extant proposals (and the development of novel permutations) by the Beveridge Report, and the government's emphasis on rallying a long-suffering wartime populace.

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[63] *ibid.*
[64] Gilbert, 233-235.

IV. The Nascent NHS, 1944-48

In order to combat the 'giant' disease was seen to represent, Beveridge proposed a comprehensive state-run health service. The government, faced with a euphoric, expectant electorate, was swift to show progress toward achieving this end. Government officials informed the House of Commons that it was ready to act on Beveridge's program. After completing consultations with relevant parties (including the medical profession), the Coalition produced a White Paper on a proposed health service in October 1944.[65] This particular government publication followed the broad outlines set forth previously in the Dawson Report. The government thus pledged to regionalize hospital operations, while making physician participation in the novel scheme voluntary (though the provision of financial incentives was expected to lure many, if not all, medical professionals). The distribution of doctors across the country was to be regulated by a Central Medical Board, thus ensuring that the distribution of medical services would become more equitable. What the White Paper did not anticipate was full nationalization of hospitals. Under this early road map to reform, hospitals were to continue to enjoy a high degree of independence. Physicians, moreover, would continue in private practice (alongside health service work), as before.[66]

As Klein and others have noted, this proposal for a national health service had something for everyone. Indeed, the framers of government policy sought to appease all

[65] Eric Hopkins, *Industrialisation and Society: A Social History 1830-1951* (London: Routledge, 2000), 238.
[66] Leichter, 177.

of the major interests involved, including local authorities, hospital leaders, physicians of various stripes, and patients. It was a tough balancing act to strike, much less maintain. The task was made even more difficult by the fact that government planners still had to contend with an increasingly uncomfortable Coalition government. The White Paper therefore had to appeal to figures ranging from Winston Churchill on the right, to Clement Attlee on the left.

The framers of the National Health Service Act of 1946 designed a health care system comprised of three distinct functional parts. They did so because such a structure provided a fine fit with the system that had existed up to that point. The three tiers of the pre-1940's system were hospital care, public health services, delivered mainly by local government, and generalized care performed by general practitioners, or GPs.[67]

Geoffrey Rivett notes in his comprehensive (online) history of the NHS and its forebears that the local authorities initially appeared the best candidates to lead any health service as might arise. Their role in the hospital sector had, after all, been steadily increasing prior to the War, and such an approach would be a good bit less politically ambitious than outright nationalization of health care. In the end, however, it was the latter that Aneurin Bevan settled upon. Under Bevan's NHS, all hospitals would be state-run.[68]

Rather than operating on the basis of local authority jurisdictions, moreover, Bevan divided England and Wales into a total of fourteen health service regions, each

[67] Audrey Leathard, *Health Care Provision: Past, Present, and Into the Future* (London: Nelson Thornes, 2000), 21-22.
[68] Rivett, nhshistory.net.

focused around a prominent teaching hospital. In order to avoid a situation in which a London-centered region lorded over the rest, draining resources from them in the process, Bevan drew regional boundaries that met in a point within the city. This way the various neighborhoods of the capital would be divided between four regions, perhaps partly in order to prevent the rise of a preponderantly powerful London-based bloc.[69]

Operations within health regions were to be overseen by a new administrative construct: the Regional Health Board, or RHB. RHB members were appointed by Bevan himself though, insofar as possible, the government worked to keep leaders within health care's *ancien regime* in positions of power. Their responsibilities were broad, and included capital planning, and the formation of Hospital Maintenance Committees, or HMCs. These latter committees would form a unified control structure of the diverse hospital facilities to be found within the various regions—effectively turning, as Rivett points out, a number of different institutions into a single organism.

At least that was how it was to work in theory—in practice, there was a large loophole in the form of teaching hospitals. Though the health regions had been partly determined on the basis of their geographical distribution across the country, teaching hospitals were only brought into the fledgling NHS on the condition that they would retain a considerable degree of independence. Though a representative from their

[69] John Carrier and Ian Kendall, *Health and the National Health Service* (London: Continuum International Publishers Group, 1998), 171-173.

respective RHBs were added to the governing boards of these institutions, they largely retained freedom of action under the new system.[70]

Anticipating and, indeed, encountering resistance from organized medicine, Bevan ensured that the system incorporated key compromises to the important groups comprising the medical community. When it came to physician compensation, for instance, GPs were to receive capitation (that is, set fees per patient/case examined), rather than an outright state salary, thus preserving their nominal independence from State control. Similarly, specialists were granted the privilege of retaining private practices, and seeing (private) patients in NHS facilities. Ironically, however, the very state salary scheme opposed by GPs was accepted by specialists.

Even after these significant compromises were struck, professional opposition remained. As in the run-up to passage of the National Health Insurance Act of 1911, the BMA took exception with certain aspects of the law.[71] This startled Bevan, who came out of an early meeting with physician leaders (in April 1945) convinced of their support. As a Dr. Cockshut, a leader of opposition to the legislation within the BMA himself noted, the NHS proposals set forth by Bevan were far less radical than that envisioned by the physician community itself.[72] On point after point, Bevan appeared to have already addressed doctor's concerns, even before they were raised.

Why then, did the BMA nonetheless launch a rather heated campaign against the NHS? To some extent, this is what professional leaders believed its members expected of the body, even if they themselves were largely convinced of Bevan's good intentions.

[70] Parry and Parry, 219-220.
[71] Parry and Parry, 205-207.
[72] Timmins, 113.

That is, to elements within the BMA leadership it appeared that organizational survival depended on public protestation against any further state encroachment in medicine. The past, however, suggested otherwise. The BMA had lost considerable credibility when it remained intransigent in its opposition to NHI in 1911, refusing to officially approve the scheme as the law(s) went into effect. Physicians, knowing it would help ensure a steadier income, signed on to NHI in droves, against the stated wishes of their professional leaders. In doing so, they revealed the impotence of the BMA in this particular case, and the lack of control (and loyalty) it enjoyed over its very own constituents.[73]

To a certain extent, then, history seemed to suggest that organizational strength could very well be eviscerated by such games of political brinkmanship. Despite the risks, however, BMA leaders also believed they could wring a few final concessions from Bevan, were they to hold out as long as possible. This, too, was a dubious conclusion, as it was clear that the medical profession needed the State nearly as much as the State required the cooperation of the medical profession. As Lloyd George had done in 1911, Bevan could thus hold his ground when faced with threats from the BMA, confident that, in the end, physicians could ill afford to join any boycott of the new system.[74]

In the end, however, no strike was called and, at the very last minute, the BMA leadership recommended its members accept and serve the new regime. By early 1948, physician opposition to the NHS Act was focused around three issues. The BMA leadership was particularly exercised by the possibility of the future imposition of a

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[73] Eckstein, 94-95.
[74] Michael Foot, *Aneurin Bevan: A Biography* (London: Athenaeum, 1973), 118.

salaried GP service. They also parted ways with Bevan and the government on two other counts, protesting the proposed prohibition of the selling and purchasing of private practices, as well as the avenues of legal redress for physicians subject to dismissal from the future NHS.[75]

THE EARLY YEARS OF THE NHS, 1948-60

Beveridge and his allies had, from the start, envisioned a national health service that would improve the well-being of society, while actually lowering health care costs. In the event (and perhaps unsurprisingly), this did not occur. Indeed, NHS resource needs were consistently underestimated by Attlee's government.[76] While absolute costs rose considerably, much of these early increases could be chalked up to inflation; as a proportion of gross domestic product, health care spending remained stable, and at a decidedly low level (only around 3% each year).[77]

Despite the relatively low investment required to maintain the NHS, the Service would continue to face cost-cutting pressures from the Treasury ministry, or Exchequer. The initial cost overruns helped strengthen the hand of successive Chancellors, at the expense of the Health Ministry, the effective political guardian of the NHS. Treasury officials labored to control health spending, at one point establishing a maximum level of government investment.[78] For this, and numerous other reasons, health expenditure would remain quite low throughout the postwar period, particularly relative to that of the United States.

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[75] Almont Lindsey, *Socialized Medicine in England and Wales* (Chapel Hill: University of North Carolina Press, 1962), 50-52.
[76] Webster (2002), 30.
[77] Rivett, nhshistory.net.
[78] Webster (2002), 31-32.

Despite the cost constraints within which it was forced to operate, the NHS was, from the start, a hugely popular program. Despite the fact that a sense of crisis has surrounded the organization almost from the start, large proportions of the British populace have and, indeed, continue to express support for the NHS. Indeed, a 2002 poll showed a full 80% of citizens surveyed to believe the NHS was critical to British society.[79] Public support aside, however, the NHS has long been portrayed as being fundamentally endangered, vulnerable to the whims of the government of the day.

This perception tends to arise from the fact that the party in opposition, Conservative and Labour alike, oft finds health policy a convenient means by which to focus criticism on the government. That this has proven a consistent theme in British politics is, in turn, the result of health care having been thoroughly politicized. This is not to say that health care somehow falls outside the realm of politics in the United States. It is, however, the case that the government possesses far fewer points of entry through which to approach and influence health policy comprehensively. In contrast, the British system is very much a command-and-control entity, over which the government exercises considerable (perhaps even preponderant) authority.

The historical circumstances surrounding the establishment of the NHS also ensure that it remains central to British political conflict. Having served generations of citizens over nearly six decades, the NHS stands as one of the crown jewels of Labour's postwar political legacy. Skeptical about the organization up to the moment of its passage, the Conservative Party has spent decades proving its worth as a custodian—even

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[79] Rodney Lowe, "Financing Health Care in Britain Since 1939," *History & Policy* (May 2002) [available online: http://www.historyandpolicy.org/archive/policy-paper-08.html].

enhancer—of the Service. In more recent years, the Tories have sought to present themselves as a big-tent party, genuinely concerned with the well-being of all citizens, particularly the most vulnerable. Stances on health policy will undoubtedly prove to be central to this transformation. In the process, they must also respond to and, indeed, help shape the course of NHS reform. Unleashed in the early 1970's, the forces of change within the NHS have proven nearly continuous. It is to this ongoing trend that I now turn.

V. Conclusions

I have now explored the early American and British health care systems in turn. Even during this initial period, it has already emerged that the respective markets in health care are evolving along decidedly divergent lines. After an initial period of populist fervor during the mid-nineteenth century, the American marketplace was increasingly dominated by the medical profession, which organized as a (self-governing) modern-day guild. In such an environment, competition among medical providers was strictly circumscribed, as alternative healers and elixirs were largely driven from the market. The voice of citizen-patients was hardly heard, and, after early efforts to expand the mission of public health establishments, government on all levels was consigned to a subordinate role.

Early British medical providers operated in a fairly unregulated marketplace that accorded a significant role to purchases and consumers. Citizen-patients, through the labor movement, became accustomed to dictating the terms of care to large swaths of the medical profession. Friendly societies held physicians captive through harsh contracts,

which drove down the price of health care across the country. By the early twentieth century, political parties stepped forward as responsive representatives of certain citizen-patients' interests. The Liberal, and later Labour, Parties expanded coverage across the populace, while releasing the medical profession from the friendly societies. A market thus skewed in favor of consumers of health care, soon evolved into one in which the state held preponderant power.

While initially opposing further state encroachment in the health sector, medical professionals eventually came to accept—even rely upon—state largesse. The BMA threatened boycotts of NHI and the NHS in 1911, and 1946-1948, respectively. In both cases, however, strong parliamentary majorities and divisions within the profession together ensured that government plans moved forward. Both developments served to limit the extent to which the profession could shape a health care market that was already structured to favor health care consumers and payers. Enough providers realized that state intervention would change little in that regard, or perhaps even improve the balance in their favor, to allow the programs to thrive from day one.

With time, medical professionals would become one of the stronger constituencies favoring a continued, comprehensive role for the state in health care. Facing the consequences of a creeping corporate ethos in the halls of the hospital at which he was employed, Dr. Nick Edwards, an English Accident & Emergency (A&E) physician frustratingly observed that "if politicians tell you that by instilling the ethos of the private sector we can improve the efficiency of the NHS and improve patient care,

then let me tell you that is rubbish."[80] While this represents the opinion of one (particularly outspoken) member of the medical profession, there was widespread displeasure among many NHS employees by the early twentieth century, as political leaders sought to inject market principles into the organization.

American medical providers reacted with markedly little enthusiasm to market reforms in that nation's health care system. By the final decades of the twentieth century the American profession had enjoyed nearly a century of market dominance. It was a market that it had largely created, and one in which it fiercely defended its prerogatives. This was particularly the case when it was presented with state efforts to expand the public sphere in medicine. In the 1910s, and again in the late-1940s, the American medical profession successfully resisted reformers' attempts to establish a greater state presence on the national health care stage.

It was aided in its establishment of hegemony over health care by the relative weakness of the American labor movement. It was an early brand of workers' group, the friendly society, which proved the bugbear of medical providers in pre-industrial Britain. During the decades that followed, a fast-maturing labor movement, led by its political partner (some would say appendage), the Labour Party, that allowed doctors to slip the bonds tying them to the friendly societies, and bound them instead to a state-sponsored NHS.

The weak, fragmented American labor movement, on the other hand, provided offered only limited support to a system of national health insurance (much less a

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[80] Nick Edwards, *In Stitches: The Highs and Lows of Life as an A&E Doctor* (London: Friday Books, 2007), 2.

government-run health service). Hoping to use the specter of (union-provided) health benefits as a membership incentive, and fearing co-optation by the state, some of the larger American unions (including the CIO) tended to stand in the way of reformers intent upon establishing a system that resembled English NHI or, later, the NHS itself. Even when unions voiced support for national health insurance, they were rarely able to translate such sentiment into concrete political action. The American labor movement enjoyed a brief period of strength on the political stage during the New Deal-era. As early as the late-1940s, however, and the Taft-Hartley Act, union potency had already reached-and passed-its zenith.[81]

Despite or, more accurately, because of these defensive measures, the medical profession in the United States saw its professional autonomy under threat by century's end. In fending off challenges by various agents of the state, the profession threw itself into an increasingly binding relationship with powerful actors with agenda of their own. After initially keeping the industry at arms' length, American physicians embraced private insurers during the 1940s and 1950s as a means of pre-empting further government action. Insurers were not, however, in the business of accommodating doctors—they sought to ensure a continuous stream of profits. For a new breed of insurer, the health maintenance organization, preservation of profits would rely on close supervision of physician behavior and, particularly, the costs they incurred. The 'less

[81] The 1947 Labor-Management Relations (Taft-Hartley) Act rolled back some of the gains achieved by American labor through the National Labor Relations (Wagner) Act of 1935. While the Wagner Act expanded the powers of the labor movement, Taft-Hartley had the effect of reining in unions. It stipulated, for instance, that the president could block strikes under certain circumstances, and prohibited the closed shop (in which employers were bound to limit hiring to union members).

expensive' physicians were rewarded through continued affiliation with the managed care organization in question.

This was a far cry from the limited peer review of activity to which physicians had grown accustomed across the decades. It was, moreover, a sharper challenge to professional autonomy than that experienced by British counterparts during the heyday of the NHS. In some ways, however, it did match the encroachment on professional prerogatives that accompanied the rise of a business culture, or ethos, as market reforms were instituted across the Health Service. There a profession long accustomed to basing decisions almost purely along the lines of clinical criteria was faced with the oft onerous constraints of contracts and heightened cost-consciousness.

On both sides of the Atlantic Ocean, a situation had come to pass in which the introduction of market innovations, and greater assertiveness on the part of private corporate actors, came to impinge on the professional prerogatives of many medical providers. The United States and United Kingdom started from very different points: with the British market in health care long dominated by a state (that nonetheless served to protect the autonomy of medical professionals), while the medical profession itself exerted preponderant influence in the American market. Nonetheless, the years that followed witness a certain degree of convergence in the reshaping of the health care landscape of the two countries.

The next two chapters will explore in greater detail the reform episodes in both nations. I will start by outlining the American course of events following the decisive defeat of national health insurance advocates during the Truman administration.

Reformers there narrowed their breadth of vision, a change in tactics that paved the way toward the passage of Medicare and Medicaid during the mid-1960s. Continued dramatic cost increases in these programs, and throughout the health care market, led policymakers to reopen the debate over national health insurance during the 1990's—though by then the terms of debate had shifted considerably.

Chapter five will refocus attention on the logic of British health care reform. After serving the populace well for around three decades, the NHS entered a nearly-continuous period of flux—an era from which it has yet to emerge. Different pressures (underfunding, and perceived lapses in care) would animate reformers, who nonetheless adopted concepts of change similar to those broached in the United States.

CHAPTER 4 – AMERICA'S BRUSHES WITH LATTER-DAY REFORM

Long inherent to the American health care landscape has been a basic tension embodied in the individual citizen, who can function variously as patient, consumer, union member, employee, or voter. The story of American health care over the past five decades is one of nearly continuous attempts to appeal to, if not particularly empower, each of these aspects of the citizen on the part of government and other major stakeholders. Owing to the internal contradictions between the roles, rare is the attempt to appeal to all of each Americans' respective states of being. The American health care reform experience can best be understood through the lens of citizens' divergent identities, and ongoing efforts to develop a health care system that appeals to each of them.

Private health insurance developed largely as a means of serving the citizen as employee and, after a time, union member. Medicare and Medicaid soon appeared as a means of attending to the health needs of those who did not necessarily possess either of these two aspects. In the 1970s, HMOs and HSAs arose as a means of engaging the citizen as empowered patient, while the regulatory reforms of the 1980s constituted partial erosion of this incipient empowerment. Finally, the Clinton reforms of the 1990s represented the culmination of various attempts to treat the various identities of the

American citizen. While the Clinton plan fell under intense political pressure, major actors in health care opted to nonetheless make a portion of the spirit of the plan a reality.

In this chapter, I will sketch out the contours of the American health care landscape during the period between around 1950 and 2006. This narrative will serve to reveal the (ongoing) process through which successive presidential administrations, and numerous political actors, have sought to address the health concerns of Americans as citizens AND patients. While the British health care story has been one of government attending to broadly held values of equity by dint of citizenship, American leaders have tended to emphasize that the individuality of citizens as patients. Put another way, the British system has placed particular stress on the citizen portion of the dual citizen-patient identity, while the American system has primarily catered to the citizen-patient as (individual) patient.

I. Narrowing Ambitions: From NHI to Medicare

During the 1940s and 1950s, government policy and employer responses conspired to create a vast market for private health insurance. Prevented during wartime from enacting direct wage increases, large businesses instead opted to offer health benefits in order to attract and retain employees. While many Americans of working age thus gained health coverage by dint of employment, the development of an employment-based system of private health insurance left many retirees without similar protections.

The citizen-patient as employee of large, insuring firm gained in this process, while a considerable number of other would-be patients remained excluded.

The name 'Medicare' first appears in the pages of the *New York Times* in connection with proposed "health and surgical" benefits for dependents of veterans. A brief report from that year notes the rise of such a proposal within the context of the State of New York, and further reports guarded endorsement on the part of the state medical society's director. The first national legislation providing health coverage to certain vulnerable populations was introduced by a relatively little-known Democratic House member from Rhode Island, Aime Forand. Forand himself would, in the end, be overshadowed by legislative heavyweights, but it was his initiative and persistence that kept the Medicare ideal on the national agenda during the closing years of the Eisenhower administration. Forand's home state of Rhode Island was also among the first, in 1942, to attempt to direct public assistance funds to medical 'vendors', an early step in the evolution of the Medicaid program.[1] The concept of government-funded care for certain age or economic groups came to appeal to those who a few years before had insisted on comprehensive coverage for all Americans.

Following the crushing defeat of Truman's proposals for national health insurance, pragmatic reformers opted to narrow their focus. Rather than providing benefits on the basis of Americans' citizenship, future plans would cater to those citizen-patients who did not have the good fortune to receive coverage on account of their position within the national economy. The period of the 1940s into the 1950s witnessed

[1] Judith D. Moore and David G. Smith, "Legislating Medicaid: Considering Medicaid and its Origins," *Health Care Financing Review*, 22 December 2005. [online: http://www.encyclopedia.com/doc/1G1-143302906.html].

the rapid spread of employment-based health insurance. Coverage was extended largely on the basis of self-interest of its payers—large employers sought to establish (or expand) health insurance programs in order to lure would-be employees. Organized labor viewed health insurance in a similar light, as a means to raise membership, and hold the allegiance of current members. Under the circumstances, reformers narrowed their vision, seeking to expand coverage to those excluded from the employer-based system of private insurance.

Some longtime health reformers refused to compromise by simply filling in the gaps created by the employment-based insurance system then rapidly unfolding across the country. Instead, they perceived Medicare as a possible device through which to obtain universal coverage. This sentiment barely registers in material drawn from the contemporary media—hardly surprising, considering such figures did not wish to have their 'ulterior motives' raised as a means of further alienated skeptics of the program. Voicing such goals would have merely fueled the fears of those who viewed Medicare as the first stop on the road to socialized medicine.

Nonetheless, there were those who pushed so-called 'salami tactics,' in which coverage under Medicare would steadily expand to take in new groups, as a means to stretch the program to the extent that it came to resemble national health insurance.[2] As Oberlander (2003) notes, many Medicare advocates viewed the program as "a beginning, not an end."[3] Said scholar even goes so far as to say that this evolutionary approach was among the 'central assumptions' of some of its strongest supporters. He draws evidence

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[2] *ibid.*
[3] Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003), 33.

from the 1995 memories of Robert Ball, Social Security Commissioner during a fair portion of the 1960s.

Despite (evidently warranted) fears that Medicare constituted the proverbial slippery slope toward socialized medicine, conservatives in the legislative and executive branch alike knew they could not be seen to simply ignore the matter of health care for the aged. Faced with a rising tempo of (Democratic) action in Congress on health insurance, the Eisenhower administration responded with a $1.2 billion proposal to cover certain medical costs for the elderly after they reached $250. The proposal was dubbed the 'Medicare Program for the Aged,' and its introduction appears to be when the 'Medicare' label ceased to be applied to a limited program targeting veterans' dependents, to a more comprehensive scheme covering most citizens over the age of 65.[4]

Taking a policy cue from President Eisenhower, congressional conservatives then formulated legislation, dubbed Kerr-Mills after two key sponsors, providing further financial boost (in the form of substantial matching grants) to those states already assisting poorer seniors afford medical care.[5] Political predictions on the impact of Kerr-Mills differed based on ideology—some liberals asserted the program represented a constructive step toward a broader, more generous approach. Conservatives, on the other hand, believed—indeed, hoped—that the passage of Kerr-Mills would pre-empt calls for further federal engagement on the issue.

In the event, the liberals proved the more prescient. A series of Senate traveling committee-sponsored hearings on senior health care needs, and Kennedy (presidential) campaign events highlighting the issue kept the idea of a broad 'Medicare for the aged'

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[4] J.E. McMahon, "Health Insuring Common Abroad," *New York Times*, 8 May 1960.
[5] Oberlander, 28.

program in the news, if only occasionally on the front page of major newspapers.[6] The Medicare debate continued to attract considerable public attention following the successful conclusion of the Kennedy campaign. The president himself had been a strong backer of such a program since the late-1950s, and his election appeared to dramatically increase the chances of Medicare's passage, if not entirely ensure such an outcome. On the eve of a major policy speech on health care to be delivered by President Kennedy at Madison Square Garden in New York, the *Times* opined that "seldom outside an election campaign has the nation worked itself up into more of a fever."[7]

As in the past, the chief opponent of proposed expansion to the federal role in health care was the providers' professional organization, the American Medical Association. The AMA stood athwart the wreckage of the Truman NHI proposal with glee, and reached the zenith of its political strength in the years immediately following that crucial 'victory.' By the late-1950s, the organization had shifted course slightly, embracing the many private insurers that it had previously spurned—particularly those that enjoyed medical society sponsorship.[8]

This alteration in policy stance was itself the result of its broader aversion to any government-imposed solutions to those seeking relief from medical costs that were beyond the financial means of many citizen-patients. However, this impulse, which had led many physicians to oppose NHI campaigns going back thirty years, led this same community to embrace private, employer-sponsored health insurance. As more employers offered insurance, the emerging institution seemed to having staying power.

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[6] Oberlander, 27-29.
[7] Marjorie Hunter, "Medicare Battle at New Peak," *New York Times*, 20 May 1962, E10.
[8] "The American Medical Society: Power, Purpose, and Politics in Organized Medicine," *Yale Law Journal* Vol. 63, No. 7 (May 1954), 992-993.

So long as the insurance companies failed to place any serious constraints on patterns of practice and setting of fees, physicians were able to add their support to private insurance, following some early resistance.

Medicare remained near the top of the national policy agenda, too, due to the apparent failure of the conservative stopgap measure, Kerr-Mills. Though the federal government offered a 50-80% matching fund formula, few state health commissioners signed onto the plan, partly due to expectations that a more generous program would soon supplant it. The fallback argument that the health care needs of America's seniors were sufficiently covered thus remained unpersuasive.

Though the A.M.A. and allies asserted that "no one in America need go without medical care," particularly since passage of the stopgap, means-tested Kerr-Mills program covering the medically indigent, the organization also lent its imprimatur to a lower-cost variant of 'Medicare.'[9] In general, however, the organization's appetite for further reform was limited at best. It therefore combined these efforts with a blocking maneuver—a public relations campaign known as Operation Coffee Cup.

Operation Coffee Cup is quite illuminating insofar as its purpose was to appeal to the citizen side of the dual citizen-patient identity. Doctors, relatives of doctors, and patients of participating doctors were urged in the most dire terms to staunch the relentless spread of socialism—by lobbying government officials to oppose Medicare. A record distributed as part of the campaign concluded with the rhetorically stirring line that the passage of Medicare would create a future situation in which "…you and I are going to spend our sunset years telling our children and our children's children what it

[9] Hunter, 1962.

was like when men were free."[10] The narrator on the aforementioned record was none other than a pre-presidential 'Great Communicator', Ronald Reagan.

Reagan and others involved in Operation Coffee Cup sought to separate citizen-patients' concerns as potential patients with regard to financing their own future care (or that of their parents), with considerations relating to political first principles. The campaign was designed to divorce the matter of health care from health care reform, and to de-activate the political instincts of those who could, at an indeterminate future point, find themselves struggling to cover medical bills in retirement. In the past, such efforts to appeal to the overall citizen at the expense of the would-be patient through the invocation of the socialist bogeyman had proven quite effective. Operation Coffee Cup, however, failed to have its desired effect, and Medicare was eventually passed. It is up to the political scientist to inquire after just why the old blocking tactics proved ineffective at this point in American history.

II. Explaining Success: The Medicare Moment in American Health Care Reform

Part of the answer involves the decisive role of organized labor in the Medicare debate. Labor and its allied political forces in Britain (and attempts by Liberals to pre-empt labor agitation) was key in the creation of NHI in that country, and, later, it was the Labour Party that played an instrumental role in establishing the NHS. Labor and its allies (and, in some cases, political rivals) were able to pass such ambitious legislation largely without the specter of socialism entering the public debate to any substantial degree. During the NHI creation debate, this was largely due to the fact that the Liberal

[10] Ronald Reagan, quoted in Oberlander, 27.

sponsors of health reform were not, after all, in any way associated with socialist tendencies. The Liberals had historically been dedicated to opening and deepening markets, and thus would hardly be expected to enact any terribly 'socialist' schemes. Lloyd George and his colleagues, moreover, quite publicly connected their innovations with Bismarckian Germany—itself hardly a bastion of Red activism.

Another part of the explanation, however, owes to the nature and relative political position of organized labor on the opposing sides of the Atlantic. By the 1920s, an avowedly socialist Labour Party had a seat at the political table in Britain, and was soon widely considered a worthy opponent by the forces of conservatism. A strong national labor movement prevented the depths of political caricature connected to the very term 'socialism' reached in the United States from being replicated in the United Kingdom. Socialism was alive and well in the British system—and swiftly earned political respectability within the context of parliamentary politics.

American labor had, during the early twentieth century, not only proven fairly impotent politically, but also tended to avoid blatantly socialist rhetoric and policy decisions. A key component of the labor movement, the American Federation of Labor under Samuel Gompers, had opposed the progressive effort to pass national health insurance. During much of the post-World War II, era, moreover, many unions came to treasure their role as intermediaries between management and the workforce in the health care realm and, indeed, some larger unions ran 'their' own health plans. Loath to abandon a lucrative policy enterprise, American unions exhibited a steadily waning interest in NHI over time. Lacking a labor movement that identified itself closely with political socialism, the vast body of Americans remained unfamiliar with just what said

movement represented. This unfamiliarity with democratic socialism, in turn, made it quite a simple matter for right-wing polemicists to conflate the cause with decidedly undemocratic Soviet communism.

That overall trend did not, however, prevent the labor movement from supporting the Kennedy administration's efforts to pass Medicare. Indeed, labor tended to view Medicare as a means of support for their retiring worker members. In order to make Medicare reality, labor leaders were quite prepared to appeal to the citizen-patient as worker. Though organized labor would never reach the pinnacle of political power attained in Britain, they did come out of the New Deal era and World War II considerably strengthened, and therefore politically powerful.[11] Therefore, as the 1960s progressed, a rejuvenated labor movement's appeal to the citizen-patient as citizen-worker proved more effective than the medical profession's rival appeal to the essential citizenship of would-be patients.

The impact of organized labor on the eventual passage of Medicare is difficult to understate. That said, the role of other political institutions, and the composition thereof, cannot be overlooked. So long as conservatives in Congress enjoyed effective hegemony in the Capitol, there was little chance that much beyond the half-hearted Kerr-Mills approach would survive votes in both chambers of the national legislature. In the hands of the Kennedy administration, the executive branch was strongly in favor of the program. The Truman NHI debacle of the late-1940s had, however, illustrated quite

[11] Union membership made its greatest gains in the 1930s, and had only begun to drop off a bit by the early 1960s. For a straightforward graph showing fluctuations in union membership, see "U.S. Union Membership, 1930-2006" *World Almanac and Book of Facts* (New York: World Almanac Education Group, Inc., 2008), 101.

vividly the idea that presidential sponsorship alone was insufficient to produce reform.[12] Little could be accomplished on the Medicare front while Congress continued to be dominated by the 'conservative coalition' of western Republicans and southern Democrats.

Congressional (conservative) intransigence in the face of the tough, "no compromise" position taken by Kennedy ensured that the debate over the reform package would continue—seemingly indefinitely. Into this political environment arrived a *Times* magazine piece by a Labour member of the British parliament seeking to crush conservative misconceptions about the National Health Service.[13] The author noted that those in "medical circles" tended to "believe the worst" about the health service.[14] The same could be said about the far more modest program set out by the framers of Medicare. Under such inhospitable circumstances, progress on attaining passage of Medicare seemed to have stalled, and clearly awaited an institutional—a Congressional--breakthrough.

Following the Kennedy assassination, President Lyndon Johnson, a veteran congressional scrapper, expressed his determination to enact the Kennedy program in full—including those elements relating to health care. Despite Johnson's stated zeal for change, however, he still faced some hurdles in shepherding Medicare through the decidedly more hospitable congressional environment. Perhaps chief among them were what the *New York Times* called the "one-man veto" perpetually threatened by House

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[12] Oberlander, 29.
[13] Kenneth Robinson, "The Case for Britain's Health Service," *New York Times Magazine*, 18 November 1962, SM21.
[14] *ibid.*

Ways and Means Committee chairman Wilbur Mills.[15] Despite this continued source of opposition, Medicare moved toward the top of the political agenda with the strong liberal gains seen in the 1964 elections.

Johnson now had the support of a larger proportion of a more liberal Democratic contingent, and gained Mills's acceptance of the program by appealing to him to help shape the contours of the legislation. Remaining skeptical of liberals' intentions with regard to future program expansion, Mills combined three pieces of legislation to form a broader Medicare program—one that would, he hoped, quell demands for even wider coverage, while cementing his role as one of the leading forces behind the creation of an expanded Medicare.

III. From Medicare to Managed Care: Ambiguous Agents of Empowerment

The establishment of Medicare and Medicaid represented a breakthrough in American health policy like none encountered before—nor, arguably, since. It was not, perhaps, quite as revolutionary as the formation of the British NHS. As in the case of the early NHS, however, costs for Medicaid and Medicare swiftly exceeded early estimates. Moreover, American political leaders, like their British counterparts in the 1940s and 1950s, sought to rein in costs by keeping the program within certain constraints, and opposing further expansion.[16]

Within five years of its enactment, scholarly observers were already painting a bleak picture of Medicaid, otherwise known as Title XIX of the Social Security Act

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[15] "One-Man Veto on Medicare," (editorial) *New York Times*, 26 June 1964, 28.
[16] Political Life of Medicare, or Marmor

(Medicare is Title XVIII of said Act). Stevens and Stevens (1970) pointed out at the time that a program originally designed to cost the federal government little more than $700 million was instead draining the treasury of a whopping $2.8 million annually.[17] To some, Medicaid was little more than a refurbished model of Kerr-Mills. Like that earlier measure, it was means-tested, and involved grants-in-aid (matching funds) to the states. Under Medicaid, however, the individual states were given greater leeway as to where to set the benchmark of 'medical indigency,'—the low income level up to which residents would be eligible for benefits.

For the most part, state levels of medical indigence or dependency tended to track neatly to the generosity of existing benefits under Kerr-Mills. New York, which had offered much under the Kerr-Mills program, was similarly generous when it came to implementing Medicaid. Its medical indigence level of $6,000 ensured that, overnight, a full 45% of the state was eligible for benefits under Albany's Medicaid program.[18] The high eligibility threshold was not simply the waking dream of liberal reformers seeking to sneak universal coverage through the backdoor: Republican Governor (and future vice president) Nelson Rockefeller justified the state's generosity by citing traditionally low levels of recipient utilization of available benefits.[19] Certain medical providers, particularly those in the poorer corners of the state, were opposed to the high income limit.

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[17] Rosemary Stevens and Robert Stevens, "Medicaid: Anatomy of a Dilemma," *Law and Contemporary Problems*, Vol. 35, No. 2 (Spring 1970), 349.
[18] Stevens and Stevens, 366-367.
[19] Stevens and Stevens, 366.

Meanwhile, on the other side of the country, early Medicare opponent and now California governor Ronald Reagan presided over the implementation of that state's Medicaid program. As in the case of New York, a generous set of benefits emerged from the state legislature. Unlike his colleague in Albany, however, Reagan opted to oppose the propose legality of his state's version of Medicaid. He did so by highlighting and, indeed, exaggerating, the financial strain the state would suffer if the program remained in its contemporary form. Just as New York and California were becoming health care battlegrounds, however, the federal government intervened. Reagan's financial concerns were mirrored by similar concerns in Congress. Of course, the two sets of concerns were hardly independent—a key opponent of New York's liberal scheme, Rochester Representative Stratton, was also instrumental in formulating federal eligibility limits.

The Social Security Amendments signed into law in January 1968 placed a ceiling on income eligibility levels (133.3% of state eligibility limits under the Aid for Families with Dependent Children assistance program, or welfare).[20] The settlement dashed the dreams of those liberals who had watched developments from the sidelines, hoping eligibility creep could eventually render a system of universal health coverage under the auspices of Medicaid. Faced with complicated realities of Medicare and Medicaid implementation and finance, health reformers diverged into two generally opposing camps. Traditional liberals turned from national health insurance through stealthy gradualism, to advocating such a program outright (again). Conservatives, however, took a relatively novel direction: managed care and, later, managed competition.

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[20] *ibid.*

The early-1970s witnessed yet another attempt by progressive Democrats, this time led by Senator Edward Kennedy of Massachusetts, to enact national health insurance.[21] Perhaps unsurprisingly, considering the increasingly conservative tenor of the era, the effort failed. Kennedy and the Democrats then refused to sign on to a compromise bill produced by the Nixon administration.[22] The ongoing hostility between the President and congressional Democrats doomed legislative health initiatives to failure. The captivating spectacle of the Watergate drama, moreover, hindered substantive policymaking further. Nixon himself had, in the meantime, become enchanted by something that had, to that point, been a very limited phenomenon—managed care.

Paul Ellwood, longtime advocate of health maintenance organizations (HMOs), introduced the concept to the Nixon administration during said president's second term. As early as 1970, however, the President's health care proposals included the incorporation of managed care into Medicare.[23] Ellwood, in concert with certain government bureaucrats within the Office of Management and Budget (OMB) and Department of Health, Education, and Welfare (HEW) introduced managed care as something of a health policy panacea—a device that could accomplish the twin objectives of expanding health insurance coverage, while placing a natural cap on health care costs.[24]

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[21] Derickson, 142-143.
[22] Hacker (1997), 80.
[23] Clavighurst, 1970.
[24]Hacker (1997), 80.

Perhaps what most appealed to members of the administration was the fact that managed care represented a long-sought private 'solution' to the nation's health care woes. Less intuitive, but nonetheless significant in the long run, was the extent to which managed care had the potential to tie the hands of health care providers, without significantly expanding the relative position of citizen-patients. As Ellwood himself was swift to note, the managed care model ran directly counter to the prevailing 'professional model' exemplified by American health care arrangements.[25] Presenting the extant health care delivery system as a relic of the past, Ellwood advocated managed care as a means of bringing health care organization out of the "pre-industrial" era.[26] He further bemoaned the lack of any real citizen-patient's "lack of knowledge about the product he buys."[27]

While acknowledging that the 'professional model' of health care delivery assumed a certain amount of knowledge (and therefore empowerment) on the part of citizen-patients, he envisioned the 'competitive HMO model' (as he termed managed care), as providing greater opportunities for would-be patients to rationally evaluate their own care, and make decisions from a higher position of power. He placed considerable emphasis on the implicit trade-off between professional clout and the emboldening of citizen-patients. Citizen-patients were to be further strengthened through simple semantics—the passive-sounding community of (potential and actual) patients was thus transformed into one of health care 'consumers.'

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[25] Paul M. Ellwood, Jr., "Models for Organizing Health Services and Implications of Legislative Proposals," *The Milbank Memorial Fund Quarterly*, Vol. 50, No. 4 (Oct. 1972), 73.
[26] Ellwood (1972), 75.
[27] Ellwood (1972), 76.

Consumerism in American health care was not, by the early-1970s, wholly new. A few pre-paid group practices had, by that point, existed for decades, among them the Labor Health Institute in St. Louis, and the Kaiser group practices on the West Coast. Nonetheless, the citizen-patient as health care 'consumer' took on greater significance as a result of several processes.[28] First, citizens overwhelmingly came to appreciate the importance of 'consuming' the services. Second, the rapidly increasing expense of said services was exacerbated by the problem of access, particularly once it became clear Medicare and Medicaid would NOT eventually expand to cover broader swaths of the American populace.

On a free market in which 'the customer [was] always king," the moniker of health care 'consumer' was a means of further strengthening the role of the 'patient', even beyond the greater dynamism the term seemed to imply on its face. Such terminology also carried the suggestion that the 'consumer' should possess a stronger voice vis a vis the 'provider' who was, after all, 'simply' selling a good or service. To a certain extent, too, the conception of citizen-patient as consumer also offered an opportunity for government (at all levels) to shift at least some of the responsibility for systemic failures on to 'the market.' After all, if there were many who looked to the ideal of the omnipotent consumer, there were perhaps just as many who paid homage to the free market, and the lack of government responsibility over its workings. The idea of consumerism in health care redirected the attention of policymakers and other stakeholders to the problems plaguing the overall health care 'market,' and the role that

[28] Samuel Wolfe, "Consumerism and Health Care," *Public Administration Review* Vol. 31, No. 5 (Sept.-Oct. 1971), 528-530.

market mechanisms could, and did, play in the provision and distribution of care. Managed care was, in turn, considered by Ellwood and other advocates to be one of the most effective ways to operationalize the concept of citizen-patient as health care consumer.

Presented with such arguments, Nixon was thoroughly converted to the cause of managed care, and acted on this newfound fervor. In what would prove to be the penultimate year of his abbreviated presidency, he oversaw passage of the Health Maintenance Organization and Resources Development Act (1973). This legislation mandated the provision of an HMO 'option' on the part of larger employers. It also offered financial assistance to eligible insurers—but at a steep cost. In order to attain eligibility, the federal government insisted that such companies offer a full line of benefits, and to set premiums based on a system of community rating.[29] The very corporations that had initially looked to HMOs as a means to lower health care expenditures soon soured on the idea. As a result, well under a third of the 65 million the Nixon administration predicted would be covered by HMOs by the end of the decade were actually subject to such coverage by that date, and that figure would rise little through the mid-1980s.[30] At the same time, however, the legislation left much to be desired from the perspective of managed care advocates. Particularly to some (but not all) who supported the expansion of managed care was the requirement that federally-approved HMOs practice community rating, in which each individual within a given

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[29] Jill S. Quadagno, "Physician Sovereignty and the Purchasers' Revolt," *Journal of Health Politics, Policy, and Law*, Vol. 29, No. 4 (2004), 827.
[30] George Anders, *Health Against Wealth: HMOs and the Breakdown of Medical Trust* (New York: Houghton Mifflin Harcourt, 1986), 28-29.

geographic region or population group paid the same rate.[31] In the minds of longtime managed care advocates, the HMO Act tied the hands of plan directors, while squelching the initiative of those who would form new HMOs.[32]

This legislative initiative passed Congress as the HMO Act of 1973. For several years, if not decades, managed care as health care panacea proved underwhelming. Lawrence Brown surveyed the policy wreckage in a 1982 volume he authored for the Brookings Institution.[33] Faced with the 'conventional wisdom' that the managed care revolution failed to take root because of the burdensome nature of the HMO Act on managed care organizations, Brown instead asserted that managed care simply could not fulfill the expectations and desires inherent in federal policymaking.[34] Decisive as well was the fact that large employers at this early date tended to stick with their existing, fee-for-service-based insurers, spurning managed care. It would take a 'revolt of the purchasers' twenty years hence to rekindle the latent appeal of managed care. In 1973, this event still lay in the distant future.

It was then that Watergate intervened, an event that, in the short run, constituted a massive distraction to policymakers concerned about the nation's health. In the longer term, Watergate and its aftermath further eroded the public's trust in the trustworthiness and, indeed, efficacy of government.[35] The political turmoil generated would not recede for years to come, and it should thus come as little surprise that there were few novel developments in the area of health policy between 1974 and around 1980, with the period

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[31]Lawrence Brown, *Politics and Health Care Organization: HMOs as Federal Policy* (Washington, D.C.: Brookings Institution, 1982), 346.
[32] *ibid.*
[33] Brown, 345-347.
[34] Brown, 318-338.
[35]Michael A. Genovese, *The Watergate Crisis* (New York: Greenwood Publishing Group, 1999), 95.

mainly witnessing the elaboration and maturation of extant programs. Even during the years that followed, few genuinely new programmatic 'tiles' were applied to the ever-shifting mosaic of American health care. Nonetheless, events continued to unfold outside of Washington that served to collectively reshape the health care system. Growing public wariness of vast expansion in federal power created a climate inhospitable to the wholesale restructuring of the patchwork, public-private hybrid forms that characterized American health care.

The aftermath of Watergate and, before that, the conflict in Vietnam, also witnessed an increase in the cynicism and suspicion with which American citizens viewed their government. Popular fears fed into the prevailing anti-statist, liberal political culture. The resultant state of affairs tended to hobble those who would push for reform from above. All manner of projects, including comprehensive health care reform, would fail to make substantial headway for decades to come. Post-Watergate presidents, moreover, swiftly picked up on the limited appetite of the American citizenry for ambitious projects emanating from Washington. Hence, while Senator Edward Kennedy still favored national health insurance during the late-1970s, his enthusiasm did not extend to the newly-elected president, Jimmy Carter.[36] This split over national health insurance never quite healed, and helped ensure that the Democrats would be a party divided on the eve of the 1980 election.

The mid- to late-1970s, while generally devoid of 'big picture' developments in health care, nonetheless witnessed the rise of a second attempt (after managed care consumerism) to increase citizen-consumer participation in certain aspects of the system.

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[36] Quadagno, 230.

Under the National Health Planning and Resources Development Act of 1974, community residents were to be accorded a majority (50-61%) of positions on a new class of institution, the health systems agency (HSA).[37] The HSA, in turn, was empowered to approve major capital expenditures on the part of hospital owners and managers of medical facilities. Hospital operators would need to obtain a certificate of public need before situating a new facility in a given community. The legislation apparently failed to provide for the question of just how this outcome was to be attained most effectively. Concerns arose early that consumer representatives would, for a variety of reasons, quickly lose touch with the community from which they had been derived. Moreover, the related concern of group 'capture' by provider interests.

Over time, the latter proved a very legitimate concern, indeed. In just one example, observers have bemoaned the extent to which the Health Systems Agency of Northern Virginia seems to consistently act according to the interests of a single hospital operator, INOVA.[38] This pattern was generally said to continue due to the supposed nobler instincts of a nonprofit organization like INOVA, compared to profit-making operations like local competitor HCA. The possibility of capture, or, in a more mild sense, of falling into certain decision-making grooves overtime highlights some of the more problematic elements of attempting to involve the average health care 'consumer' (or a representative of the latter) in such key decisions as whether to expand an existing hospital, or allow a hospital owner to construct a new facility. Without a certain amount of expertise and training, lay members of HSAs could hardly make particularly informed

[37] Theodore R. Marmor and James A. Morone, "Representing Consumer Interests: Imbalanced Markets, Health Planning, and HSAs," *The Milbank Memorial Fund Quarterly, Health and Society*, Vol. 58, No. 1 (Winter 1980), 131.
[38] "An Unhealthy Merger," *Wall Street Journal,* 14 May 2008.

decisions. Extensive training could, however, sever the ties of representative and represented, making the former more responsive to the needs of organization or, in some cases, the capturing interest.[39]

In the end, there was little evidence to suggest that HSAs led to any substantial infusion of popular participation and, therefore, democracy, into health systems planning. Just as citizen-patients would, in many cases, fail to enjoy empowerment under managed care, when the latter finally reached its zenith in the mid and late-1990s, HSAs failed as a means to effectively empower potential patients. Health systems agencies remained a part of the health care institutional infrastructure nationwide with the dawn of the 21st century. If they were ever designed to better register the desires and concerns of citizen-patients, however, they seemed to have failed to live up to policymakers' expectations.

Following the 1974 foray into health systems planning, congressional attention began to shift back to Medicare and Medicaid, and how to limit the budget bloating that tended to result from said programs, and threatened to continue into the indefinite future. The continuing anti-government attitudes prevailing in the post-Watergate era worked to the benefit of conservatives who avoided large-scale change at the federal level. This process was merely deepened by the electoral success of Ronald Reagan in the election of 1980.

Initially, however, the post-Watergate anti-government sentiment generally favored the Democrats. Crusading figures like Senator Frank Church of Idaho was quite effective in zealously investigating executive overreach—most notably that carried out by

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[39] Lewis Freidland and Carmen Sirianni, *Civic Innovation in America: Community Empowerment, Public Policy, and the Movement for Civic Renewal* (Berkeley, CA: University of California Press, 2001), 146-147.

the Central Intelligence Agency (CIA). Over time, however, a new breed of conservative Republican ably harnessed the widespread distrust of government extant across many sectors of the American populace. This trend culminated in Ronald Reagan's 1980 defeat of the Democratic incumbent, President Jimmy Carter. The high tide of (neo-)conservatism seemed to portend across-the-board loosening of federal regulations, while slamming the door shut on the prospects of any ambitious reform projects. While the latter proved, in the main, true, the Reagan administration actually presided over the strengthening, not weakening of regulations pertaining to Medicare.

While managed care (and, indeed, HSAs) had seemed the wave of the future in the 1970s, the following decade witnessed few developments on these fronts. In the end, it was not federal *diktat* that was the chief factor driving the rise of HMOs, and managed care generally. Instead, a so-called 'buyer's revolt' hastened the spread of managed care.[40] Large employers, faced with perpetually-increasing health care costs, reacted to the problem before them in several ways. Some actually advocated national health insurance, or something close to it.[41] Many others reacted to escalating health costs by shepherding workers into managed care plans. Health maintenance organizations were again the center of political attention, and business figures, politicians, and some academics were increasingly convinced that they should comprise a major component of any fundamental health care reform plan. Before managed care (again) took root, however, massive regulatory changes altered the health finance landscape by changing the way Medicare funded care.

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[40]Quadagno, 122.
[41]Nicholas Laham, *A Lost Cause: Bill Clinton's Campaign for National Health Insurance* (Westport, CT: Greenwood Publishing Group, 1996), 127.

IV. The Reagan-era Regulatory Revolution: DRGs and Prospective Payment

For many observers, the 1980s represents a nadir when it comes to substantive health care reform. This false conclusion, however, tends to disregard developments that occurred largely behind-the-scenes, and chiefly involved officials from the executive branch of government. Not only was one major legislative program passed (and swiftly repealed), but the Department of Health and Human Services (HHS) enacted programs that sowed the seeds for later, larger scale health care reform. The latter were spurred by innovations at the level of the states that had earlier been sponsored by the federal government. Responding to academic studies commissioned by HHS, New Jersey inaugurated a far-reaching system of prospective hospital payments, for those care episodes that were funded partly by the state. May 1980 witnessed the reimbursement of twenty-five hospitals across the state on the basis of diagnostic-related groups, or DRGs.[42] More hospitals were incorporated into the payment system over the next few years.

Shortly after the New Jersey experiment in DRG-based hospital payment commenced, federal resolve to enact cost-saving measures also stiffened. A new, conservative (and, initially, cost-conscious) presidential administration faced the prospect of budget deficits well in the future. It was thus only natural that administration figures would search for ways to trim outlays on expansive, and expensive, government

[42] Robert A. Berenson and Rick Mayes, *Medicare Prospective Payment and the Shaping of U.S. Health Care* (Baltimore: Johns Hopkins University Press, 2006), 34-35.

programs. One such program was Medicare, which had long exceeded budgeters' expectations in terms of the amount of annual funding required.

Prospective payment systems had the potential to considerably alter the American health care landscape. Specifically, they were seen to impose a new incentive structure upon medical professionals. The chief means of remunerating American physicians has long been retroactive in nature. Providers were thus compensated *after* a given procedure or care episode had transpired. Within certain broad constraints, moreover, they could determine just how much they would receive in the way of compensation. It was a system that strongly favored providers—and opened the door to substantial medical inflation. Prospective payment effectively took the case-by-case determination of fees out of the hands of providers. By ensuring they received a set amount for the year, moreover, providers would no longer be incentivized to offer more care, or elaborate procedures—but, theoretically, only those that were medically necessary. 'Efficiency' was, instead, to be rewarded—particularly since providers could keep all funding received, including that in excess of that covering care provided.

Appeals to efficiency attracted the support of conservatives in Congress, and drew the attention of the Reagan administration. At the same time, prospective payment met with the approval of more liberal members of Congress, on account of the increase in government regulation of the hospital industry the plan would entail.[43] Prospective payment of Medicare hospital costs thus sailed through Congress—within the stunningly brief (by congressional standards) interval of six weeks.[44] Appealing to conservatives

[43] Jonathan Oberlander, *The Political Life of Medicare* , 126-128.
[44] Oberlander, 124.

and liberals alike, prospective payment of Medicare hospital costs constituted a radical break with the status quo that nonetheless elicited little political controversy.

Impressed by the apparent success of prospective payment in New Jersey, officials in the federal Health Care Finance Association (HCFA) and key administration officials allied with leading congressmen to (rather quietly) enact a similar program for national Medicare hospital payment.[45] Owing, perhaps, to the technical (if not technocratic) nature of the policy under consideration, prospective payment passed easily. Ironically, perhaps, such a step in the British NHS would have encountered considerable opposition among medical groups, if not in Parliament. Indeed, nearly thirty years after the federal enactment of DRG payment for Medicare hospital charges, the British government is only today compiling a national fee schedule for procedures—not unlike that employed in American prospective payment systems.

Within the context of the American health care system, one would have expected considerable opposition from medical providers to prospective payment schemes. The reality, however, was quite different. The policy trajectory on which the federal government embarked in the years immediately leading up to the enactment of DRGs goes far in explaining hospitals' acquiescence. First, the profession had come to expect far worse. Even after the specter of national health insurance vanished from the national political agenda, the Carter administration had, in the late-1970s, put forward an ambitious set of caps on hospital payments that would have encompassed *all* payers. The 1982 DRG plan, by contrast, would only affect revenue derived from Medicare patients.

[45] HCFA was founded during the Carter administration in order to coordinate Medicare and Medicaid benefit payments, when responsibility for the former was divested from the Social Security Administration.

Second, and perhaps most significantly, the hospital industry was, by 1982, toiling under the prospect of a system involving even greater financial austerity—the Tax Equity and Fiscal Responsibility Act (1982), or TEFRA. As much as mere utterance of the acronym 'HCFA' tended to strike fear in the hearts of hospital management, mention of TEFRA likely had an even less salubrious effect. The TEFRA provisions affecting hospitals aimed to redistribute federal (Medicare) funding from inefficient to more efficient institutions. Medicare hospital payment would now be limited to a maximum of 125% of costs for equivalent procedures at similar hospital facilities. Compared to audacious attempt to impose austerity, federal efforts to enact prospective payment seemed benign. Hospital industry representatives were thus persuaded to sign onto prospective payment, and this acquiescence allowed for swift congressional passage, and implementation.

After seeking to rein in Medicare hospital payment, the attention of health policymakers logically turned to remuneration of physician care under the program. Just as prospective hospital payment had been put forward as a means of creating incentives for such institutions to run efficiently, officials hoped paying physicians a standard fee based on diagnosis would similarly reward greater productivity and budget-consciousness. Before instituting the program across the physician community, however, policymakers wished to ensure the hospital payment program showed early signs of success. It was thus not until 1992, however, that Medicare prospective payment for physician care episodes went into effect. Just as Congress buttressed its policymaking and implementation capacity by establishing an independent bureaucratic body to oversee

prospective hospital payment, it formed a similar body to assist in the smooth functioning of the new physician compensation regime.

As Oberlander makes clear, it was not the market-like quality of prospective payment that produced Medicare cost savings, it was increased government regulation.[46] This episode in (incremental) health care reform underlines the inevitable blurring of the conceptual line between market deepening and certain modes of government intervention. In many cases the two go hand in hand—the development, and then elaboration, of markets require ongoing governmental vigilance and, at certain points, decisive action. The passage of prospective payment in Medicare certainly altered the incentives facing hospitals, and may have encouraged some to operate more efficiently—all in all, a market-friendly outcome. The means toward this outcome, however, was a rather substantial expansion of the government's supervisory role vis a vis institutional remuneration. Hospital prospective payment was merely the first chapter in a steadily-lengthening saga of attempts to impose (market) efficiency through government intervention. Another such development would accrue under the terms of the 1997 Balanced Budget Amendment. Well before that legislation was introduced, however, Congress tinkered further with the Medicare program.

The rise of DRGs and prospective payment was an effort on the part of government to rein in the free-spending ways of American medical providers. In some ways, the weakening of professional prerogative was a net advantage to health care consumers—particularly if one considers the federal government to be a consumer of care (since it pays the bills for Medicare and Medicaid recipients). DRGs could have

[46] Oberlander, 183.

potentially further standardized care, and therefore made it more predictable, and reliable, for the INDIVIDUAL consumer of health care. Prospective payment, moreover, would theoretically encourage providers to only offer that care the quantity of care that was necessary for a given patient.

DRGs certainly went some way in changing the behavior of certain providers. The new scheme did not, however, amplify the clout of citizen-patients in any meaningful way. Penny-pinching providers sometimes faced disincentives to offer more expensive (but perhaps helpful) treatments. On a broader level, the imposition of DRGs and prospective payment brought new groups to the fore—groups endowed with technical and financial expertise. Hospital accountants and managers found themselves in a powerful position compared to individual medical professionals.[47] Government bureaucrats in agencies like HCFA were similarly empowered. Largely lost, under the circumstances, were the voices of individual citizen-patients. During the next decade-plus, the rise of a reinvigorated managed care industry would have similar effects—clamping down on providers, while failing to increase the group strength of citizen-patients.

V. National Health Insurance Meets Managed Care: The Clinton Health Plan

After effecting a fundamental change in the way medical professionals were paid by applying DRGs and prospective payment within the context of Medicare, policymakers sought to further improve the latter program. Their efforts to enact a system of

[47] Mayes and Berenson, 6-7.

catastrophic coverage within Medicare failed miserably, as wealthier seniors chafed at the prospect of financing supplemental care for poorer members—without enjoying any further benefit themselves. Just as the Medicare Catastrophic Coverage Act was being repealed in 1989, the country lurched into economic recession. This particularly severe disruption in the nation's economic health made those who did not lose their jobs anxious that they could lose theirs next—and, with it, their health care.

Certain times in the history of nations present ideal 'windows of opportunity' for extensive reform of prevailing health care arrangements.[48] Such times appeared close at hand when Harris Wofford won the Senate seat vacated upon the death of Republican John Heinz, largely by campaigning on a platform of health care reform.[49] One of the most compelling arguments presented by Wofford was that, if a suspected criminal had a right to an attorney, surely citizens have a right to health care.[50] His startling 1991 upset victory over former U.S. Attorney General and Pennsylvania Governor Richard Thornburgh garnered the attention of policymakers, including candidates for president in the 1992 campaign. The victor of that race, Bill Clinton, pledged to make health care reform one of his chief policy priorities.[51]

By the waning days of 1993, most observers agreed major reform of the nation's health care system would be swift in coming. In the event, however, a combination of poor time management, secrecy in development of the proposed legislation, complexity of the resulting reform package, and fractiousness among Democrats doomed the Health

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[48] Tuohy, 263-264.
[49]Hacker, 32-33.
[50] Michael John Burton and Daniel M. Shea, *Campaign Mode: Strategic Vision in Congressional Elections* (New York: Rowman & Littlefield, 2002), 28.
[51] Laham, 2.

Security Act. Numerous post-mortems have been composed on the project, including that by Hacker (1997).[52] Various lessons have been taken from this sequence of events. What the defeat of the Clinton health reform plan illustrated was the continued difficulty of raising and, more importantly, sustaining a coalition committed to root-and-branch reform of the nation's complex health care "system". Moreover, the process highlighted the continued effectiveness of the old canards surrounding so-called "socialized medicine," as well as revealing the power of the new alliance of opposition to health care reform.

Pressures for large-scale reform of the American health care system began to emerge at nearly precisely the same time that market-oriented reforms were launched in the United Kingdom. This is hardly a coincidence—after all, some of the same figures from the academic community inspired change on both sides of the Atlantic. Prominent among them was Alain Enthoven. Certain British and American officials were equally intrigued by the perceived increase in accountability and 'efficiency' that the broad concept of managed care seemed to promise. There is something counter-intuitive in the convergence of reform episodes across the two systems, considering just how dissimilar they were at the time, and remain to the present day.

Even the policy problems facing leaders in Anglo-American health policy circles were different. While Margaret Thatcher established the goal of cutting social spending (and government spending generally) quite early in the tenure of her first government, the NHS was, by many measures, a bargain. The overall budget was strictly capped, with successive treasury chiefs ensuring health spending did not rise dramatically from year to

[52] For instance, Hacker (1997).

year. Indeed, by the start of the 1990s, under-spending appeared to be more of a problem than skyrocketing costs.[53] Under-spending, and its inevitable consequences, was not on its own sufficient to explicate British health care reform toward the end of the twentieth century. Similarly, it is not merely enough to put forward excessive spending, and rising health care costs, as the lone rationales driving (American) reform efforts.

As in the past, the timing of reform was a symptom not of the presence of serious problems in the health care system per se, but that the shortcomings built into the American system were now beginning to affect a vocal, politically significant community—the middle class. The poor, after all, have been continuously underserved by the American health care system. This state of affairs has been evident to would-be reformers stretching back to members of the AALL, and its successor organization, the CCMC. Health care costs have generally proven prohibitive to the poorest in society. This section of the population has long had charity to which to turn—receiving care at reduced (or no) cost at times, though evidence has long suggested that the most common individual response to high health care costs has simply been to go without care.

Perhaps most importantly, the poor have generally been underrepresented politically, and there has thus been little drive (with a few exceptions) to make quality health care widely available to such members of the community. Political leaders have traditionally felt little urgency in addressing health system inequities—particularly in light of the liabilities associated with such efforts on the part of government, itself a factor of the overwhelming strength of supporters of the status quo. The inclusion of

[53] British policymakers were particularly concerned about how national spending on health compared to other EU countries.

Medicaid (the entitlement program targeted to the poor) within the original Medicare bill was largely a legislative fluke, inserted ingeniously (if not disingenuously) by influential committee chairman Wilbur Mills—partly in order to discourage future expansion of Medicare into a system of national health insurance.[54] Once the middle class—that broad majority of the electorate—feels threatened by the shortcomings of the system, however, politicians finally feel moved to act.

There is nothing uniquely American in the fact that middle-class anxiety, often drives policy change. After all, it was when health care costs rose to such an extent as to price the moderately well-to-do out of the British health care market that root-and-branch reform became a very real possibility. In polities across the world, and throughout history, it has usually taken far more than the misfortune of the poor, alone, to drive policy change. When the middle class as a body begins to give voice to widespread insecurity, however, the conditions for reform become decidedly more favorable.

In the 1980s and 1990s, the continued steady rise in health care costs combined with the erosion of employer-sponsored health plans to make many within the middle class question the basic parameters of the system. With many employers beginning to narrow the range of benefits available (and some cutting health care altogether), members of the middle class had reason to question the adequacy of the prevailing arrangements. After all, the middle class relied to a large extent on employer-sponsored benefits—more than the poor, who were covered (if minimally) under Medicaid, and seniors, who were covered under Medicare.

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[54] Oberlander, 121.

Before legislation passed in the 1990s to rectify the problem, moreover, health plans were not, for the most part, 'portable' when beneficiaries changed jobs. Health care thus kept many employees tied to their jobs—and all the more fearful at the prospect of unemployment.[55] The threat of unemployment increased exponentially with the onset of economic recession around 1991. Several interrelated factors thus helped determine the precise timing of the latest government experiment in health care reform. Rising costs made health care less affordable for employers, who began to cut benefits. This trend, moreover, made the prospect of unemployment, and the corresponding loss of coverage altogether, all the more problematic. Finally, the softening economy of the 1990s made many in the middle class rightfully concerned about the possibility of future unemployment. While a meteorological 'perfect storm' would roil the waters off the New England coast in the autumn of 1991, a socioeconomic perfect storm elevated health care toward the very apex of the national policy agenda.

Even among those who were in no immediate danger of losing their jobs as a result of the ongoing recession, anxiety was rife. According to some policymakers, it is this pervasive sense of anxiety that best explains the timing of the renewed interest in health care reform across Washington, and the country. Hence Gail Wilensky of Project HOPE notes that the fear and anxiety on the part of the middle class, more than the actual erosion of health coverage, got the attention of would-be reformers in 1992-'93.[56] Growing anxiety was soon reflected in public opinion data. By the early-1990's, over

[55] Marwick, Charles, "Middle Class Too Feels Loss of Health Insurance" *Journal of the American Medical Association*, Vol. 271, Issue 19 (18 May 1994), 1470.
[56] Personal Interview by the author, Washington, DC, December 10, 2005.

90% of those surveyed in one poll believed that the time for fundamental health reform had arrived.[57]

The accession of Harris Wofford to the U.S. Senate on a platform of health care reform in that very year made the issue politically palatable to many powerful colleagues in Washington.[58] The close association with the (fairly short-lived) economic recession of the 1990s ensured the window of opportunity for radical reform would be equally fleeting. Unfortunately for the cause of health reformers inside and outside of Washington, the nation's fragmented political system, and the partisan animosity then gripping the American political universe was not conducive to swift action on any policy front. Nor did the Clinton White House make the task of radically reshaping the nation's health care patchwork any easier through the means they chose to employ.

The travails encountered by the Clinton administration in its quest to enact national health insurance (or, in the political parlance of the day, 'health security') have been amply documented elsewhere.[59] Nonetheless, it would perhaps be worthwhile to revisit this episode in recent American political history, as it comprises the point of departure for reformers up to the present day. Multiple post-mortems have been written to account for the failure of the Clinton Health Security Plan, including many in the immediate wake of the 'debacle.'[60] Out of this body of literature, two key (contradictory) conclusions are particularly prominent. Some scholars and observers alike argue that the

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[57] Cited in Hacker, Jacob, *The Road to Nowhere* (Princeton, NJ: Princeton University Press, 1997), 17.
[58] Hacker, 10-11.
[59] Hacker (1997), entire, for instance.
[60] Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton, NJ: Princeton University Press, 2003), 44.

Clinton reform plan failed because it was too ambitious, and sought to change the system too dramatically, too swiftly.

Others, however, point not to what the Clinton health plan would have entailed, but what the reform effort, and its chief authors, failed to do. Hacker, for instance, does not fault the Clintons and their colleagues for the breadth of their vision, but for the pairing of an expansive program with the construction of a political narrative focused around limited government.[61] Historian Colin Gordon, meanwhile, points to the inherent weakness in the Clinton administration's approach of attempting to appease as many interests as possible. In the process of trying to locate the ultimate middle ground, and please all involved, the team setting forth the Clinton health plan alienated potential allies and opponents alike.[62]

Rather than support the traditionally liberal solution of a single-payer health care reform plan, the Clinton administration sought to position itself squarely in the (messy) political center. Borrowing heavily, though by no means exclusively, from Alain Enthoven and the work of the Jackson Hole group, the Clinton team set down a form of managed competition within tight budget constraints. The federal government would define the parameters of a standard health plan, and mandate employers to provide benefits that fit, or exceeded these national benchmarks. Envisioning a system not unlike that of Germany, the health plan called for the formation of regional health alliances that, within distinct geographic bounds, would bargain with insurers for lower prices.[63]

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[61] Hacker, 178-179.
[62] Gordon, 43.
[63] The German system is based on sickness funds (krankenkassen) that operate on the level of employer groups, and enter into service contracts with state-sanctioned provider groups.

In this way, the Clinton health plan sought to resolve the two major problems plaguing the American health care system—high (and continually increasing) costs, and the limited nature of health coverage. All the while, the administration effort worked to assuage the fears, and serve the interests, of all the major health care stakeholders. As my sketch of history has shown, the concerns of these stakeholders have never been strictly compatible and, indeed, have rarely been able to unite in support of any reform plan. As Hacker and Gordon note, it was the internal contradictions of the plan, among other weaknesses of design and implementation, which served to initially limit the possibility of (legislative) passage. [64]

The methods employed by the framers of the proposed legislation, and those of the plan's opponents, together served to seal the fate of the Clinton health plan. Much has thus been made of the secretive nature in which the health reform plan was formulated. While the health care task force headed by Ira Magaziner and Hillary Clinton contained over five hundred members representing (nearly) the full spectrum of interests and positions, there was very little communication with Congress, much less the general public during the period over which the plan was taking shape.[65] The process was seen as one open only to 'experts', and dominated by 'special interests.' Attempts to effectively articulate the key aspects of the plan, moreover, fell largely on deaf ears.[66]

America's 'citizen-patients' expressed initial enthusiasm in response to the Clinton health plan. Nonetheless, subsequent polling showed little real understanding of just

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[64] Hacker (1997) and Gordon.
[65] On this topic see, for instance, Daniel Yankelovich, “The Debate That Wasn't: The Public and the Clinton Health Plan, *Health Affairs* (Spring 1995), 7-9, and Hacker, 122-123.
[66]Hacker, 143.

what the plan entailed.[67] This void of public awareness was most effectively filled by those who opposed the Clinton health plan on a variety of grounds—but particularly forces to the right of the administration on health care. One of the chief weapons in the latter groups' arsenal was the now-infamous Harry and Louise ad campaign. The series of advertisements, which each featured an average (white, middle class) American family, attempting to untangle aspects of the complicated Clinton plan has been credited with accounting for a fair portion of the 20-plus point drop in opinion poll approval of the Health Security Plan. Leading Democratic lawmaker Dan Rostenkowski was so concerned about their potency with regard to the vicissitudes of public opinion that he attempted to strike a bargain with a leading sponsor of the ads, the Health Insurance Association of America (HIAA) that would have involved the latter ending the campaign.[68]

There was little new in the position embodied by the fictional Harry and Louise in the HIAA ad campaign. The scripts from which the two 'average Americans' road could have been lifted word for word from the AMA's desperate attempt to block the imminent passage of Medicare in 1965. Louise's concerns centering around the supposed "long waits for health care" under the Clinton plan mirrored the AMA's 1960s-vintage ads warning of "long waiting lines at doctors' offices." Harry's hysterics over "government-controlled health care" echoed the AMA's appeal against what it perceived to be "a dangerous adventure in government medicine."[69]

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[67] *Ibid.*
[68] Darrell West and Richard Francis, "Electronic Advocacy: Interest Groups and Public Policymaking," *PS: Political Science and Politics*, Vol. 29, No. 1 (March 1996), 26.
[69] Robin Toner, "Ideas & Trends: Government Health Insurance, An Idea Whose Time Has Come? It Came in 1965," *New York Times*, 7 Auguest 1994, Section 4, page 1.

The effectiveness of the Harry and Louise campaign lay not in its historical originality, but in its emphasis on the citizen-patient's potential patient aspect. The citizen-patient as individual navigator of the health care terrain that would allegedly accrue under the Clinton plan was shown to be hopelessly bewildered. Predictably, the advertisements did NOT draw attention to solidarity across divers sectors of American society, instead focuses on concerns of self-interest. If one understands 'citizenship' in the classical, small-r republican sense, in which individuals are expected to concern themselves with the broader good of the community, then the HIAA's ad campaign can be seen to include few aspects of responsible citizenship.

But, then, nor did the narrative governing the tactics used by the Clinton administration to 'sell' its health care plan contain many elements of responsible citizenship and solidarity. The administration and its allies did not outwardly ask for any significant sacrifice in the way of dramatically higher taxes, and further redistribution of funds from the wealthy to the poor. Nor, under the political circumstances of the 1990s, could it have effectively done so without a strong political backlash. Instead of highlighting the ways in which the health reforms would aid the less well-off, citizen-patients were assured that their own care would change little, and that few real disruptions would occur under the plan. The Clinton administration and its allies thus answered the charges of 'Harry and Louise' on the latter's own terms, without presenting an entirely different alternative theme to justify the complexity and scope of the planned

reforms. In such an environment, the proponents of the Clinton reform plan could not offer a compelling answer to those "killer yuppies," Harry and Louise.[70]

In the wake of the 1994 defeat of the Clinton health plan, observers and participants were swift in penning (in many cases blatantly self-serving) policy post-mortems. Some pointed to tactical issues, including the timing of the process. Senator Edward Kennedy stated flatly that "Time was our principal enemy, and time just ran out." In a similar vein, John C. Rother of the senior advocacy group AARP chimed in that the Clinton health plan was doomed when "…Congress and the Administration had to completely divert themselves at a critical time" in order to vote on an unrelated anti-crime bill. Aside from timing, others stressed the boldness and comprehensiveness of the reforms as elements in the plan's demise. Bill Gradison, the one-time congressman and president of HIAA, scored the administration for failing to take health reform "a step at a time." In parallel terms, AMA chairman P. John Seward blamed the "complexity of the solutions proposed." Paul Ellwood and conservative Democratic congressman Jim Cooper cited a lack of bipartisanship as a key ingredient in the defeat of the Clinton reform effort. Finally, Ira Magaziner bemoaned the basic truism that "change is difficult in the current Washington environment."[71] He could have easily added that change at the federal level has always been difficult, even if moments like the 1965 passage of Medicare proved that it is not always impossible.

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[70] Robin Toner, "The Clintons' Health Care Nemesis: The Man Behind 'Harry and Louise'", *New York Times*, 6 April 1994, Section A, page 18.4

[71] "The Health Care Debate, In Their Own Words; Why Health Care Fizzled: Too Little Time and Too Much Politics," *New York Times*, 27 September 1994, Section B, Page 11.

Lacking broad-based support, and broad political opposition, the Clinton Health Security Act failed to attract the necessary support in Congress. Another reform episode in the history of America's health care saga seemed to have passed. Certain aspects of the plan set forth by the Clinton administration, were soon pursued by major stakeholders in the private sector. Employees of large firms continued to be shuffled into managed care plans. Indeed, this occurred to such an extent that the initial 'buyer's revolt' on the part of employers was soon eclipsed by a more popular, grass-roots political uprising against the constraints of HMOs and insurance plans of their ilk.[72]

Faced with perpetually rising health care costs, corporate purchasers of health care sought to realize the promise of managed care. Increasingly convinced of the potential efficacy of health maintenance organizations in cutting costs, many larger American businesses prodded their workers to join such plans. In many cases, some variant of managed care became the only option available to employees. Other companies pared coverage further, causing the ranks of the uninsured to expand further.

The federal government, moreover, had not entirely abandoned health care reform. At no other point during the 1990s, though, would Washington produce a comprehensive plan to expand health coverage. Reform would, as has been customary throughout recent American political history, be incremental and targeted toward existing programs and institutions. Hence 1997 witnessed the passage of the Medicare + Choice program as part of the Balanced Budget Amendment (BBA) of that year.

Planted firmly in the tradition of Republican-sponsored proposals going all the way back to the Nixon era, Medicare + Choice offered incentivized the spread of

[72] Mahar, 331.

managed care among Medicare beneficiaries. Medicare was, under the program, opened to HMOs and related organizations, and beneficiaries were encouraged to sign on to such plans. The Balanced Budget Amendment of the same year also restrained Medicare funding growth, while further tightening government regulation by bringing several more key categories of care under a regime of prospective payment. As in the 1980s, Medicare reform came in the absence of wider health system reform, but nonetheless had consequences for all of American health care. The opening of Medicare to managed care organizations sped the dominance of HMOs and plans of that ilk over the national health care landscape. While they seemed to offer something of a policy panacea, they swiftly proved to be far from perfect in practice. Consumer revulsion at the tight care constraints imposed by managed care brought further change to the overall system—but nothing so dramatic as the repeal of a major piece of legislation (ala Medicare catastrophic coverage in 1989).

In the absence of comprehensive federal reform, few expected the American health care system to face dramatic change during the course of the 1990's. Despite the fact that another 'window of opportunity' for reform had slammed shut, however, American health care changed considerably during that decade, and beyond. Facing continued cost increases, large employers herded many workers into managed care organizations of various stripes. Health care providers, many of whom assumed they had avoided government infringement on autonomy, suffered instead at the hands of HMOs, PPOs, and other such corporate entities. Citizen-patients fared little better. As a mournful (if slightly tongue-in-cheek) Russell Baker lamented in the pages of the *New York Times*,

> The told us national health care would deprive us of the right to choose our own doctors. So we said no to national health care. And we found ourselves in something called in HMO. It gave you a list of doctors to choose from. If your doctor wasn't listed, they told you to forget him… They had deprived us of our right to choose our own doctors…

Struck by this sad irony, Baker continued:

> And they told us if we had national health care there would be government Bureaucrats interfering with our medical treatment. Strangling us with red tape. …So we said to no to national health care and yes to great-insurance-company health care. And we found ourselves up to the neck bone in bureaucrats.[73]

The BBA of 1997, followed by the Medicare Modernization Act (MMA) of 2003 encouraged Medicare beneficiaries to seek out private 'Medicare Advantage' plans, rather than relying upon traditional fee-for-service Medicare. The failure of comprehensive health care reform nonetheless left the market in health care transformed by the start of the twenty-first centuries. Just as the introduction of HMOs in the 1970s and 1980s inspired roughly similar reforms within the NHS, 'silent' market reforms of the 1980s and 1990s led to adoption of equivalent changes in the twenty-first century NHS. It is to the modern growing pains of the NHS that I turn in the next chapter.

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[73] Russell Baker, "Observer; Harry! Louise! You Lied," *New York Times*, 1 June 1996, section 1, page 19.

CHAPTER 5 – MARKET REFORM AND A MATURING NHS

"Though the market model may give patients a louder voice, this will be the shrill cry of consumer choice, not the skeptical thought and responsible voice of the citizen."

--Welsh Health and Social Services Minister Jane Hutt (Labour), 2004

"By giving frontline professionals and the public more say and control over the services they provide and receive, I am confident that we will continue building a high-quality health and social care system that which meets the future needs and wishes of the country"

--Tony Blair, introduction to 2006 white paper, *Our Health, Our Care, Our Say*

I. The National Health Service at the Turn of the Century: A Snapshot

Despite the cost constraints within which it was forced to operate, the NHS was, from the start, a hugely popular program. While a sense of crisis has surrounded the organization almost from the start, large proportions of the British populace have and, indeed, continue to express support for the NHS. Indeed, a 2002 poll showed a full 80% of citizens surveyed to believe the NHS was critical to British society.[1] Consistent, strong public support aside, however, the NHS has long been portrayed as being

[1] Rodney Lowe, "Financing Health Care in Britain Since 1939," *History & Policy* (May 2002) [available online: http://www.historyandpolicy.org/archive/policy-paper-08.html].

fundamentally endangered, vulnerable to the whims of the government of the day. Finding the NHS to be important was quite a different matter than being satisfied by the way it operated. The dawn of the twenty-first century saw the NHS in the midst of steady transformation—a process that had been afoot for nearly twenty years, and which showed few signs of approaching conclusion.

At century's start, massive cash infusions were being directed at the NHS by the government of Prime Minister Tony Blair. The lavish funding was connected to a 2000 pledge by the prime minister to bring British spending on health up to the EU average. In this way, the Blair government hoped to set aside charges of NHS under-funding, which had dogged successive administrations nearly from day one. The increased financial investment did not, however, come without strings attached. Indeed, the government was interested in getting greater 'value for money,' by imposing greater efficiency into the system.[2] But the government mission was broader than that. Blair and his colleagues hoped to preside over the veritable transformation of the NHS, a process by which it would go from being a provider of care, to being primarily a purchaser of care provided across a diverse array of settings.[3]

This recent period of drastic change within the NHS is all the more extraordinary on account of the stability that characterized the early history of the organization. While policy alternatives were actively debated during the 1940s and 1950s, particularly when it came to the proper means of financing the NHS, the basic parameters of the health service remained fairly consistent throughout the first three decades of its existence. This

[2] Baggott, 145
[3] "Health Care Finance: Keep Taking the Medicine," *Economist*, 15 July 2004.

period of overarching policy stasis began to give way during the 1970s, when labor militancy and perceived NHS underperformance led ministers to study new methods of management. While the ascendance of Conservative government in 1979 initially appeared to herald the onset of dramatic change, it would be nearly a decade before prime minister Margaret Thatcher unveiled her controversial program of reforms.

II. Setting the Stage for Reform: Planning Processes in the Early NHS

Before exploring how the NHS endured under nearly-continuous reform from the 1970s through the present, it is important to consider the evolutionary changes that impacted the institution in its early period. The market reforms of Margaret Thatcher and her successors were preceded by a drift toward managerialism, under which the formation of a business ethos was pushed as a means of curing the ills that bedeviled the NHS. The targets and focus on strategic planning for the health of the British population followed by several decades the 1960s-vintage emphasis on planning within the NHS.

In examining the process of system reform, it is always tempting to push back the birth date of the recent chapter of change. Here I wish to emphasize that, in the view of the present writer, one can only realistically look back to the late 1970s-early 1980s in order to locate the roots of the current episode in change—to situate the historical moment much earlier would be an exercise in infinite regress. In order to show just what about the NHS has changed, and how, I here present a broader sketch of the design of health service institutions, and some earlier (and often abortive) periods of gradual change.

During the first twenty years or so of its existence, little attention was paid within the NHS to long-term trends in health, and how the organization would respond. The 1960s witnessed the first attempts to incorporate long-range planning into the operation of NHS institutions. An early planning document, the 1962 Hospital Plan of then-health minister Enoch Powell, highlighted present and future shortcomings in the hospital sector, offering recommendations focused around expansion of facilities, and construction of new hospital space.[4] One of the chief advantages of a unified national health system was the ability of administrators to plan rationally for health needs across the length and breadth of the polity. Ironically, there was no serious attempt to plan across the national health sector during the first several decades of the existence of the NHS.

The hospital served as the focal point of overall NHS organization the first several decades of the NHS. Regional Hospital Boards were vitally important in the NHS presence in the community. District Health Authorities were generally based around a single district hospital, and considerable care went into apportioning resources based on the number of beds (and associated staff) deemed necessary to fulfill the needs of a given population.[5] The state of affairs was only slightly different in the case of the most prestigious teaching hospitals. Such institutions were, during the first decades of NHS operations, independent of the Regional Hospital Boards, instead being led by an independent Board of Governors. This was one of the key concessions granted this powerful interest bloc during the negotiations leading to NHS legislative enactment. The

[4] John Appleby, et. al. *The Reorganized National Health Service*, 6th. Ed. (Cheltenham, UK: Stanley Thornes, 1999), 40.
[5] Appleby, et. al., 40-41

hospital-centric mode of organization reflected the extent to which health care was identified with hospital visits in the early NHS (and, indeed, across other systems as well)—oft at the expense of physicians and other care providers in the community.

Physicians themselves enjoyed a great deal of continuity in their condition during the transition from NHI to NHS. Lloyd George's national health insurance system had served to free doctors from the harsh terms of employment offered by many of the so-called friendly societies. The latter were replaced by local Insurance Committees, which contained representatives of the medical profession, insurers, and local notables. While some friendly societies morphed into 'approved societies,' retaining a sizable role under the new system, these groups could no longer dictate to doctors the conditions under which they were to provide services.

Under Bevan's NHS, community physicians continued to work much as before—with Insurance Committees simply being replaced by Executive Councils. The Councils, in turn, had much the same staff composition as the prior Committees. Indeed, for some it was simply a matter of altered signage.[6] Executive Councils were now charged with maintaining the lists of patients corresponding to each local GP, and physician remuneration flowed through them. In accordance with the accommodation reached with the medical profession by Bevan upon the founding of the NHS, physicians were, for the most, paid on a capitation (per head) basis. This method of compensation was employed as an alternative to salaried service, which physicians feared would constitute a severe blow to professional autonomy.

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[6] Moran, 30.

Doctors who attracted more patients, then, received greater compensation. While this payment method may have had a salutary effect on the overall independence of the profession vis a vis the state, it nonetheless served to place rural doctors at a disadvantage. Under the system, those physicians serving sparsely-populated areas often had to travel greater distances, toil under less than desirable conditions—and yet receive less compensation for their efforts.[7]

Despite the expectation of Bevan and others that health care costs, while spiking in the early years of the service, would fall over the long term due to improved public health, continually rising expenditures instead proved the rule. By the early 1950s, government concerns about the cost of the NHS led to the formation of the Committee of Enquiry into the Cost of the National Health Service, rendered in (merciful) shorthand as the Guillebaud Committee. Much to the surprise (and chagrin) of some of the more thrifty parliamentarians, the Committee failed to recommend any drastic cuts in government health expenditures; to the contrary, members found fit to highlight the fact that health spending as a share of GDP had actually dipped slightly during the past several years.[8] Nonetheless, the existence of the Committee was itself an early manifestation of the perpetual political problems relating to cost control within the NHS.

In some important ways the first few decades of the NHS were marked by policy improvisation. Putting it a bit less charitably, one scholar of the late-1960s characterized policymaking in the NHS to that point as bearing all the hallmarks of a process of simply

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[7] Digby, 131-132.
[8] John Kinnaird, The British National Health Service Retrospect and Prospect," *Journal of Public Health Policy*, Vol. 2, No. 4 (December 1981), 387-388.

'muddling through.'[9] While a sizable stream of studies was published on hospital utilization rates, and other technical topics relating to the provision of health care, there was little sign, according to said observer, that policy had been adjusted to account for the findings contained therein.[10] As eminent NHS scholar Rudolf Klein has noted, it wasn't until well into the second decade of the health service that "administering the status quo gave way to the politics of technocratic change."[11] This early strategic drift was, perhaps, inevitable in a necessarily decentralized organization like the NHS, in which the Minister of Health at the top had very little actual control on medical professionals on the one hand, and stubbornly independent local authorities on the other. While responsible for the overall functioning of the health service, the health minister could directly and immediately impact next to nothing that fell under his purview.[12] The second and third decades of the NHS were to feature efforts to rectify this state of affairs.

The 1960s, and, more especially, the 1970s, witnessed the rise of rational planning within the NHS, and a corresponding effort to led substance to the health ministry's legal accountability. This process would take time, and did not entirely resolve the problem of internal accountability. As late as 1983, when businessman (later) Sir Roy Griffiths noted disgustedly that even equipped with her trademark lamp, a reincarnated Florence Nightingale would be unable to find the person in charge within

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[9] George L. Maddox, "Muddling Through: Planning for Health Care in England," *Medical Care*, Vol. 9, No. 5 (Sept.-Oct. 1971), 439-448.
[10] Maddox, 443.
[11] Rudolf Klein, *The New Politics of the NHS* (
[12] Baggott, 91.

any corner of the NHS.[13] Nevertheless, the era of planning did not lack long-term consequences.

The planning era was consequential despite the fact that it did not come close to fulfilling all the goals propounded by successive governments of the period. Perhaps the most notable example of the gap between initial targets and actual policy outcomes is the government White Paper (policy planning document), known as the Hospital Plan of 1962. Though put forward by then-health minister (and future notorious right winger) Enoch Powell, the 1962 Plan was the result of several years of preparatory work.[14] It reflected studies that had recently been conducted by the BMA, illustrating the need for a certain number of hospital beds per unit of population. The fact that credit for the plan nonetheless tends to accrue to Powell is a particularly interesting political footnote. The Conservative Powell's embrace of rapid programmatic expansion within the NHS is the rough political equivalent of the crucial role played by Wilbur Mills in shaping the final Medicare package. Indeed, it contains elements of the Nixon-going-to-China truism—it often takes a dedicated conservative to preside over program creation and expansion that could itself be considered broadly 'liberal.'

The cost to the government of the ambitious plan was, for the time, staggering: though only about 9 million British pounds had been expended on hospital construction annually between 1948 and 1952, the Plan proposed an investment of 500 million pounds over ten years. The centerpiece of the Hospital Plan was the cultivation of the District General Hospital, a facility that would contain 600-800 beds, and serve a population of

[13]Klein, 118: The precise quote is, "if Florence Nightingale were carrying her lamp through the corridor of the NHS today she would almost certainly be searching for the people in charge."
[14] Baggott, 92.

100,000-150,000.[15] While the framers of the Plan envisioned an extravagant investment in capital expenditure, they also had in mind the consolidation of hospital functions—not the net expansion of facilities. Thus the Plan would have had the ironic effect of actually decreasing the total number of hospital beds across England and Wales.[16]

Where previously hospital placement had been largely contingent (at least in the case of the voluntary institutions) wherever the wealthy benefactors wished, the 1962 white paper sought to distribute facilities more evenly, with an eye toward where the largest number of citizen-patients would be most efficiently served.[17] Medical professionals, who could look forward to better working conditions and technological improvements, provided a powerful base of support behind the Plan. Theoretically, so, too, should the citizen-patients of England and Wales.

Since citizen-patients were, as a 'group', the 'ghosts in the machine' vis a vis NHS policymaking, the opinion of this bloc counted for very little indeed.[18] Significantly, the extant regional hospital boards and local hospital management committees offered few opportunities for public input. Why should a system that itself partly resulted (as I contend) from a traditionally prominent role accorded citizen-patients in medical care contain few, if any, mechanisms for patient input? Partly it is the result of this very legacy. Health policymakers were determined to harness and, more to the point, control the stream of citizen-patient views on proper health care arrangements. As Klein puts it, "The NHS was designed as an institution for controlling, not articulating

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[15] David Allen, "An Analysis of the Factors Affecting the Development of the 1962 Hospital Plan for England and Wales," *Social Policy & Administration*, Vol. 15, No. 1 (Spring 1981), 3.
[16] *ibid.*
[17] Allen, 4.
[18] Klein, 57.

demands."[19] Relative public silence on the matter of hospital construction made it all the easier, in the end, for proceeding governments to go back on their pledges, and to turn their respective backs on the Hospital Plan.

The Hospital Plan of 1962 in some ways represented the high point of rational planning in the NHS, though other attempts to apply long-term strategic planning to the health service would continue through the early-1970s. In execution, the Hospital Plan underwhelmed. While hospital spending doubled in the decade following its promulgation, it did not come close to matching the level of investment envisioned in the white paper.[20] Despite the apparent political consensus surrounding dramatic rises in hospital spending and construction of facilities (these goals showed up as planks in the platforms, or manifestoes, of both major parties), investment in hospitals was one of the first targets of cost-cutters voicing the need for budget-trimming. Successive ministers of health accepted the gutting of the hospital-building program in order to stave off deeper overall cuts in NHS funding.[21]

The Hospital Plan revealed to all the natural limits of long-term planning within the context of the NHS. The United Kingdom would never end up with the effectively-distributed (population-based) grid of district hospitals, though many extant facilities were renovated, while others were built. The British experience tracks nicely with the hospital planning project in the United States, insofar as one can be said to exist. Considered among the first (successful) efforts to plan for future health needs in the United States on a broad scale, the Hill-Burton Act achieved legislative passage in 1946,

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[19] i*bid.*
[20] Klein, 55.
[21] Klein, 55.

the same year as the NHS Act. It required the individual states to adjudge their needs with regard to hospital capacity in succeeding years, and, pending the completion of that process, offered federal funding to construct such institutions. The legislation came with what would prove to be two highly significant conditions—that Hill-Burton facilities offer free care for the 'medically indigent', and that they provide care regardless of the patient's racial or ethnic background.[22]

Unlike the Hospital Plan of 1962 in the United Kingdom, the Hill-Burton Act resulted in a boom of hospital construction that would last decades. Federal money was not only offered, but expended liberally. Nonetheless, Hill-Burton did not lead to a particularly comprehensive or, for that matter, rationally-distributed system of hospitals nationally. Instead, duplication continued to be the rule in some areas, while others were left with a dearth of facilities—and remain thus bereft to this day.[23] Perhaps this is hardly surprising in a hyper-decentralized, patchwork 'system' of health care provision as that which is found in the United States. The plight of the Hospital Plan of 1962, however, shows how difficult it can be to enact comprehensive change across a even the most highly centralized of health systems. The apparent centralization of the NHS was, however, partly an illusion. Reforms of the 1970s were concerned with the restructuring of the tripartite NHS, and its transformation into an organization more effectively controlled from the center.

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[22] "Health Planning's Beginning: A Tribute to Dr. Henrik Blum," *Community Health Planning and Development* (section newsletter), American Public Health Association (APHA), Fall 2006. [online: http://www.apha.org/membergroups/newsletters/sectionnewsletters/comm/fall06/2980.htm].
[23] See, for instance, Jennifer Steinhauer, "A City Where Hospitals are as Ill as the Patients," *New York Times*, 5 June 2008.

III. Bringing the Citizen-Patient Back In: The 1974 Reorganization and CHCs

It was partly frustration with the lack of progress on the hospital construction front that led governments of the late-1960s and early-1970s to examine ways to organizationally streamline the NHS. Hence a 1969 hearing before a parliamentary select committee on the Hospital Plan came shortly after the Conservative health minister of the time, Kenneth Robinson, drafted a policy recommendation ('green paper') proposing the elimination of the regional level of NHS management, and greater unification of functions under area health authorities.[24] The green paper started a process that concluded (for the moment) with the reorganization of the health service in 1974.

The 1974 reorganization represented an attempt to harmonize the three distinct parts of the NHS to date—the regional hospital boards, local government (authorities), and GP-dominated Executive Councils. While the original Robinson green paper had pointed to the need to actually eliminate intermediate levels of governance, and, if possible, reverse the tripartite structure of the NHS, the 1974 reorganization retained three main components. Area health authorities were charged with planning the overall health needs of localities. Local government was, however, still responsible for environmental health programs. In something of a step backward (from an administrative point of view), general practitioners were placed under their own Family Practice Committees, that stood awkwardly separate from the other components of the reorganized health service.[25]

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[24] Klein, 67-68.
[25] Baggott, 89-91.

While the 1974 round of structural reform thus did little to change the way its various parts were organized, it did spawn an administrative foil that would provide a target for future reformers, most notably those working under Margaret Thatcher. This came in the form of consensus management: in which the bulk of decisions, particularly at the local level, had to be based on consensus. The 1974 changes also formalized the effective power medical professionals had enjoyed in decision-making from the beginning, by adding a layer of district management that would be dominated by local doctors. This formal empowerment, however, was balanced by a novel development—and one that would echo down the years to the present—a greater stress on citizen-patient representation through the formation of Community Health Councils (CHCs).[26]

Community Health Councils were granted greater overall powers of oversight and consumer representation than their (very rough) equivalent in the United States, health systems agencies (HSAs).[27] The reorganizing legislation called for 206 such bodies, on the level of the NHS district. Representatives were to be selected jointly by local government and voluntary (read: advocacy) groups in the community.[28] Klein (1979) classifies their chief function in colorful terms—it was nothing less than to "kick up hell if their views were ignored."[29] Fascinatingly, said scholar draws on very similar broader public feelings among the British populace, as those associated with post-Watergate America, namely a "wider reaction…against big government" and "…a more general disillusionment with what is perceived to be a 'technocratic solution' to social and

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[26] Klein, 69-70.
[27] For more on the original HSAs, see previous chapter
[28] Rudolf Klein, "Control, Participation, and the British National Health Service," *Milbank Memorial Fund Quarterly*, Vol. 57, No. 1 (Winter 1979), 75.
[29] *ibid.*

political programs."[30] The British, in otherwise, were similarly weary of heavy-handed governance, and sought greater (local) public participation and policy transparency. This, according to Klein, is one of the chief factors that inspired policymakers to establish institutions for public representation within the NHS.

Also animating policymakers in their drive to better represent consumer interests was the perceived deficiency of extant representative bodies. Bevan and the NHS founding generation had placed significant faith in the efficacy of local health authorities and hospital management committees to represent both the interests of the health ministry AND area citizen-patients. In the event, they were seen to be more concerned with organizational self-preservation, and less so about articulating the interests of the community.[31] Moreover, the hiving off of the citizen-patient representation function appealed to strict managerialists, who wished to clearly separate democratic expression and technocratic management. The inclusion of CHCs in the reorganization legislation was thus considered a sop to local democracy enthusiasts AND those more focused on technical expertise.

While the establishment of local representation mechanisms was, for advocates of greater democracy, laudable, the actual results have been mixed at best. As early as the late-1970s, it was already clear to observers that the high hopes being attached to CHCs were, perhaps, unwarranted in view of their policy impact.[32] While the incoming Labour government in 1974 empowered the councils slightly by granting them the power to hold up major changes in care provision (including hospital closures) put forward by the area

[30] Klein (1979), 78.
[31] Klein (2006), 70.
[32] Klein (1979), 80.

health authorities, they still did not actually possess independent policymaking power.[33] They were thus quite limited statutorily as to what they could accomplish and, in their ability to affect the direction of policy, resembled the thoroughly declawed late-20th century House of Lords.

That is not to say the CHCs collectively constituted an entirely redundant institution. Indeed, some scholars believe they were quite effective in blocking disruptive change on behalf of those they represented, even if they could offer little in the way of substantive (overarching) policy input.[34] Moreover, Baggott, for one, believes they could have accomplished a good bit more if they had been endowed with a more appropriate level of resources, political and otherwise.[35] Such scholars thus mourned the passing from the scene of CHCs under the 2002 iteration of Blair-era reform. Ironically, the abolition of CHCs occurred during a wave of consumer-oriented reforms, as I will document later in this chapter. That is, however, to anticipate developments on a grand scale—the 1974 reorganization was followed by yet another NHS structural makeover in 1980. This set the stage for the reforms inspired by the portentous Griffiths Report in 1983, which itself opened the door to market mechanisms within the NHS.

IV. The Crisis of the 1970s and the Impetus for Market Reforms

The 1970s was not a particularly prosperous, nor tranquil time, for most corners of the world. Certainly 1970s Britain enjoyed little in the way of either, with economic uncertainty paired with labor militancy to create a climate of apparent 'ungovernability.'

[33] Klein (1979), 81-82.
[34] Baggott, 307.
[35] *ibid.*

Indeed, political scientists used the United Kingdom as a case study in examining the conditions of 'overload' in democratic governance—a state of affairs in which the ever-growing expectations of the populace could not be met by an increasingly constrained state.[36] This era is thus remembered fondly by few, particularly not by those who had the misfortune of possessing political power at the time.

By the late 1970s, the Labour government of James Callaghan was under serious strain. The energy crisis and its aftermath, followed by years of industrial unrest and general economic uncertainty, led to plunging national morale. A country dominated by strikes and flailing politicians increasingly seemed ungovernable. In this climate, Callaghan's immediate predecessor, Harold Wilson, actually seemed to fear a military coup.[37] The difficulties of contemporary governments were exacerbated by the anti-technocratic mood that made many wary of further large-scale government intervention in the economy. Predictably, the Labour Party took the brunt of this mass frustration, though the broadly interventionist Conservative leader Edward Heath also suffered its consequences during its tenure during the early-1970s.

Predictably, the party in power bore the brunt of public frustration over the pervasive bleakness across the polity. Following electoral defeat in 1974, the Labour Party returned to power, first under the second prime ministership of Harold Wilson, and then under James Callaghan. Faced with a maelstrom of ongoing labor unrest and a long-running economic downturn, the position of the Callaghan government was particularly

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[36] Anthony H. Birch, "Overload, Ungovernability, and Delegitimation: The Theories and the British Case," *British Journal of Political Science*, Vol. 14, No. 2 (April 1984), 135. The author cites Anthony King and Michael Crozier as the originators of this concept.

[37] See, for instance, Wheeler, Brian, "Wilson 'plot': The Secret Tapes," *BBC News* [online: http://news.bbc.co.uk/1/hi/uk_politics/4789060.stm], accessed October 14, 2007.

precarious. The Conservative Party was the chief beneficiary of the anti-incumbent mood that had settled over the populace. While in the political wilderness, that party had been undergoing considerable internal change, driven largely by one determined, outspoken parliamentarian and sometime cabinet minister, Margaret Thatcher.

By the second half of the twentieth century, the Conservative Party had been at the political forefront for such frequent, lengthy stints that it was known as the natural party of government. For a fair portion of its history, the party largely catered to the wealthy, particularly members of the gentry. As late as the 1960s, the party put forward an aristocrat (Lord Douglas-Home) as prime minister, in what proved to be a decidedly costly blunder. Conservatives were conscious of the competition the landed gentry faced from self-made elites and thus sought to work with them. If many Tories tended to be elite figures, then, not all of them were born into privilege.

As a small-c conservative organization, the British Conservative Party traditionally took some political positions that would appear familiar to American self-described conservatives, but many others that would not. Despite having a mixed-elite membership, the party nonetheless tended to favor policies that favored the 'natural leaders' of a class-conscious society. This broadly aristocratic orientation eroded during the course of the 1960s and, particularly, the 1970s. A party that had long celebrated society's 'betters', and the role of traditional British institutions, including the Church of England, increasingly favored such younger 'institutions' as the free market, and the self-made man, and woman. This change within Conservative circles allowed Margaret

Thatcher, to rise to a position of leadership within the party.[38] Having served as Education minister in a Conservative government of the 1960s, and returning to the cabinet in the early-1970s, by 1975 Thatcher was well-placed to capture the leadership of the party.

If Thatcher and her new governing philosophy, which focused on harnessing the power of the free market to improve the lot of society were to truly take hold, however, she needed someone to prepare the ground for what was a fairly dramatic ideological shift. Thatcher, being among a group of 'new' Conservatives, was not without fellow free-marketers. Among this first generation of 'new' Conservatives was (later Sir) Keith Joseph. Initially quite in tune with Conservative orthodoxy, Joseph soon came to assume a strong pro-market stance. Just as the fellow right-wing politician Enoch Powell placed himself at the head of 'big government' hospital planning in the 1960s, Joseph found himself introducing the technocratic, top-down NHS reorganization of 1974.[39] Shortly thereafter, however, he would abandon begrudged acceptance of the efficacy of government in long-term planning and provision of services in favor of unquestioning fealty to free-market principles.

This belief (some would say obsession) in the efficacy of markets and the 'Invisible Hand' that was seen to drive them, led to a whole series of concrete policy implications—implications that would play themselves out during the course of the Thatcher era. Joseph himself, however, did not feel himself cut out for the pinnacle of

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[38] Anthony King, "The Outside of Political Leader: The Case of Margaret Thatcher," *British Journal of Political Science*, Vol. 32, no. 3 (July 2002), 443-444.
[39] For more on Joseph's political philosophy, see E.E.H. Green, "Thatcherism: An Historical Perspective," *Transactions of the Royal Historical Society*, 6th series, Vol. 9 (1999), 18-20.

national political power, and he thus founded an influential right-wind think tank that would provide the intellectual underpinnings to rising political movement, of sorts, known as Thatcherism. Having bungled his own chance to rise to national prominence, Joseph worked to foster and cultivate Thatcher's fortunes within the Conservative Party.[40]

Margaret Thatcher, a grocer's daughter and college chemistry major, challenged the High Tory grandees of the Conservative Party in the mid-1970s. Faced with the endemic weakness in the economy, and bouts of public disorder, the Tories under Edward Heath (prime minister 1970-74) seemed to struggle nearly as much as their Labour opponents. The political climate was so toxic that Heath was led to call two general elections during the course of 1974, the second of which led to the formation of a Labour government under Harold Wilson. Rather than step down, as some party leaders had done so on past occasions of electoral defeat, Heath pledged to cling to power. Reformers within the party, including the growing cadre of pro-market Thatcher acolytes, however, felt a new leader was needed to improve the party's political fortunes. Thatcher offered a fresh political vision, even if her radical devotion to the free market did not appeal to large swaths of the party membership. The 'anyone-but-Heath' movement elevated Thatcher to the Conservative Party leadership, and she would use the next three-plus years to prepare for government—not quite ready for political 'prime time.'

The (second) Labour government of Harold Wilson started off promisingly, but conditions worsened under his successor as prime minister, James Callaghan. Labor

[40] Particularly damaging to Joseph's prospects was a radical-sounding speech delivered in 1974. See Green (1999), 18.

unrest spread across the country during the late-1970s, culminating in the so-called Winter of Discontent (1978-79), when so many public employees were on strike that gravediggers were reportedly unavailable in certain parts of the country.[41] With the country at a standstill, the time was ripe for dramatic political change. In the end, Callaghan was forced by sometime-allies to call an election, ostensibly over the issue of Northern Ireland. The state of the economy, and of Britain's place in the world, proved the decisive issues in the proceeding election campaign. The bold innovation the Conservatives seemed ready to offer appealed on some level to some of the more dispirited voters, and the Tories under Thatcher were thus vaulted to power in the autumn of 1979. At the same time, however, the British electorate simply seemed ready for a change—any change—that could possibly steer the ship of state out of the troubled waters in which it struggled to remain afloat.[42]

While 1979 can, from nearly thirty years distant, be seen to represent a seismic shift in British politics, the immediate mandate Thatcher enjoyed was, in actuality, fairly precarious. Despite the public loss of confidence in the Labour government of James Callaghan, the Conservatives could still only garner 44% of the vote to Labour's 37%, and a small majority in the House of Commons of 43 seats.[43] If she had been elevated to the Conservative leadership largely on the basis of an "anyone but Heath" campaign four years earlier, her government was ushered into power on the basis of an "anything but Labour" campaign. Despite her limited mandate, Thatcher put herself forward with

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[41] Geoff Eley, *Forging Democracy: The History of the Left in Europe, 1850-2000* (London: Oxford University Press, 2002), 388-389.
[42] Sanford J. Ungar, "Dateline Britain: Thatcherism," *Foreign Policy*, No. 35 (Summer 1979), 180-182.
[43] Earl A. Reitan, *The Thatcher Revolution* (London: Rowman & Littlefield, 2003), 26.

considerable confidence, declaring herself to be a 'conviction politician' that would raise the country out of its ongoing state of decline.[44]

Expectations were rife that the new government's free-market, small-government agenda would affect the NHS. Nonetheless, Thatcher seemed hesitant in her first few years in number 10 Downing Street to take on what she viewed to be a politically risky behemoth of the welfare state.[45] At first, little change occurred within the NHS. It initially appeared Thatcher and her colleagues did not know quite how to handle the large public body, or that the government possessed a specific policy in the field of health.[46] Nonetheless, it was widely believed that she would soon turn her budget-cutting, privatizing instincts to the health service. The NHS appeared too large a target to avoid for a government committed to cutting public expenditure and overseeing market reform of divers ministries. During the first Thatcher government, therefore, largely cosmetic changes were made in the way the NHS operated. Many of these small revisions were put forward in a 1981 planning document, dynamically dubbed *Care in Action,* which was followed by (yet another) reorganization the following year.[47]

The 1982 reorganization was an attempt to compensate for some of the more glaring deficiencies of the reforms of eight years previous. While the 1974 reorganization had as its goal the streamlining of the NHS, in many ways it accomplished just the opposite. Consensus management and the divisions that remained between the local, regional, and national tiers within the NHS conspired to make meaningful change

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[44] Reitan, 27.
[45] Klein (2006), 109—in the author's words, Thatcher treated the NHS during her first term (1979-83) as an "unexploded bomb, liable to be set off by any imprudent move…"
[46] Klein (2006), 145-146.
[47] Klein (2006), 99.

next to impossible.[48] Continued dominance of medical profession within the NHS, moreover, did not prevent other providers and ancillary employees from participating in frequent strikes. Not for the first time, nor for the last, did the NHS appear to be in crisis, and mired in stasis. While momentum toward health care reform under Thatcher was initially quite gradual, the NHS began to take center stage by the mid-1980s, and particularly by decade's end.

A more sustained period of health care reform appeared to be heralded in 1983 with the release of the so-called Griffiths Report. Griffiths had been charged by Prime Minister Thatcher to examine manpower and management within the NHS, and report back on strategies for reform. His study pointed to the perceived lack of proper management within the NHS, and prefaced his recommendations to instill a management (read: business) culture within the organization. This would involve inserting managers strategically throughout the organization, including within individual hospitals.

The Report also stressed the need to insulate managers from meddling politicians. To that end, Griffiths recommended organizational duality in the upper echelons, with a separate Management Board running the NHS, while a more politicized Health Services Supervisory Board planned long-term strategy.[49] Below this highest tier of NHS planning and management, the power structure of the individual health authorities was steadily transformed, with centralization of power generally residing in the person of the chairperson or chief manager.[50]

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[48] Klein (2006), 93-95.
[49] Baggott, 102-103.
[50] Baggott, 104.

The Griffiths Report did more than reform management structures within the NHS. It set the stage for and, indeed, facilitated the execution of, the far more radical reforms that would follow in the late-1980s. The establishment of a managerial class within the NHS ensured that orders and recommendations from political leaders could henceforth be more smoothly circulated and, presumably, executed. At the same time, evaluative mechanisms were gradually built, in keeping with the corporate spirit of the modest reforms Griffiths set forth.[51] The publication of the Griffiths Report seemed to represent the opening salvo in an extended campaign of NHS reform.

Nonetheless, despite expectations to the contrary, wholesale reform of the NHS did not immediately follow the release of the Griffiths Report. Indeed, with the exception of the buttressing of management within the organization, the NHS ran largely as before through much of the remainder of the 1980s. The Griffiths Report, however, awakened many to the government's intent to view the health service more as a business, comprised of suppliers and consumers (as opposed to patients). Along with this change in perspective came the idea shared among Thatcher and her political allies that the NHS should run more efficiently and, indeed, that it could be made to do so through fixes in staffing and management.

The real change enacted within the context of the NHS during the first half of the 1980s involved health service funding. The Thatcher government could (and did) rightfully point to funding increases during much of her tenure. Nonetheless, these increases barely kept pace with inflation, and were considerably lower than funding

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[51] Carolyn Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (New York: Oxford University Press, 1999, 66.

surges under previous governments.[52] With health care costs rising dramatically worldwide, the paltry injections of additional funding during much of the decade of the 1980s were not nearly enough to cover all of the health service's needs. Moreover, NHS staff members began to feel the effects of inadequate funding levels. Thatcher and her inner circle became progressively more frustrated with the seeming lack of return on what they viewed as a generous investment. In the face of ever-increasing NHS spending, problems continued to plague the organization, a state of affairs seemingly highlighted by several high-profile medical incidents.[53] Staff morale was low, and public confidence in the future of the NHS was shaken.

Particularly egregious cases of hospital shortcomings signaled to the public that the NHS was suffering. The situation came to a head when representatives of several of the Royal Colleges, which had historically served an independent regulatory function in British health care, declared the NHS to be chronically short of funds.[54] The prime minister, who had hoped to keep public spending steady, if not cut it across many areas, was not about to authorize dramatic NHS funding increases—at least not without certain strings attached.[55] It was within this atmosphere of (perceived) crisis and stalemate that the Thatcher government unveiled its ambitious reform program—a program that would be enacted in full as the NHS and Community Care Act of 1990.

The accumulation of media reports about various hospital abuses has long been cited as a key factor driving the precise timing of the Thatcher NHS reform program.

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[52] Baggott, 134.
[53] Klein (2006), 141-142.
[54] Tuohy, 63-64.
[55] A panicking government did initially agree to an emergency increase in funding. Unrest among NHS employees, however, ensured that the failings of the health care system continued making news, putting continuous pressure on the government to respond.

Medical providers were eager to paint a picture of crisis in the NHS, as a means of receiving the substantial rise in funding they felt was long overdue.[56] Also mooted as an independent variable accounting for the late-1980s starting point for reform is the fact that Thatcher had, not long before, secured a third election victory. Advocates of this explanatory factor point out that she must have thus felt empowered to make her long-delayed foray into health care, which followed similar overhauls of education and housing policy.[57] In all likelihood, a combination of the aforementioned forces was likely at work, conspiring to determine the timing of the true start of dramatic health policy reform.

Whatever the Prime Minister's reasons for selecting the occasion, nearly five years after the publication of the Griffiths 'report', the prime minister convened a small, ad hoc group of close advisors to study the issue somewhat more methodically.[58] The contrast with the 500-strong committee seated to study issues of health reform under the Clinton administration could not be greater—though both policy formulation organs did work largely in secret, with the grand plan being unveiled at the end of lengthy proceedings. Convinced at an early date that the laws of the free market could solve most of the problems facing the public sector, Thatcher and her advisors were nonetheless faced with an imperfect (though still highly regarded by much of the British public) NHS that lent itself to no specific avenues of reform.[59] The free-marketers had a rough idea of

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[56] Klein (2006), 144.
[57] Baggott, 105.
[58] *ibid.*
[59] Tuohy highlights a key distinction in contemporary public opinion: the populace was increasingly dissatisfied with NHS performance, but its support for the NHS generally remained high throughout.

how to proceed—replicate market behavior, or construct actual markets, but no easy way to implement these broad guiding principles.

It was at this point that Joseph recommended exploring the work of American health reformer Alain Enthoven. As the reader will recall from the previous chapter, Enthoven, along with Paul Ellwood, had been working with the ideas behind so-called managed care for around a decade. As noted in the previous chapter, Ellwood's ideas appealed to President Nixon, who used divers incentives to attempt to move more American citizen-patients into fledgling health maintenance organizations. Studying the British health care system during the mid-1980's Enthoven actually recommended against the application of certain managed care principles within the context of the NHS.[60]

Having praised his policy stances in a 1984 piece on the American health care system, the *Economist* ran a lengthy summary of Enthoven's prescription fro NHS reform the following year.[61] He opened the piece by noting the achievements the NHS could claim, and the brand loyalty thereby inspired: "The National Health Service (NHS) is the democratic choice of the overwhelming majority of the British people. It produces a great deal of care for the money spent…" The casual reader could be forgiven for wondering why reform was therefore being mooted. Perhaps characteristically for an American observer, Enthoven related his concerns to shortage, or future shortage, of

[60] Klein (2006), 149.
[61] "Remedies and the Reverse," *Economist*, 28 April 1984.

technologically advanced medical equipment, before identifying the chief flaw of the NHS as "the lack of real incentives for good performance."[62]

Headlining Enthoven's ideas for change were the formation of internal markets within the NHS, and the freeing of individual GPs from stifling national norms. Also mentioned in this early work (vis a vis the British system) was further contracting with private surgical and treatment facilities.[63] Despite the fact that the scheme had only recently gone into operation, he also mentioned prospective payment as a means of restructuring incentives within the NHS. As if attempting to entice the reader-policymaker, Enthoven also dangled the prospect of HMO development within the British context. As noted above, however, he concluded the piece by (somewhat haughtily) venturing that the British citizenry was likely not ready for such dramatic reforms.

Enthoven's study of the NHS was music to the ears of the hardline market advocates in the Thatcher government. The 1985 piece, coupled with informal collaboration between Enthoven and other American scholars on the one hand, and government officials on the other, marked the beginning of an extended period of policy diffusion from the United States to the United Kingdom. Material like the Enthoven study ensured that, when Thatcher felt politically confident to handle the 'unexploded bomb" that was the NHS, she would be equipped with a set of policy alternatives.

Something of a riddle presents itself in the degree to which British health policymakers looked to the United States for constructive policy alternatives. After all, if

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[62] Alain Enthoven, "Some Reforms That Might Be Politically Feasible," *Economist*, 22 June 1985.
[63] *ibid.*

the NHS suffered from chronic underfunding during the mid-1980s, the American 'system' was marked by the opposite problem. Perhaps more to the point, the American health care marketplace was a far different environment than that within the NHS. The former was characterized by extreme decentralization, diversity of health care purchasers, and less (if still substantial) direct government intervention. The NHS, on the other hand, occupied the opposite end of the health care spectrum, with centralization, a single health care purchaser, and continuous involvement by the government of the day. Under the circumstances, American market-based solutions seemed to make little intuitive sense. Donald Light (1997) put it best when he noted the irony that

> …whereas a policy of true managed competition would aim to correct the distortions of largely unmanaged market competition in the United States, managed competition in the United Kingdom was used to introduce market forces into a highly managed system that was among the cheapest, most comprehensive, and equitable in the West.[64]

One of the keys to solving this policy riddle is the sheer frequency of health care studies coming out of the United States. Precisely because American health care arrangements were found to be lacking by many, studies of alternatives were readily available, as were pieces examining the relative strengths of medical care in the United States. The cultural ties that bind the two countries should not be underestimated, either. When asked this very question—just why the United States has traditionally served as something of a model for those who shape British health policy—eminent NHS historian

[64] Donald Light, "From Managed Competition to Managed Cooperation: Theory and Lessons from the British Experience," *The Milbank Quarterly*, Vol. 75, No. 3 (1997), 301.

Geoffrey Rivett pointed to the importance of speaking the same language, both literally and in terms of cultural bonds.[65] By the 1985 publication of the Enthoven NHS study, close relationships had long existed between British health policy specialists and their American colleagues. The easy communication between the two populations of scholars and policy 'wonks' ensured that the case of the American health care 'system' would loom large once radical reform of the NHS was on the (political) table, as occurred in 1988.

V. From *Working for Patients* to the NHS and Community Care Act

Somewhat in line with her maverick political style, a style which generally disguised a pragmatic political strategy, Prime Minister Thatcher introduced the idea of a top-to-bottom review of the NHS on the political television program *Panorama.*[66] Many were shocked by the announcement that her government intended to oversee a comprehensive review of the health service, including many political figures. With her small group of policy intimates, she forged ahead, releasing the white paper *Working for Patients* at the start of 1989. The document was, at the time, considered revolutionary. In some ways, it is startling just how much the paper resembles the ideas propounded by Enthoven four years earlier.

Indeed, the latter's chief policy recommendation, the formation of an internal market within the NHS, was also the centerpiece of *Working for Patients.* Thatcher planned to implement the internal market through the expedient of the so-called

[65] Personal interview by the author, January 9, 2005, London.
[66] Klein (2006), 140.

purchaser-provider split. Under the system, the responsibilities of district health authorities and providers would be separated, with the authorities purchasing care from specialists (consultants) on behalf of those falling within their geographic catchment area. Specialists would compete with each other for authority business. They would also compete for referrals from certain general practitioners. A further novelty of the plan was the concept of fundholding, which would allow GPs with patient lists of a certain minimum size to control their own (limited) budgets. Granted a certain amount from the health authorities, they could then use any funds remaining at the end of the year to invest in practice improvements.

Under the purchaser-provider split, however, local authorities would now share the responsibility of purchasing and obtaining care for patients within their catchment area, along with 'fundholding' physicians. The latter doctors would be given a limited budget, with which they could procure health care services from whichever local (or even distant) specialist (or hospital) could provide them at the most reasonable cost. Higher-cost procedures and patients would be covered by the local authorities, in their newly reconstituted role as purchasers of care.[67] In this way, it was hoped physicians would order services with an eye to frugality, thus limiting health spending. At the same time, specialists would be forced to offer services at lower costs (and deliver them effectively) in order to retain patients referred from fundholding physicians and local health authorities.[68]

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[67] Baggott, 107.
[68] Patricia Day, "The State, the NHS, and General Practice," *Journal of Public Health Policy*, Vol. 13, No. 2 (Summer 1992), 173-174.

The purchaser-provider split was also designed to serve another, slightly less obvious, purpose. General practitioners had traditionally lagged behind specialists in terms of prestige. The purchaser-provider split would place GPs in the position of directing business (patients, that is) to certain specialists. Specialists would thus rely on GPs, and the prestige of the latter would perhaps rise in keeping with their newfound (relative) power within the medical profession.[69] The extent to which this has actually occurred under the reforms is, however, questionable.[70] Early evidence suggested that fundholders did not dramatically alter referral patterns, nor did patients of fundholding physicians generally receive superior, faster care simply by virtue of their doctor's fundholding status.

Policymakers did not, at the start, generally believe that fundholding would prove the most revolutionary aspect of the market-based reforms, but tended to focus instead on the structural significance of the purchaser-provider split.[71] As any surplus amount could be used by the physician to improve his practice, it was thought fundholders would act with a considerable amount of care when it came to actually purchasing services from hospitals and specialists, without being exposed to the perverse incentive of financial gain on the basis of reduced patient services.[72] Despite the lack of relative fanfare surrounding fundholding, the scheme would have quite a pronounced effect on the future operation of the NHS. After first abandoning the initiative, moreover, Thatcher's one-off successor, Tony Blair, would actually expand the program. It was through the reform of

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[69] Day, 174-175.
[70] Anthony J. Harrison, "Hospitals in England: Impact of the 1990 National Health Service Reforms," *Medical Care*, Vol. 35, No. 10 (Oct. 1997), OS52.
[71] Stephen Harrison and Nabila Choudhry, "General Practice Fundholding in the UK National Health Service: Evidence to Date," *Journal of Public Health Policy*, Vol. 17, No. 3 (1996), 331-332.
[72] Harrison and Choudhry, 332-333.

general practice that the greatest impact would be felt within the NHS. Fundholding and the purchaser-provider split, as well as a variety of other changes, were implemented following the 1990 parliamentary passage of the NHS and Community Care Act.

VI. The Profession, Public, and Politics Push Back

The NHS and Community Care Act is, quite rightly, considered a landmark piece of legislation. It was based on a 1989 white paper (consultative document composed by the government) outlining a vision for radical change within the NHS. The legislation included the purchaser-provider split and fundholding scheme, as outlined above. It also made reference to proposals to move more health care out of hospitals, and into the community, though the implementation of these provisions was delayed until after the following general election, which transpired in 1992.[73] The focus on efficiency and flexibility within the constraints of the NHS was nothing new and, indeed, had been central concerns since the inception of the organization. What differed at this point in the organization's history was the intensity with which such concerns were expressed, and the zeal with which reform was advanced.[74]

The medical establishment at first reacted rather gingerly to the reforms. A fair proportion, though by no means all, of physicians with larger practices would opt to participate in fundholding. Opponents of the reforms immediately voiced concerns about the development of a dual-tiered system of primary care, in which fundholding GPs

[73] Baggott, 277-278.
[74] Klein (2006), 105-106.

would be capable of obtaining care for their patients more swiftly than the (redirected) local authorities. Others expressed reservations about the capability of local authorities to accurately estimate the care needs of the community, and therefore order the appropriate amount (and types) of care. Concerns also abounded over the amount of additional costs the reform program would generate in the name of greater overall efficiency.[75]

The opposition Labour Party did not delay in its condemnation of the reforms when they were first introduced. With regard to the roll-out of fundholding, one Labour MP expressed concern that, if not properly advised as to the acceptable use of surplus funds, physicians might "improve their lifestyle with better suits, cars, or holidays," to which health minister Kenneth Clarke replied rather coyly that if that state of affairs were to obtain, it would "be only because of the generosity of the pay awards that the Government have been implementing."[76] Clarke further leaned on technocratic complexity as a means of explaining any negative response to the reform program on the part of the wider public, helpfully pointing out that, "The proposals are complicated and go into details about how the service is managed and financed, which normally, as a patient, the average member of the public would not encounter, so understandably there is some public reserve about the proposals."[77]

The public response to the NHS reform program was mixed. One Labour parliamentarian, a Mr. Lowden, indicated in Commons proceedings that "most people see

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[75] Baggott, 114.
[76] United Kingdom House of Commons, Hansard Debates for Tuesday, 21 February 1989: Oral Answers to Questions on Health (Mr. Ashley to Mr. Clarke)." [online: http://www.publications.parliament.uk/pa/cm198889/cmhansrd/1989-02-21/Orals-1.html].
[77] Hansard (1989), Mr. Clarke to Mr. Bruce.

this [the Thatcher reform plan] as the first step to privatization."[78] Overall, Prime Minister Thatcher could (as of the concluding weeks of 1989) claim the dubious distinction of being the least popular British prime minister since the rise of modern polling techniques.[79] While she celebrated her tenth anniversary in power in 1989, less than a year would elapse between the passage of the NHS and Community Care Act in January 1990, and her ousting at the hands of fellow Conservatives in November of the same year.

Just as the American medical profession harnessed public displeasure at the abuses of managed care in order to improve its members' own position vis a vis HMOs and related species, the BMA sought to mobilize British public opinion against the government's reform program. The organization commissioned a poll in September, 1989 that found a good three-quarters of the citizenry surveyed opposed the Thatcher government's changes, then newly unveiled.[80] As the broadly sympathetic *Economist* noted at the end of September 1989, "the doctors have laboured mightily against their [the reforms'] implementation."[81] They did so largely through a well-financed advertising campaign.[82] The echo thus provided to the AMA's ad blitz against national health insurance in the United States is quite ironic, to put it mildly. While government supporters hopefully placed their trust in the capacity of public opinion to "catch up with

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[78] Hansard (1989), Mr. Lowden to Mr. Clarke.
[79] Rodney Brazier, "The Downfall of Margaret Thatcher," *The Modern Law Review,* Vol. 54, No. 4 (July 1991), 472.
[80] "Listen for the Better Way" (editorial), *The Guardian*, 26 September 1989.
[81] "Drugs and the NHS: A Tighter Prescription," *Economist*, 30 September 1989.
[82] *ibid.*

reality," by embracing the Thatcher reforms, there was little evidence over the next several years to suggest that actually occurred.[83]

Not long after the health care reforms began to take hold, Margaret Thatcher was forced to step down as prime minister in the wake of internal Conservative party conflict. She was succeeded by her sometime chancellor, and perceived political pragmatist, John Major. Major, a figure considered by many observers to lack the aggressiveness and dynamism of a Margaret Thatcher, was nonetheless left with the unenviable task of implementing radical reform programs set in motion by his predecessor. Despite making reassuring noises to the medical profession at the start of his ministry, Major would nonetheless largely hew to the patch carved by Thatcher under the NHS and Community Care Act.

As the NHS and Community Care Act was implemented in the years immediately following, the issue of health care remained an albatross around the neck of the governing Conservatives. Around one year following the departure of Thatcher, and the arrival of John Major as prime minister, one poll showed that a full two-thirds of potential voters believed NHS privatization probable if it remained in the hands of his government.[84] As the 1992 general election approached, little change could be detected in the attitudes of the vast body of the electorate.

If anything, the potentially deleterious effects of the NHS reform program loomed even larger in the minds of many would-be voters. Thatcher had been dismissed by her

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[83] Brian Walden, "General Thatcher Needs to Regroup Her Troops," *The Sunday Times*, 10 September 1989.
[84] Alexander MacLeod, "Health Care Issue is Seen as Key to Tory Hopes in British Election," *Christian Science Monitor*, 13 November 1991.

party colleagues partly on the basis of her government's growing unpopularity over the matter of local taxation—the so-called (and much-derided) poll tax.[85] The government of John Major, however, successfully eliminated local taxation as an election issue, allowing continuing concerns about the NHS reforms to become one of the top, if not the top, consideration of voters slated to head to the polls on 9 April 1992.[86] The Labour campaign tactic of directing public attention to those who possibly lost their lives due to the narrowed constraints of the post-reform NHS ensured opposition to the 1990 legislative overhaul package would remain the dominant public position on the issue.[87] It was perhaps partly due to Major's success in nonetheless "spreading reassurances about the NHS" that his government was able to score a startling victory over Labour in the 1992 general election.[88]

Given a new five-year lease on life, the Major government continued its policy of generally allowing the broad outline of reform to continue, while intervening when it appeared the logic of the market could lead to considerable disruption in health care delivery. Major himself walked a fine line between those relative hard-liners within his government (like initial health minister William Waldegrave) who appeared committed to allowing the Thatcher reforms to go forward at any cost on the one hand, and his own moderate instincts on the matter, on the other.[89] Health policy under Major thus went forward with something of an ad hoc quality. Looking into the future from the

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[85] Brazier (1991), 471.
[86] "The Voters are Unimpressed" (editorial), *The Independent*, 28 March 1992.
[87] David Lord, "Labor Plays Health-Care Card; Voters' Fears of Change Could Swing British Election," *The* [Montreal] *Gazette*, 24 March 1992, page A8.
[88] "An Obligation to Take Stock," (editorial), *The* (Glasgow) *Herald*, 11 April 1992, page 8.
[89] Ian Aitken, "Commentary: Mr. Waldegrave's Arm in an NHS Sling," *The Guardian*, 21 October 1991

perspective of the early 1990s, it was unclear just what this form of policymaking would mean for the further development of the NHS.

VII. Minor Policy Shifts During the Major Interlude

What it appeared to mean was that markets would be allowed to form within health care and follow their own logic. As in most market experiments in health care, however, this is not what actually occurred. Newly-autonomous hospitals that went over-budget, or were otherwise in dire financial straits, were generally not allowed to close. Instead, they were bailed out with substantial government subsidies. Political leaders were not about to allow reforms to play themselves out, if it meant facing the difficult, unpopular task of shuttering a much-cherished community hospital. At the end of the day, the markets, or quasi-markets, in British health care were still very much subject to the direction of the relevant political leaders.[90]

Not only did the implementation of 'managed competition' thus involve the introduction of competition into a previously-managed sector, it also entailed a definite increase in government supervision of the health care system. In some respects, it involved a return to the reliance on planning that marked health policymaking in the 1960s and 1970s.[91] It was the government of the day, after all, which at this point remained ultimately responsible to voters for even the smallest perceived defect within the NHS. Public expectations, moreover, had been raised by repeated promises that the

[90] Klein (2006), 164-165.
[91] Klein (2006), 164.

reformed NHS would be more responsive to the needs of citizen-patients. So long as that remained the case, it was simply impossible to expect such electorate-accountable politicians to give the health care quasi-market entirely free rein.

Public expectations had been further raised by the Major government's attempt to pay fealty to the NHS consumer. The first year of his government witnessed the promulgation of a so-called 'Patients' Charter,' that listed the broad rights enjoyed by each individual citizen-patient. In outline, the Charter was not unlike the imagined 'Patients' Bill of Rights', the virtues of which the U.S. Congress of the late-1990s would often debate. The Patients' Charter represented the government's attempt to empower consumers of the new, supposedly market-driven NHS. Just as the consequences of the internal market were not allowed to spiral out of the government's control, however, the potential implications of the Patients' Charter did not come to pass. The changes the document wrought were limited, and even its value as a political symbol could only be taken so far. Voters, after all, remained wary of the Conservatives' motivations when it came to serving the needs of the average citizen-patient.

Nonetheless, the Patients' Charter introduced an element of consumerism into the ethos of the health service. Hence Klein notes that the "mimic market produced, in turn, a mimic consumerism," embodied in a document that was fraught with symbolic significance.[92] Moreover, if the actual policy implications of the document were decidedly slight, the Patients' Charter did lead to a steady expansion in the information available to citizen-patients dealing with the quality and performance of various provider units. Particularly notable in this regard was the star rating system that was unveiled in

[92] Klein (2006), 168-169.

1993-94, assigning a certain number of stars based on the quality of a given institution, as illustrated by performance along a set of indicators.[93]

The extent to which citizen-patients could physically act on the information set before them vividly illustrates the extent to which the Patients' Charter, and the star ratings system it begat, were substantively illusory. General practitioners still played a crucial gatekeeper role within the NHS, largely determining, along with health authorities, where the individual patient would seek specialist treatment in any given care episode. Thus there was little, practically speaking, the average citizen-patient could actually do with the information at hand, beyond contemplating the performance of the hospital(s) to which he or she was likely to be referred.[94]

Observers noted that the Patients' Charter, and the Major government's program of consumerism generally, was of a rather Janus-faced orientation. While the language employed, and the overall tone, of the documents associated with the program represented something of a break with the immediate Thatcherite past, in substance they constituted a continuation of the crusade to ferret out bureaucratic inefficiency.[95] In effect, citizen-patients, assuming the role of consumer, were being played off against bureaucratic (State) actors, in hopes of improving the output of the latter. The dual purpose of reshaping the government bureaucracy in the image of the pro-business 'New

[93] Klein (2006), 169.
[94] Klein (2006), 169-170.
[95] Anne Barron and Colin Scott, "The Citizen's Charter Programme," *The Modern Law Review*, Vol. 55, No. 4 (July, 1992), 526-527.

Right' leadership, and pacifying the greatest quantity of citizen-patients (in their 'consumer' and 'voter' guises), could thus be accomplished simultaneously.[96]

The Patients' Charter and systems of evaluation and information propagation that followed served as confirmation of the Conservatives' avowed commitment to involving citizen-patients more in their own care under the auspices of the reformed NHS. The extent to which mere rhetoric on the sovereignty of the consumer, or even the ready availability of provider evaluations genuinely empowers the citizen-patient is debatable. I have argued previously that the institutionalized role of the health care consumer early in the history of British health care contributed to the generosity and comprehensiveness of care provision under the NHS. Once the NHS had been established, the political vulnerability of successive governments to the charge of substandard health care provision ensured that ministers would at least pay lip service to the needs of citizen-patients while shaping NHS policy.

While the Patients' Charter (and broader Citizens' Charter initiative) came around the beginning of John Major's tenure in office, another health policy document, *A Service With Ambitions* (1996) bookended it in the government's waning days. As the title of the policy document indicates, the analysis contained therein was designed to be forward-looking, situating contemporary reforms within the context of improved services (far) down the road. The conciliatory, inoffensive health minister of the period, Stephen Dorrell, hoped to 'reassure' citizen-patients that the NHS remained safe in Conservative hands.[97] It was not by accident that the foreward of said document started with a

[96] *ibid.*
[97] Klein (2006), 172.

recapitulation of the chief goals of the NHS since its founding: universality, high quality of care, and provision of care free at the point of service.[98] While the Conservatives attempted to reiterate their continued commitment to the founding principles of the NHS, they also attempted to make the most of the market reforms which had been set in motion nearly seven years before—effectively having it both ways. While Dorrell and others appealed to citizen-patients as citizens, they also sought to reserve the right to dialogue with the consumer in each individual.

The continuous fusion of the citizen-patient as both citizen AND patient within the context of the public, universalist NHS encouraged policymakers to design institutions that would allow said constituency to voice their opinions on the health service. This tendency truly started to take root when the traditional political expediency of keeping citizen-patients happy happened to coincide with the unique governing philosophy of Margaret Thatcher and, to some extent, her immediate successor. Thus the citizen-patient was explicitly recast as 'consumer', with the key market role that formal title entailed.[99] While political observers would have expected this project to be suspended, or even reversed, once a Labour government was returned to power, that outcome did not, in actuality, accrue. In the event, 'New Labour' acted very much along the lines followed by the 'New Right' that it replaced.

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[98] Stephen Dorrell, , "The National Health Service: A Service with Ambitions (Foreward)" United Kingdom Department of Health and Social Services, 1996.
[99] Barron and Scott, 526.

VIII. Putting Consumers 'in Control': New Labour and the NHS

Though it could (quite legitimately) claim to simply be 'staying the course' in terms of reform (as opposed to introducing policy innovation in its own right), the Major government and Conservative Party were both broadly identified with radical reform in health care. This remained the case all the way through the tenure of John Major, and the sum effect of the Conservative record on health care undoubtedly contributed to the margin of victory achieved by 'New' Labour under Tony Blair. The increasingly de-populated Tory government was statutorily required to call an election in 1997.[100] The Conservatives under John Major managed to hang onto power in an upset over Neil Kinnock's Labour Party in 1992.

Five years, and two leaders later, Labour put itself forward as a thoroughly reconstructed entity—one unrecognizable in comparison with the radical organization it appeared to be during much of the 1980s.[101] During the Thatcher era, Labour found itself deep in the political wilderness. The (fairly) moderate parliamentary party was largely at the mercy of the more radical local party organizations, many of which were effectively controlled by union members. As the 1980s progressed, Labour slowly began the climb back to the heights of political relevance. This trend picked up steam following the entry into parliamentary circles of such modernizers as Tony Blair and Gordon Brown (future prime ministers, both), and the meteoric rise of said figures into the 'shadow government', as the opposing party's policy leaders/potential cabinet members are

[100] Several high-level ministers were dogged by sex scandal during the course of the Major government, including the Citizens' Charter Minister—see, for instance, Peter Osborne, "New Sex Scandal Hits the Tories; Citizens' Charter Minister Quits Over Affair," *The Evening Standard*, 6 March 1995, pages 1 and 2.
[101] Klein (2006), 188-189.

known. Aged party leader Michael Foot was followed by the younger, moderate Neil Kinnock. After the brief tenure of his immediate successor, John Smith, Tony Blair took control of the party reins in 1994.

The incoming government of Tony Blair inherited an NHS that was still in the midst of considerable flux. The first seven years following the promulgation of the 1990 reform program had failed to entirely reshape the British health care landscape. Newly-empowered in their role as purchasers of care, for instance, health authorities tended to exhibit conservatism in their selection of providers, with little evidence of ample 'shopping around' on the basis of quality or price.[102] This closely matched the broadly conservative referral patterns of fundholding physicians, referenced earlier in this chapter.

Tony Blair and 'New Labour' campaigned on the issue of health care. In the day leading up to the May, 1997 election, the Party warned in decidedly dire terms "you [the electorate] have only 24 hours to save the NHS." In later years, Blair would admit that this was more than a bit of an exaggeration.[103] In 1997, however, it helped Labour win a general election. Once that election was won, however, it was less clear just how the pledge to bring salvation to the beleaguered NHS could be translated into actual policy.

In pledging to 'save the NHS,' the incoming Blair government express its intention to roll back the health care reforms of the Thatcher-Blair era. That proved an improbable, if not impossible, task, in light of the fact that certain aspects of the

[102] Klein (2006), 173.
[103] Gabriel Milland, "Now Blair Boasts: I Have Saved the NHS," *Express*, 1 May 2007.

Thatcher-Major health program seemed to be producing positive change.[104] This was not, however, what actually transpired—indeed, the Blair government extended market reforms beyond anything the Thatcher team seems to have envisioned. The government did scrap fundholding, and claimed to abolish the purchaser-provider split. In reality, however, the split remained—the only real difference being that the contracts reached between local authorities and hospitals would be of longer duration.

The first health minister of the Blair era, Frank Dobson, seemed (rhetorically) committed to a stark reversal of Conservative NHS policy. Dobson was one of the figures in the new government who was generally considered to fall quite far to the left—certainly further than the new centrist prime minister. Dobson's appointment was part of a larger conciliatory drive toward those on the 'Old Labour' left, in which the NHS was, initially at least, to play a key role.[105] Eulogizing this one-time health minister, leftish observers tended to portray Dobson as one whose intentions were good, but who was nonetheless tethered to a New Labour's self-imposed tethering to Conservative spending plans.[106] Nonetheless, the '24 hours to save the NHS' campaign threat-cum-promise had itself been an effort to draw political capital from the traditional public association connecting Labour and prudent custodianship of public service organizations. This appeal to tradition, in turn, obligated New Labour to mend fences with party traditionalists.

Dobson thus tended to emphasize the extent to which competition would be purged from the health service. Official policy pronouncements during this early portion

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[104] Klein (2006), 192.
[105] Klein (2006), 192.
[106] Allyson Pollock, *NHS plc* (New York: Verso, 2005), 53.

of Blair's tenure, however, tended to possess a Janus-faced quality. The first government White Paper on the NHS, "The New NHS—Modern-Dependable", ironically (considering the title) seemed to promise a return to the old (pre-Thatcher) days in health care. It promised to 'abolish' the internal market—even as the purchaser-provider split was to be left in operation. In practice, this meant health authorities were still to contract with hospitals and other provider institutions. Rather than relying on short-term contracts, however, longer-term service agreements were to define the terms of transaction between the two groups.[107] Also on the chopping block was the fundholding scheme pioneered by Thatcher, and extended under Major. Here the white paper was little short of disingenuous—fundholding as it had previously existed was dead. Left very much alive, however, was the general idea of general practitioners purchasing care for their patients. Rather than leaving individual GPs to their own devices on this count, however, the Blair government proposed the formation of large primary care groups (PCGs) tending to the purchasing needs of all GPs within a given geographic region.[108] In effect, every physician in England became a fundholder, even if budgeting decisions were collectivized across a larger number of practices.

Having been tapped as potential Labour nominee for Mayor of London, Dobson was succeeded by a committed New Labourite, Alan Milburn. Milburn's accession to the health ministry seemed to herald a second reversal in health policy. As one Department of Health adviser notes, however, the change was constituted more evolution than revolution: Milburn and his close colleague Simon Stevens, had been formulating reform

[107] Klein (2006), 193-194.
[108] Klein (2006), 194.

plans during much of the two-year health ministry term of Frank Dobson.[109] The health ministry elaborated on its plans to universalize fundholding by moving from Primary Care Groups to (more independent) Primary Care Trusts, and allowed hospitals to regain the independent status they had enjoyed under Thatcher and Major.[110]

Moreover, the Milburn ministry witnessed the dramatic expansion of the so-called Private Finance Initiative, or PFI. This scheme was, in a sense, the logical conclusion to the ongoing effort of contracting (at first minor) services and portions of facilities to the private sector. The PFI plan was also inextricably linked with the effort to decentralize within the hospital sector. Though it had been launched under the Major government (see above), it was under Blair that the program truly took off, promising, as they seemed to do, dramatically increased capacity without corresponding steep rises in government spending.[111]

Under PFI, new hospitals were to be built, and older facilities renovated, through long-term leasing arrangements with private contractors. Hospitals were responsible for ensuring payment of yearly lease levies. At the same time, such institutions were able to keep a fair proportion of the revenue they generated, though the regular payments to the leaser could prove prohibitive.[112] Prior to PFI, all hospitals were wholly owned by the NHS, which paid directly any necessary costs. The PFI plan actually involved moving funds from the public to private sector, and the potential arose for private corporations to derive considerable profit from business with the public sector. Policy proponents hoped

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[109] Personal interview with former health adviser to Tony Blair (anonymity requested), 15 January 2005, Department of Health, London.
[110] Pollock, 54-55.
[111] Klein(2006), 237.
[112] Indeed, some hospitals found themselves in dire financial straits before they even opened! See Pollock, 28-29.

this would, in the long run, cut costs for the NHS, which would no longer be responsible for direct ownership of many hospitals. Moreover, some assumed PFI would also force such hospitals to be more efficient, in order to serve all patient needs, while fulfilling their obligations to the private corporation from which hospital facilities were leased.[113]

The PFI program has not been without detractors. Critics accused Blair-era health ministries of selling off public facilities in the name of free-market mythology.[114] Some hospitals found the contractual obligations under PFI schemes difficult to bear. The lease payments on facilities could prove onerous, and critics naturally assumed (sometimes correctly) that cost pressures arising from PFI conditions led to reductions in service and staff. All the while, the private sector was making inroads into primary care, under the LIFT (Local Improvement Finance Trust) program. NHS GP practices have been encouraged to draw on private funding within the context of said program.[115]

Despite the cost pressures they faced, few hospitals actually closed during the Blair era (nor, for that matter, under the preceding governments). As in the case of the United States, the closure of hospitals could prove political dynamite. Americans seemed to become less exercised about the loss of a local hospital, however, if the closure was justified by recourse to the market—that is, if the facility was seen to close as a result of failing to 'measure up' within the broader context of the market. The new structure of incentives constructed as part of the broader market reform program could not be utilized so long as the threat of hospital closure remained a largely idle one.

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[113] Pollock, 116-118.
[114] Klein (2006), 206.
[115] Pollock, 157-158.

On the other side of the Atlantic, it was, until recently, difficult to make the case that a particular hospital closed due simply to market conditions. Hospitals, after all, were not subject to competition, and could therefore only close if the government made a political decision to that effect. The introduction of market principles to hospitals, and the health sector more broadly, gave politicians the opportunity to escape accountability when 'the market' forced a more 'efficient' allocation of resources and facilities across the NHS. Health officials had long hoped to achieve greater efficiency in the allocation of resources nationally. By the 1990s many believed that the market could accomplish this task on their behalf, and do so relatively painlessly on the political level, even if the increased administrative costs arising from the introduction of market principles ensured the opposite outcome often accrued.[116] While the Blair government thus trumpeted the virtues of patient involvement and, eventually, patient choice on the one hand, on the other it turned to the private sector to assist in the expansion of capacity, and the reshaping of health service delivery. Both broad measures had the effect of removing the government from direct responsibility over the inner workings of the NHS.

The increased emphasis on private investment and market mechanisms within the health sector was partly driven by the ideological commitments of the Blair government generally, and health minister Alan Milburn, specifically. As the turn of the twenty-first century approached, however, NHS policy was also influenced by events external to the corridors of power in London. During the closing months of 1999, an influenza epidemic struck portions of the United Kingdom. This national tragedy, paired with a high-profile case in which a citizen-patient stricken with throat cancer died, likely as a result of delays

[116] Pollock, 22-23.

in lining up a hospital appointment for surgery, focused public attention on the state of British health care. In what one observer described as the "most expensive breakfast in history," Tony Blair pledged a vast increase in health funding that would, over the course of the following four years, bring the United Kingdom up to the EU average.[117] In the extent to which it startled others in the health community, the moment was eerily similar to Margaret Thatcher's announcement of wholesale NHS reform on the *Panorama* program a tad over a decade earlier.

Estimates at the time placed British health care investment at 6.8% of GDP, with the (conservatively-derived) EU average at 8%. Even to make up this seemingly small gap in spending would require a massive infusion of funds, and Gordon Brown was known to grumble about the distortion in national budgeting that would result.[118] Despite Brown's differences over the nature of the announcement and, indeed, its timing, he was generally in accord with the prime minister with regard to the imperative of increasing health spending.[119]

Alongside the commitment to increasing health care funding came a blueprint for further reform. As in the case of the Thatcher government, the government did not expand health care financial commitments without offering change—and, it was therefore hoped, value for money. As health advisor Simon Stevens rationalized the dual policy of increased funding and reform, "if the extra investment fails to deliver more consumer-responsive health care, the British people will probably conclude that it is the NHS model

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[117] John Rentoul, *Tony Blair: Prime Minister* (New York: Time Warner Paperbacks, 2001), 538.
[118] Rentoul, 539-541.
[119] *ibid.*

itself that is the problem, rather than just underfunding or political stewardship."[120] The policy document that set out the latest round of reforms, entitled "The NHS Plan", was largely the work of Milburn.[121]

The key provisions of the NHS Plan included the transformation of all primary care groups into primary care trusts (see above), pledges to further sort out the slated role of the private sector in health care provision and an increase in that role, abolition of the Community Health Councils and their replacement with patient forums, and specific targets for expansion in hospital infrastructure, as well as the number of GPs and specialists.[122] Considered most significant by many was the stress on private sector involvement in the health care marketplace, and the increased diversity of players within the health sector.[123] Greater flexibility in care delivery was the overarching theme of the policy document and, indeed, the white paper that elaborated upon it, "Delivering the NHS Plan" (2002).

Multiple points of tension marked health care reform under the latter years of the Blair government. A stated commitment to localism in delivery, and patient-centered care coexisted (uncomfortably at times) with the promulgation of national performance targets, and tighter national regulation generally.[124] During the initial stages of the New Labour reform program, the rhetoric of patient empowerment seemed to conflict with the lack of patient choice that the government initially offered. The abolishing of the CHCs also seemed to belie the government's commitment to soliciting, and acting on, citizen-

[120] Simon Stevens, "Reform Strategies for the English NHS," *Health Affairs* Vol. 23, No. 3 (May/June 2004), 38.
[121] Klein (2006), 215-216.
[122] Baggott, 123-124.
[123] Baggott, 125.
[124] Klein (2006), 219.

patient opinion. The tendency to rely on central planning generally clashed with the government's instinct to leave more to the market, and to distance government from responsibility for decision-making at several levels of the NHS.

In addition to turning to corporations in the private sector to assist in various aspects of health care planning and provision, health ministry officials in the Blair government also utilized the resources offered by charitable organizations. The erosion of the public sector role in direct provision of care also coincided with a new focus on the experience of citizen-patients. Increasingly prominent in the discourse on British health care by the turn of the twenty-first century was the concept of 'patient-centered care.' Perhaps no organization reflected both the prioritization of patient experience, and the delegation of care and planning responsibilities to the private and voluntary sector, than the growing prominence of the Picker Institute and its Oxford-based arm, PickerEurope.

Harvey Picker (1915-2008), American polymath, led a distinguished life dedicated first to business and academia, and finally to advocacy on behalf of patients worldwide. Inheriting a successful purveyor of X-Ray machines, he turned to further exploring the experiences of patients while his wife was hospitalized for treatment of a terminal condition. While obituaries of Picker note that his wife had a positive experience in hospital, interactions with less 'fortunate' patients led Harvey Picker to alter the mission of the charitable organization over which he already presided.[125]

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[125] "Harvey Picker Dies; Godfather of Patient-Centred Health Care Mourned," Picker Institute Press Release, (online: http://www.pickereurope.org/Filestore/PressReleases/News_release_death_of_Harvey_Picker_March_08.pdf) Accessed 1 April 2008.

Picker's foundation, the Picker Institute, had once specialized in assisting university radiology programs. Acting on his experience of witnessing the care of his wife and others, he directed the organization to focus on the quality of patient care in hospitals, and throughout the health care sector. The Institute was soon engaged in the preparation of patient surveys and questionnaires, the results of which, it was hoped, would help citizen-patients seek out the best care available, while making professional caregivers more accountable to those they treated.

Picker surveys soon found their way throughout many hospitals across the United States. It was in the United Kingdom, however, that the work of the Institute had the greatest impact. Picker's work had been ongoing for several years when the Blair government expressed its commitment to serving health care citizen-patients-consumers. Indeed, journalists and other observers would later credit Picker and his team for introducing the very concept of 'consumer-centred care', as it became known—a concept that, by 2008, had become "the watchword of today's NHS."[126] Once the British government became particularly concerned with patient experience, it came to rely on the Picker Institute to create the evaluative tools that would allow for greater awareness of the quality of care to be found through the various parts of the NHS. The Picker project was itself an example of a public-private partnership—just the sort of hybrid long pushed by the Blair reform team.

The consumer-centred care movement had an American counterpart, of sorts, in consumer-driven health care. The latter, however, tended to focus on further market

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[126] Andrew Cole, "Health in the Future: Less Waiting, More Decision-making," *Guardian*, 18 June 2008, page 5.

deepening. Patients were to be treated purely as 'consumers' charged with holding providers responsible, and readily 'voting with their feet' should the care of an individual provider prove less than satisfactory. Progressing a few steps beyond this proposition, however, have been those who suggest patients should seek to determine all (or most) aspects of their care, thus breaking down the long-impenetrable barrier between professional and layman. As health reform scholar Maggie Mahar has noted, one thus crosses the line between the concept of 'consumer-centered care', and consumer-driven health care (commonly known by its acronym CDHC).[127] While attempts are being made within the context of the 'new NHS' to further empower patients, there have thus far been limits placed on the extent to which citizen-patients can become true consumers.

The next chapter will bring the NHS reform story up to the present. It will, moreover, present closing thoughts on the evolution of health care reform on both sides of the Atlantic, viewed particularly through the lens of the citizen-patient. How will the dual role of citizen and patient continue to evolve within the context of national health care arrangements? I will take on that question, and others, in the pages that follow.

[127] Maggie Mahar, *Money-Driven Medicine* (New York: HarperCollins, 2006).

CHAPTER 6 – CONCLUSION

"As consumers every day we are faced with a dizzying array of choices. Which big screen television should I buy? Which fancy coffee drinks should I have this morning? …Sooner or later, we will all be faced with a far more crucial decision that could have life-and-death consequences: What physician should I choose or what hospital should I go to for my healthcare?"[1]

"Ignorant, irrational patient-consumers provide an easy explanation for the persistence of problems: they refuse to believe in the truths revealed by science or economics, they resist paying what services are worth; they seek the wrong services…and ignore the prudent action…"[2]

I. Accounting for HSAs and Consumer-Driven Health Care

The landscape through which the contemporary citizen-patient must navigate is infinitely complex—on both sides of the Atlantic. As payers of health care have sought to keep costs down, and accountability limited, the citizen-patient as consumer has been elevated, and intricately enshrined, within the health care systems of the United States and United Kingdom. The disengagement of payers, whether private or public, has led to

[1] Wayne Sensor, "The Price is Right Here; We're Giving Patients the Kind of Data Available in Any Other Consumer Market," *Modern Healthcare*, 30 April 2007, 22.
[2] Nancy Tomes, "Patient Empowerment and the Dilemmas of Late-Modern Medicalisation," *The Lancet*, 24 February 2007, 698.

a state of affairs in which a vast array of often-unwanted choices are thrown in the face of those simply seeking care and solace while in desperate straits. As health care blogger and critic Merrill Goozner asks plaintively (and rhetorically),

> Must I, Patient, now become I, Health Care Consumer, when I am Sick and vulnerable? Must I conduct an internet search of the latest articles on PubMed and the U.S. Preventive Services Task Force database before determining if I should shell out an extra $30 for that test or drug?

Goozner concludes by asking, "why am I, Patient, being asked to make these decisions at all? How many years of medical school do I have under my belt? Isn't that my doctor's job?"[3]

The American health care hodgepodge recently witnessed the rise of health savings accounts HSAs, a mechanism proponents claimed could vastly increase the range of coverage (and care) options available to the citizen-patient-consumer. Conceptually constructed around HSAs is the movement for consumer-driven health care (CDHC). CDHC similarly involves greater out-of-pocket spending on the part of health care consumers in exchange for a supposed broader range of care, while attempting to hold providers responsible for the care received.

A mere six years after it was first conceptually unveiled, it seemed to some observers that the 'consumer-driven healthcare' movement (or CDHC, as it is

[3] Merrill Goozner, "Overutilization," *Gooznews* (weblog), 18 June 2008.

affectionately known), was already "on its way out"[4] Consumer-driven care had been founded on several principles, including the wide availability (to patients) of cost and quality data, greater transparency over costing of procedures, and informed patient choice of provider.[5] Plans based on the principles of consumer-driven care have also generally contained provisions for some form of health savings account (HSA, not to be confused with the 1970s-vintage health systems agencies), designed to cover 'marginal' or even 'predictable' minor care episodes. As I will explain below, the idea of health savings accounts actually predates the rise of CDHC by over a decade. The overall system was to be predicated on direct patient involvement, and voice, in the nature of his or her care. This brand of active participation, however, could not come to pass without robust provider evaluation and data collection systems. It is precisely in this area, however, that the health care system lacks, thus dooming efforts to spread the gospel of CDHC—at least for now.[6]

Without the proper tools with which to make rational care decisions, citizen-patients have been left to fend for themselves, and have largely clung to providers in pre-existing managed care networks.[7] While consumer-driven schemes have, in fact, reported savings, these have largely been the result of reduced utilization, and not the prudence of empowered 'consumers.'[8] Revealingly, though CDHC seems to be concerned with democracy amongst patients, a pre-existing lack thereof was not the force that originally inspired its rise. Consultant Jeff Munn perhaps summed it up most aptly

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[4]Joanne Wojcik, "Consumer-Driven Health Care Debated: Employer, Insurer Adoption Rates of CDHPs Fall Short of Expectations," *Business Insurance*, 8 October 2007, 4.
[5] "Face Value: Health Care Heretic," *Economist*, 2 June 2007.
[6] Fay Hansen, "Consumerism Still Not Living Up to the Name," *Workforce Management*, 7 April 2008, 28.
[7] Wojcik, 4.
[8] Hansen, 28.

by stating that "this broader trend toward consumerism…is being driven by unrelenting cost increases to healthcare."[9] The fundamental mismatch between the cost-cutting goals of policymakers, and the democratic aspirations ascribed to citizen-patients could hardly be more glaring.

Of course, consumer-driven health care appealed to different constituencies for a wide range of reasons. Its chief theorist, Regina Herzlinger of Harvard Business School, has the sound of a true believer, who genuinely believes in the empowerment of citizen-patients. She presents herself as the consummate populist, fighting on behalf of patients to "attack" present health care arrangements, eschewing a strategy of 'minor skirmish' for one marked by a 'full-blown attack' on just about all of the sacred cows to be found in American health care.[10] While herself dispensing policy advice from the halls of higher learning, she nonetheless takes aim at 'health policy academics,' excoriating them for setting a 'paternalistic,' technocratic tone that came to undergird government regulation of health care.[11] She is equally hostile, however, toward other third parties—managed care corporations gone astray, greedy hospital managers, and wayward policymakers among them--seen to come between the citizen-patient and the care she believes all deserve.

While CDHC envisions greater participation on the part of citizen-patients in seeking and experiencing, it also leaves much to the impersonal forces of the market. It is no coincidence that one of Herzlinger's previous books was entitled *Market-Driven* Medicine. Indeed, consumer-driver health care has provided an ideal entry for business

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[9] Quoted in Rebecca Vesely, "Consumer-drive, at Slow Speed," *Modern Healthcare*, 19 November 2007.
[10] Regina Herzlinger, *Who Killed Health Care* (New York: McGraw Hill, 2007), 15.
[11] Herzlinger (2007), 20.

school faculty into a debate long occupied by those specializing in public policy, political science more broadly, economics, and the medical sciences. This development is not unlike the process by which the corporate magnate Roy Griffiths struggled to incorporate business practices, and the virtues of private enterprise into the NHS during the 1980s—a process that eventually led to the Thatcher reforms of 1989-91.

For many employers, the main draw of CDHC was, as Munn points out, the prospect of cost savings.[12] Having attempted to squeeze savings from health care delivery through better coordination, and allowing managed care companies to limit provider choice to those physicians with reputations for austerity, they lurched toward the opposite approach, emphasizing the right of citizen-patients to choose the physician, and even the course of care, appropriate to that individual. Given the range of options for provision and finance of care that were now available to citizen-patients, consumer-driven plans have, unsurprisingly, proven quite complicated, and difficult to present to would-be enrollees. Their sheer complexity, and the burden they tended to place on the individual, has led to slow, uneven acceptance of such plans.

As of 2007, only 3.8 million, or around 5% of workers possessing health insurance, were enrolled in consumer-driven health plans. Despite rosy predictions of enrollment figures up to 20% of employees put forward by business leaders, available data suggested that few additional companies planned to offer consumer-driven health care as an option to their workers.[13] Some insurers have responded to citizen-patient skepticism by offering transitional, or hybrid-CDHC plans, combining a form of health

[12] Vesely, 30.
[13] *ibid.*

savings account with low, or even no, deductibles.[14] Even this cautious step has not assuaged the fears and suspicions of potential enrollees and, indeed, employers attempting to shepherd workers into consumer-driven plans. Some businesses, for instance, have expressed frustration over the lack of provider pricing and evaluation data, a key piece of the 'consumer-driven' puzzle. In the absence of such information, some observers have gone so far as to change naming conventions, labeling CDHC schemes as 'high-deductible' or 'account-based' plans.[15]

Consumer-driven health care and associated concepts not only appealed to employers, payers in the private sector, and select academics, but to certain government officials, as well.[16] Leaders all the way up to President Bush have proven themselves intrigued with one specific mechanism within CDHC, the health savings account (HSA). Such tax-exempt accounts, set aside for health care costs, have been a prominent part of (mainly Republican) health reform plans in recent years.

In 2006, the White House gave voice to conservative goals in health reform that incorporated HSAs, and principles of consumer-driven health care by stating that, "empowering consumers is essential to improving value and affordability in American health care." The administration further enunciated its belief that "Americans should be able to choose their health care based on individual needs and preferences."[17] Despite the fact that nearly every occasion that prompts the use of health care confounds prior planning, the White House decried the "excessive reliance on third party insurance for

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[14] Vesely, 31.
[15] Hansen, 29-30.
[16] *ibid.*
[17] "Reforming Health Care for the 21st Century," (Washington, D.C.: National Economic Council, 2006), Executive summary [http://www.whitehouse.gov/stateoftheunion/2006/healthcare/index.html#section4].

even predictable, non-catastrophic care." This 'unfortunate' state of affairs, in turn, was condemned on account of the fact it "reduces consumer-sensitivity to the cost of health care."[18]

The perceived over-consumption of health care is central to the beliefs of those who advocate the further expansion of HSAs, and consumer-directed health care generally. While the fact of medical overutilization in the United States is difficult to contest—though the American volume of care is lower than international averages, treatment tends to be more aggressive, and therefore more expensive--tracing the roots of the problem is a more controversial exercise. Hence the *Journal of the American Medical Association* recently published a list of seven sources of overutilization, and while three could be traced to citizen-patients, four were related to the culture and practices of physicians.[19] Moreover, reforms that treat only the 'demand' side of the health care sector will always be found wanting.[20]

Those toward the right end of the political spectrum have long been strong advocates of HSAs and related schemes because of the promise they seemed to offer to cut health care costs. Conservatives find such mechanisms appealing because they 'lock in' the freedom of providers on some level to determine price (within certain pre-existing constraints), and allegedly increase the responsibility of individual citizen-patients to make prudent decisions relating to care.[21] They have thus been presenting HSAs as

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[18] National Economic Council, 7.
[19] Ezekiel J. Emanuel, M.D. and Victor Fuchs, M.D., "The Perfect Storm of Overutilization," *Journal of the American Medical Association*, Vol. 299, No. 23 (18 June 2008), 2789-2791.
[20] Daniel Callahan and Angela A. Wasunna, *Medicine and the Market: Equity vs. Choice* (Baltimore: Johns Hopkins University Press, 2006), 223.
[21] Christopher Lee, "Health Plan's Impact Debated: Critics Say Bush's Insurance Proposal Would Favor Wealthy," *Washington Post*, 27 January 2007, A8.

something of a health care panacea for the better part of a decade—and several years before the formal conceptual introduction of CDHC.

Consumer-driven health care was conceptually 'born' little over five years ago. Health Savings Accounts, on the other hand, appeared on the American political scene in the early-1990s, not long after Harris Wofford's upset victory in the special Pennsylvania senatorial election on a platform of health reform. They had been gestating amongst think tanks and individual policy experts for about a decade up to that point. An early proponent of medical savings accounts was John Goodman, a leading member of the conservative think tank, Institute for Policy Analysis.[22] Along with the then-chief economist of the U.S. Chamber of Commerce, Goodman penned an opinion piece pushing medical savings accounts as a long-term alternative to Medicare for the *Wall Street Journal* in 1984.[23] In this piece, the authors drew reference to a similar proposal that had been floated by the members of Reagan's Social Security reform commission in 1982-1983—the same commission that had helped give rise to diagnostic-related groups and hospital prospective payment.[24] In this early incarnation, health savings accounts were to save a dual, and in the minds of their framers, related function—keeping down federal health care spending, and eliminating a public program in favor of a market-disciplined approach.

A more comprehensive HSA plan was put forward in 1992 by then-representative, and future Wofford electoral opponent, Rick Santorum (Republican of Pennsylvania),

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[22] "A Brief History of Health Savings Accounts," National Center for Policy Analysis website [http://www.ncpa.org/prs/tst/20040811_hsa_history.htm], accessed 23 June 2008.
[23] John Goodman and Richard W. Rahn, "Salvaging Medicare with an IRA," *Wall Street Journal*, 20 March 1984, pg. 1.
[24] See Mayes and Berkowitz,

which he dubbed—though the name would apparently fail to stick—Medisave, after a similar program of health savings accounts launched in Singapore during the 1980s.[25] Santorum's proposal was designed to appeal to those Americans who had set up individual retirement accounts (IRAs), and made the connection explicit. The proposed legislation thus emphasized the tax-exempt nature of contributions to a citizen-patient's account. His press release also stressed the virtue of greater patient choice in health care, and the way 'Medisave' would allow for it. Accounts of the sort also had the virtue of being portable—carrying over with the individual citizen-patient to any new place of employment. Without fear of losing coverage, then, would-be patients could then work to better plan for their future health needs—a potentially tall order in a society more often focused on the immediate.[26]

Government, moreover, is largely left out of the equation in such scenarios, and health savings accounts are generally presented as a means to preserve the existing private health care system, while attaining cost savings resembling those most often associated with single-payer schemes. It is no wonder, then, that HSAs appealed to Republicans and some conservative Democrats. In the opening stages of the battle over health reform under Clinton, Republicans like Santorum held health savings accounts in reserve as a potential policy alternative. When the Clinton health reform plan fell, so, too, did serious discussion of HSAs. Like the idea of managed competition, however, health savings accounts did not meet their demise along with the administration's plan. As noted above, HSAs, enshrined in the broader formulation of consumer-directed health

[25] Office of Rep. Rick Santorum, "Santorum Offers Health Care Legislation; Urges President to Include in State of the Union," *PR Newswire*, 22 January 1992.
[26] *ibid.*

care, returned with a vengeance shortly after the turn of the twenty-first century, and even a bit before.

The 1990s were instead the decade during which managed care took off, faced citizen-patient rebellion, and evolved to allow for greater consumer choice. Health savings accounts reemerged as an alternative to the tightly-regulated managed care model. While 1996 legislation opened the door to the creation of medical savings, and flexible savings accounts, very few signed on to the scheme, and this early form of HSA were actually eliminated by law in 2004.[27] HSAs in their present form hail from that year. The previous pages of this chapter have documented how their second incarnation within the broader framework of CDHC similarly failed in recent years.

Faced with employer and citizen-patient dissatisfaction, however, it now appears consumer-driven health care will either evolve or wither on the vine, barring any dramatic new federal initiative. At the same time consumer-driven care enjoyed a brief renaissance, British policymakers were striving to formulate a slightly less ambitious model—'patient-centered' care.

Within a few short years, the policy pendulum showed evidence of swinging back once again. *Health Affairs* editor James Robinson thus observes that, as the self-service approach in health care has been found wanting, payers are directing renewed attention to what he terms "population health management."[28] In this composition, I have strived to show how divers remedies to America's health care ills have (seemingly) disappeared from public attention, only to resurface in novel forms several years, or even decades, later.

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[27] Callahan and Wasunna, 222.
[28] Wojcik, 4.

The early-21st century has not only witnessed the rise of seemingly novel concepts in the organization of health systems. Recent years have also witnessed the large-scale reform of one of the most cherished existing health care programs—Medicare. The Medicare Modernization Act of 2003 contained within its labyrinthine 600+ pages provision for the largest program expansion in decades. Program expansion was, however, paired with measures fostering deep inroads on the part of the private sector, and of market ideals more broadly. One of the key ingredients of consumer-driven health care, HSAs, were officially launched under the dictates of the 2003 legislation—though as the preceding paragraphs have shown, they did not produce any revolution on behalf of health care consumers. Indeed, the long-term consequences of the MMA have yet to play out. The following section of this chapter will examine the provisions contained within the mammoth MMA, and will explore some of its political implications as well as what it means for the future of Medicare and, indeed, health care in America.

II. Further Marketizing Through Medicare 'Modernization'

The discourse surrounding consumer-driven health care has been marked by frequent references to the values of choice, and systemic flexibility. Such rhetoric was also common in reference to perhaps the largest and potentially lasting health care initiatives of the second Bush administration, the Medicare Modernization Act of 2003. As in the case of CDHC broadly, and HSAs more narrowly, decentralization of decision-making, and implied expansion of democratic choice outwardly animated those advocating a lesser role for government in the provision and finance of health care, and a corresponding expansion of individual (citizen-patient) accountability.

Just as the Labour Party has long been identified with competent custodianship of the British National Health Service, the American Democratic Party has long held the edge when it comes to public trust in its ability to 'properly' handle health care.[29] The enticing possibility of stealing this issue advantage from Democrats is what partly inspired the Medicare Modernization Act of 2003.[30] The passage of the legislation allowed Republicans to claim that they, and not the original parent party, had finally filled in a long-standing 'hole' in Medicare coverage. As Republican Senator Bill Frist put it upon unveiling that legislation, "Americans have waited thirty-eight years for this prescription drug benefit to be added to the Medicare program."[31]

This is not to say that the problem of rising drug costs was manufactured. By 2003 the average Medicare recipient was investing nearly $2,500 in much-needed drugs annually.[32] While many of the managed care plans that had entered the Medicare market under the Medicare+Choice program initially offered prescription drug coverage for enrollees, a fair portion of these plans had withdrawn from the program by 2001, leaving millions of seniors (once again) without drug coverage.[33] A problem that had been left largely to managed care thus failed to fade over time, as policymakers had initially anticipated would occur.[34]

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[29] See, for instance, "Trust on Issues," *Rasmussen Reports*, 21 June 2008 [http://www.rasmussenreports.com/public_content/politics/mood_of_america/trust_on_issues/trust_on_issues], Accessed 28 June 2008.
[30] Thomas R. Oliver, et al, "A Political History of Medicare and Prescription Drug Coverage," *The Milbank Quarterly*, Vol. 82, No. 2 (2004), 328-329.
[31] Oliver et al, 284.
[32] *ibid.*
[33] Michelle Casey et al., "Medicare Minus Choice: The Impact of HMO Withdrawals on Rural Medicare Beneficiaries," *Health Affairs*, Vol. 21, No. 3 (2002), 192.
[34] Oliver et al, 290.

Nonetheless, it was party politics that largely accounts for the timing of the Medicare drug coverage and reform legislation. Not only did President Bush and his Republican colleagues in Congress hope to 'steal' a long-effective issue from the Democrats, the president also hoped to prove himself a new kind of 'compassionate conservative.'[35] Moreover, the President felt under considerable political pressure to pass some form of prescription coverage while unified Republican government prevailed, so as to neutralize the issue in advance of the 2004 election.[36] Predictably, Democratic opposition soon surfaced to what many party members viewed as a fundamentally flawed piece of legislation.

Spearheaded by health policy veteran Senator Edward Kennedy, the Democrats' objections were focused around the means employed to achieve Medicare coverage, if not the ends. Specifically, many Democrats looked on the legislation as little more than a lucrative moneymaker for the drug companies. They particularly objected to portions of the legislation that overtly disempowered the federal government from using its bulk purchasing power in order to obtain medication for program beneficiaries at discounted prices. Also unpopular were provisions that opened a sizable and much-maligned 'doughnut hole' in coverage, with generous Medicare co-funding ending abruptly at $2,250, and not resuming until annual drug costs had reached the costly (though hardly unheard-of) level of $5,501.[37]

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[35]United States Office of Management and Budget, "The President's 2002 Budget: Thematic Highlights," [http://www.whitehouse.gov/omb/budget/fy2002/guide05.html].
[36] Jonathan Oberlander, "Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act," *Journal of Health Politics, Policy, and Law*, Vol. 32, No. 2 (2007), 190.
[37] Oberlander, 188.

Over time, Democratic opposition to the Medicare Advantage portion of the Medicare Modernization Act would grow. The former amounted to government subsidies directed to managed care plan operators as an incentive to enter the Medicare market. It was through these means that the framers of the legislation hoped to entice the private sector back into participation in Medicare, after its partial disengagement at around the turn of the twenty-first century.[38] Democrats were also hostile to provisions that further encouraged the development and spread of HSAs. With the signing of the legislation in December, 2003, the new generation of medical savings accounts—HSAs—were formally conjured into existence. The new and improved health savings accounts were touted for their greater accessibility, being open to all, regardless of employment sector, and the lower deductible plans that were to qualify.[39]

Despite the party's broad differences with the Bush approach to Medicare expansion, the legislation passed (if barely) with the assistance of several Democratic defectors. Kennedy's attempts to filibuster the bill were swiftly defeated and, with a dramatically (and, many argued illegitimately) lengthened time window for voting made available by the Republican congressional leadership, the MMA received legislative backing and the President soon signed it into law. Critics soon pounced on the lack of transparency with which the legislation was drafted, connecting this democratic (and Democratic) deficit to its substantive shortcomings.[40]

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[38] Robert Berenson, "From Politics to Policy: A New Payment Approach in Medicare Advantage," *Health Affairs*, Vol. 27, Issue ½ (2008), w156-w157.
[39] White House Office of the Press Secretary, "Fact Sheet: Guidance Released on Health Savings Accounts (HSAs)," 22 December 2003 [http://www.whitehouse.gov/news/releases/2003/12/20031222-1.html].
[40] Louise Slaughter, M.P.H., "Medicare Part D: The Product of a Broken Process," *New England Journal of Medicine*, Volume 354, No. 22 (June 1, 2006), 2314.

Despite broad misgivings, the 2003 Medicare reforms did not prove wholly ruinous. Program beneficiaries, who had initially been ambivalent (at best) toward the proposed changes, widely embraced the addition of prescription drug coverage. Indeed, by 2007, a full ninety percent of those eligible for Medicare were utilizing the new benefit.[41] Complications arose almost immediately. While the prescription drug coverage portion of the MMA would not go into effect until 2006, additional federal funds began flowing to managed care organizations almost immediately following passage, as part of the financial 'sweetener' designed to encourage the expansion of private sector involvement in the Medicare market. As the 2006 start date for prescription drug coverage approached, the situation began to look decidedly grim. The media was awash in stories detailing mass confusion among Medicare beneficiaries as they attempted to absorb the full range of options now available to them.[42] Though policymakers had initially feared private insurers would be slow in signing on to provide drug coverage, in the end a large number chose to enter this new market.[43]

If anything, the problem facing Medicare beneficiaries by the final months and weeks of 2005 is that there were *too many* participating plans, each offering slightly different variants of coverage. While differences between individual plans could appear negligible, they could have serious consequences for those who chose to enroll. Indeed, the cost differentials between plans were, in many cases, in the thousands of dollars. Stiff penalties, moreover, faced those who enrolled after the statutory deadline.[44] The best

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[41] Oberlander (2007), 189-190.
[42] See, for instance, Susan Levine, "Seniors Find Medicare Plan Options Bewildering," *Washington Post*, 19 November 2005, A1.
[43] Oberlander (2007), 189.
[44] Levine, A1.

way to research the full range of choices available was online—but, with relatively few seniors web-savvy, this option proved a particularly challenging one to pursue.

Further troubles faced so-called dual enrollees, who had been eligible for both Medicare and Medicaid. Particular poor seniors, many of whom faced debilitating ailments, encountered obstacles in obtaining prescriptions under post-reform Medicare due largely to technical (IT-related) difficulties. The problem became so pervasive that a class-action lawsuit was launched, which was only settled in June 2008.[45] Even outside of the dual enrollee population, millions of other Medicare beneficiaries were wrongly denied coverage when the new benefit was introduced.[46]

For the most part, however, these early snafus constituted technical growing pains. As early as the second half of 2006 (the first year the new prescription drug benefit was offered), polling was already suggesting that seniors were coming to terms with the reforms, and that their satisfaction of the program was on the upswing.[47] A sizable eighty percent of those who signed up for coverage were, by August 2006, reporting in surveys that they were satisfied with their new plans.[48] The aforementioned fact that ninety percent of seniors possessed prescription drug coverage by the beginning of 2007 was itself a sign that Medicare beneficiaries were 'voting with their feet'—in the direction of the new benefit.

The prescription drug benefit portion of the MMA has thus proven to be a qualified success—at least thus far. HSAs have, as noted previously, made lesser

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[45] "Bush Administration Settles Nationwide Class Action in Medicare Rx Case," *Pharma Marketletter*, 23 June 2008.
[46] Dina Greenberg, "Medicare Drug Program Hurts Most Vulnerable," *Philadelphia Inquirer*, 13 February 2006, page B2.
[47] Oberlander, 212.
[48] Christopher Lee, "Surveys Show Satisfaction with Medicare Drug Plan," *Washington Post*, 1 August 2006, page A5.

progress in the four years since they were formally introduced. It is still too early to evaluate the effects of several other hidden provisions of the legislation that have received far less media attention. Lost in the rush to analyze (and criticize) the arrangements surrounding drug coverage were two policy 'time bombs' that could collectively play a decisive role in shaping the future politics of Medicare—and, indeed, American health care generally.[49] Under the terms of these less publicized provisions, Medicare Part B contributions have been tied to income level, reversing the universalism of Medicare that had long contributed to its status as a widely popular, robust federal program. This development is particularly startling, considering the furor that surrounded the progressive-taxation basis of the ill-fated Medicare catastrophic coverage package of the late-1980s.[50]

On past occasions, Medicare has attracted the attention of policymakers on account of supposed funding crises. Oberlander (2006) shows that there are broad patterns to the timing of these alleged 'crises', but no formal triggering mechanism.[51] That state of affairs changed with the passage of the 2003 Medicare Modernization Act. In future years, funding 'crisis' will be objectively determined—any time general revenues rise to comprise forty-five percent of total program funding, the president will be encouraged to urge Congress to search for further savings—most likely by cutting benefits or raising contributions.[52] There is no mechanism within this portion of the legislation to absolutely ensure that such action will be taken, but it does provide further

[49] Oberlander (2007), 212.
[50] Oberlander (2007), 212-214.
[51] Oberlander (2003), 84-86.
[52] Oberlander (2007), 213-214.

political ammunition to those seeking greater austerity, or broader reform, within the program.

It is still to early to explore what political implications will arise from the 2003 round of Medicare reforms. The prescription drug benefit has been in operation for barely two years. I have already outlined the limited enthusiasm accruing to HSAs. As in the case of HMOs in the 1970s, however, such saving devices could yet play a larger role in the overall health care system—perhaps decades into the future. On a broad level, the MMA is significant insofar as it represents the further expansion of market values and consumerism across the American health care landscape. Not only is the prescription drug benefit designed in such a way as to involve the private sector to the maximum extent possible, while limiting the potential role to be played by government, but it also serves to endorse the perceived efficacy of health savings accounts. The reforms stress the role of choice on the part of health care consumers—indeed, some Medicare beneficiaries find themselves confronted with too many choices of prescription drug policy under the 'reformed' system. The stated purpose of HSAs, moreover, has always been to allow citizen-patients greater freedom in determining the parameters of their care, rather than leaving such decisions to employers, or even managed care networks. While few cost savings are likely to result from the prescription drug provisions of the MMA through the foreseeable future, HSAs have been pushed with just that goal in mind. To a limited extent, they have succeeded along those lines—though largely by decreasing utilization of basic services.[53]

[53] Hansen, 28.

Similar processes have marked the direction of British health reform in recent years. The governments of Tony Blair and Gordon Brown, having showered increased funding on the NHS, increasingly relied on public choice and greater private provision of services to improve the efficiency of the Service. Of course, these steps also had the effect of decreasing government accountability for the parameters of care received by individuals and, to some extent, the outcomes of care episodes. Decision-making surrounding the nature of care received has been steadily devolved from the state, and clinicians, to the individual citizen-patient-consumer. It is to the most recent developments in British health care reform that I turn in the next section of this chapter.

III. Health Reforms from Late-Blair to Early-Brown

"…the rhetoric of patient-centeredness has a hollow core."[54] Thus was the verdict of Angela Coulter, head of the Picker Institute, in response to the latest survey results released by her organization. Despite being offered broad choices on the hospital in which they wished to schedule surgery, a majority of patients thought that when it came to some of the more prosaic questions of health management—like acquiring knowledge of medical side effects—they were hardly engaged.[55] Though the government was, by 2008, holding out the prospect of so-called 'expert patient' programs designed to better engage the chronically ill in managing their conditions, only a third of those surveyed the

[54] John Carvel, "Extra Spending Fails to Foster Patient-Centred Health Service," *The Guardian*, 21 September 2006, page 16.
[55] *ibid.*

year before reported receiving similar services—a low base of service upon which to build.[56]

Despite the shortcomings of consumerism in the NHS, some observers of the health service felt that greater citizen-patient engagement was only a matter of time. The one-time NHS 'Director for Patients and the Public' (a telling appointment in its own right), Harry Cayton, went so far as to assert that, "sooner or later patients will have to be enlisted as equal partners if the health service is to survive."[57] He implicitly pointed to the United States by noting that citizen-patient involvement was a trend occurring the world over and that, indeed, it could be seen as a "force of history."[58] Left unanswered was the question of whether the particular brand of citizen-patient empowerment was a perfect match with the expectations of those very individuals. The 2007 data are quite revealing, insofar as they seem to show that the expansion of 'choice' in the abstract has actually left citizen-patients sensing a relative loss of control when it comes to some of the basics of patient care. While undoubtedly self-serving to a point, the assertions of the chief health services union, Unison, seem to be borne out by the evidence: "…personalized care need not be bound by the consumerist logic of patient choice, something which…patients show no great desire for anyway."[59]

With additional choice, moreover, comes additional responsibility. In both the American and British cases, consumer-directed, or patient-centered health care, assumes considerable absorption and analysis of provide information on the part of 'newly

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[56] Andrew Cole, "Health in the Future: Less Waiting, More Decision-making," *The Guardian*, 18 June 2008, page 5.
[57] Cole (2008), 5
[58] *ibid.*
[59] Unison Policy Unit, "NHS Next Stage Review: Unison Submission," 16 January 2008 [http://www.unison.org.uk/file/B6331.pdf], accessed 7 July 2008.

empowered' citizen-patients. In the early years of the Blair government, patient choice was abandoned in favor of greater patient satisfaction.[60] These priorities have been reversed in (more) recent years, with the expansion of patient choice often associated with a decrease in patient satisfaction. A constant in the ongoing process of reform has been ambivalence with regard to the debate over the relative virtues of centralization and localism.

Labour's most recent drive to put patients' needs and voices first can be seen as an extreme form of decentralization—that is, insofar as authority is devolved to the level of the individual citizen-patient. On the other hand, the government has on repeated occasions stated the need for a (decidedly centralizing) NHS constitution outlining basic principles for the health service in all three 'countries' under the British crown and, crucially, explicitly setting out individual patients' right to a basic level of service.[61] The idea of a centralized NHS constitution has often gone hand in hand with proposals to grant the NHS formal independence, thus releasing it from the prospect of day-to-day political 'interference.'[62] NHS independence on its own can be seen to constitute an exercise in devolution, even if the act of authorizing independence necessarily has its roots in a prior drive toward greater centralization.

The complexities of the debate over the proposed NHS constitution show that, while methods of organization and delivery tailored to the reception of (and response to) patient input are fundamentally devolutionary, this outcome can be achieved through

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[60] Klein (2006), 210.
[61] " NHS Common Ground Sought for Constitution," *Western Mail*, 15 May 2008, page 15.
[62] Tom Smith, "Health Policy Debate—Making the NHS More 'Independent' from Central Political Control," *Health Policy Review* (British Medical Association Health Policy & Economic Research Unit), Winter 2006, 65-67.

means that are infused with a spirit of paternalistic centralizing fervor. At least four approaches to achieving some form of NHS independence have been put forward in recent years.[63] The government of Gordon Brown has its own conception of independence, though one that has only been vaguely articulated thus far. The prime minister apparently envisions the formation of an independent 'management board' for the NHS, one that could serve the dual purposes of insulating the health service from the everyday hurly-burly of 'politics,' and perhaps overseeing the national purchasing of health services, a function currently left to the local primary care trusts (PCTs).[64]

Another approach mooted by certain sectors of the British health policy community is more regulatory in nature. It is associated with the Conservative opposition, currently led by David Cameron. Cameron and colleagues have prefaced their plan, as Conservatives have found the need to do numerous times since 1948, with reassurance to citizen-patients that they would not countenance "any move toward an insurance-based system."[65] Striking a similarly defensive posture, shadow health secretary Andrew Lansley, counted out extending out-of-pocket payments by stressing that, "rationing healthcare by price simply reduces demands, but does not improve cost efficiency." In one sentence, the Conservative Lansley eviscerated the prevailing American conservative stance on health care.[66]

Vowing to do the impossible, by "taking politics out of the NHS," Cameron unveiled his own NHS Independence Bill. Paired with promised strengthening of PCTs

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[63] Smith, 65.
[64] Smith, 67.
[65] David Cameron, "Perspective: What We Would Do Differently for NHS," *Birmingham Post*, 14 October 2006, page 8.
[66] "News Focus—Politics: Who is the Next 'Saviour' of the NHS?," *GP Magazine*, 20 April 2007, page 10.

and other local bodies, the proposed legislation pledged to free medical providers from overzealous government target-setters. Most importantly for the role of citizen-patients, the Conservative program prominently featured a new representative body called HealthWatch.[67] The latter independent group would oversee complaint proceedings from citizen-patients—perhaps strengthening the outlets for patient input lost with the abolition of the Community Health Councils in the 1970s. HealthWatch would supposedly be endowed with some (indeterminate) power to influence the range of drugs and treatment options available to NHS citizen-patient-consumers.[68] A prominent figure behind the 2006 Conservative reform plan was none other than the chief author of the transitional 1996 policy document, *A Service With Ambitions,* Stephen Dorrell.[69]

A third method proposed to reach the end of NHS independence is the constitutional approach, which I mentioned briefly above. This policy preference has been linked to Labour government health minister Andrew Burnham.[70] Burnham and fellow adherents oppose the creation of the sort of independent governing board proposed by Conservatives. Instead, he has proposed the promulgation of a constitutional document for the NHS, for the first time setting down in writing the founding principles of the health service which, though widely assumed and respected, have never been formally 'enshrined.'[71] Though the idea of a national constitution may, on its face, sound as if it is a heavy-handed move on the part of central government in London, Burnham seems more intent on breaking the conceptual mode. The constitution is required, he

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[67] *ibid.*
[68] Graeme Wilson and George Jones, "Cameron Promises Patients a Powerful Watchdog," *The Daily Telegraph*, 10 October 2006, page 12.
[69] *ibid.*
[70] Smith, 70.
[71] John Carvel, "Interview: Outspoken Off-roader," *The Guardian*, 14 February 2007, page 5.

claims, precisely because the overall structure of the NHS is becoming (and promises to become even more) decentralized.[72] Read almost precisely ten years after the publication of *A Service with Ambitions*, Burnham's calls for a constitution reassuring NHS users of adherence to first principles bears some resemblance to Dorrell's desperate move on the eve of the 1997 general election to similarly reassure government critics that the government of the day was loyal to the legacy of Bevan.

The constitutional drive was partly conceived as an effort to paper over differences between New Labour adherents, and those more inclined toward the Old Left. Hence Burnham, in a piece that unveiled NHS constitutionalism, cited the need to "be united in facing down calls for rationing and insurance" by defending the fundamental fairness of the health service model. Having attended to system first principles, Burnham warned that, as members of a united Left, British progressives should set aside petty squabbles and embrace reform as the true—indeed, the only--means of preserving the NHS in turbulent times.[73] Acknowledging the need to convince the skeptical of the positive role of reform, implying, as it may, the closure of hospitals and other facilities, Burnham thus proposed the drafting of a charter for the NHS, similar to that previously designed to govern change within the BBC. While preserving the timeless qualities and values of the original NHS, it was also to be a dynamic document, open for renewal every ten years.[74]

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[72] *ibid.*
[73] Andrew Burnham, "A Health Constitutional," *Progress Magazine*, 23 September 2006 [http://www.progressonline.org.uk/Magazine/article.asp?a=1399], Accessed 7 July 2008.
[74] David A. L. Levy, *An Independent NHS: What's in it for Patients and Citizens*, (Oxford, U.K.: PickerEurope, 2008), 22.

Following introduction in September 2006, the NHS constitution moved swiftly to the forefront of government health policy. By June 2008, health secretary Alan Johnson prepared a policy document outlining the points to be covered in the proposed document, which had been informed by several months of health ministry dialogue with key stakeholders. Meanwhile, the reforms over which the constitution was to serve as political cover were continuing apace. Early in his term as prime minister, Gordon Brown appointed distinguished clinician Lord (Ara) Darzi to conduct what the government termed a 'next stage review.' Officially launched in July 2007, the final report based on Darzi's findings was timed for release in June 2008, when the NHS would be celebrating its sixtieth anniversary, following the publication of a preliminary report in October 2007.[75]

Darzi's task on the national level had been preceded by sometimes controversial work in London. There he studied the area-wide system of health delivery, and drew up a set of recommendations based on his findings. Receiving the most attention and, indeed, criticism, was the idea of 'polyclinics,' also known as 'super surgeries. Combining physician and hospital services, these threatened to make certain wards and, in some cases, entire hospitals redundant.[76] Local hospital employees were joined in their indignation by certain neighborhood and community groups.[77] Lord Darzi's responsibility to reimagine the NHS (in the tradition of Ray Griffiths) could be read as a

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[75] NHS South of Tyne and Wear, "NHS Next Stage Review: Progress Report," Integrated Board Meeting (notes), enclosure 11, agenda item 8.7, 28 May 2008 [http://www.stpct.nhs.uk/documents/board_papers/agendas/agenda_may08/Enclosure%2011%20-%20NHS%20Next%20stage%20Review%20_ES_.pdf], accessed 7 July 2008.
[76] Henry Ellis, "Polyclinic Plan Branded a Threat to London's Health," *GP Magazine*, 17 August 2007, 4.
[77] Anna Davis and Sophie Goodchild, "Patients' Fears Ignored as Polyclinics Increased," *Evening Standard*, 4 June 2008 [http://www.thisislondon.co.uk/standard/article-23490131-details/Patients'+fears+ignored+as+polyclinics+increase/article.do].

sign of the government's enthusiasm for his London project. The media attention dedicated to the hospital closures that the plan(s) disguised the extent to which Darzi's vision constituted the culmination of New Labour's discourse on citizen-patient empowerment.

Working from the basis of the Burnham constitutional movement, Darzi pledged in his final 'Next Stage' report to enshrine patient choice—of provider AND treatment—in the new charter.[78] He seemed to break new ground, if cautiously, in calling for 'personal health budgets,' a vehicle suspiciously reminiscent of HSAs—with the same benefits of flexibility and tailoring to individual needs enumerated. The health ministry apparently envisioned these 'personal budgets' accruing to those with 'complicated' or 'long-term' conditions.[79] With regard to hospital care, Darzi suggested tying funding of individual facilities to quality of treatment, as revealed by patient surveys.[80] Such a development would presumably mean an even more prominent role to be played by the Picker Institute.

Though the idea of polyclinics seemed to fly in the face of prevailing public opinion, the Next Stage Review nonetheless placed great emphasis on the concept of citizen-patient participation. The report, like so many others of its ilk, was caught in the tension between professional expertise and democratic politics—a state of limbo in which much of health policy is situated. The most rational organization of health delivery does not always—indeed, really—accord with the (political) preferences of key actors in the health sector. This is a truism those backing the Darzi Report and its proposed reforms

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[78] Lord (Ara) Darzi, *High Quality Care for All: NHS Next Stage Review Final Report* (London: Department of Health, June 2008, 10.
[79] Darzi, 20.
[80] Darzi, 12.

will be forced to confront, as the guidance documents give way to actual legislative initiatives and, eventually, law.

On the surface, much on the health policy front would seem to hinge on the outcome of any upcoming British general election. A change in the partisan composition of the American Congress or executive, after all, has often been crucial in determining the range of health reforms considered during a given period, as well as just what proposed policies stand a chance of passage into law. Medicare, for example, long seemed mired in political gridlock until the Democratic president Lyndon B. Johnson was joined, after the elections of 1964, with an overwhelmingly Democratic legislature.[81] Only a Republican legislature (and presidency), moreover, was likely to be particularly receptive to market reforms within Medicare at the turn of the twenty-first century. If one identifies with John Kingdon's garbage can model of policymaking, it would seem solutions often arise independent of policy problems. The solution selected, in the end, depends far more on the identity of the policymaker, or group of policymakers, involved at any given point.[82]

In the case of the contemporary British policy arena, however, it seems there is a high degree of convergence among actors as to the range of relevant reform options. The Labour government of Gordon Brown has been moving closer to the Conservative positions on health care, and the two parties therefore seem to differ little as to the sorts of policies they would pursue over the next several years, if not decades. The NHS will undoubtedly remain a political 'hot potato', even as calls for a formal declaration of independence continue to echo through the corridors of Whitehall.

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[81] Oberlander (2003),
[82] John W. Kingdon, *Agendas, Alternatives, and Public Policies* (New York: Longman, 2002), 90.

IV. Conclusions

Writing in 1995, in the midst of a flurry of health care reforms around the world, Dov Chernichovsky identified an 'emerging paradigm' based on international consensus across a range of values and ideals. Specifically, Chernichovsky pointed to broad agreement on the solidarity principle of care (all should receive needed medical care, regardless of need), shared concern over the level of consumer responsiveness, and common realization of the need for some form of health system regulation.[83] Consumer satisfaction had to be addressed within predominantly public systems because popular discontent could fuel pressure for expansion of the private health sector.[84] This development can, in turn, erode the solidarity principle upon which care arrangements in such systems are based. Consumer dissatisfaction is less of a concern in mainly private systems, not only because the solidarity principle is not a guiding value, but also because the fee-for-service payment provisions that predominate in these systems tends to produce greater satisfaction on the part of patients (AND providers).[85]

Chernichovsky's work should be viewed within the context of a broader interest in health system convergence which reached its apex around the mid to late 1990s, but had roots in 1970s scholarship and, more specifically, to the scholarship of sociologist David Mechanic.[86] With the first decade of the twenty-first century nearly concluded, it is clear health care systems around the world continue to face common challenges

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[83] Dov Chernichovsky, "Health System Reforms in Industrialized Democracies: An Emerging Paradigm," *The Milbank Quarterly*, Vol. 73, No. 3 (1995), 339-346.
[84] Chernichovsky, 346.
[85] *ibid.*
[86] David Mechanic and David A. Rochefort, "Comparative Medical Systems," *Annual Review of Sociology*, Vol. 22 (1996), 239.

presented by such shared difficulties as cost pressures, citizen-patient displeasure with system performance, concerns over equity, and quality of care. Though these common 'stimuli' have dominated the international conversation on health care for decades, however, it is far less clear that they are responsible for continuing convergence of policy solutions. Today scholars are thus far more likely to examine the unique political and institutional settings that shape the nature of health care arrangements across divers countries.

While health care systems no longer appear to be converging toward some ultimate point of policy perfection, they still share common 'threads' of reform, and a good bit of this connective tissue concerns citizen-patient input, and overall satisfaction within the context of their national systems. The American and British systems present a fascinating opportunity for comparison, as they represent two exceedingly different health care edifices, but two in which similar concerns over citizen-patient empowerment have been treated—occasionally through similar means. Particularly prominent in the health care discourse in both countries has been the proper role of market mechanisms, and how entrepreneurialism in its various guises can be harnessed to produce greater citizen-patient involvement in the preservation and maintenance of their own health, while making health care delivery more efficient.

Though penny-pinching and citizen-patient empowerment would seem, on the surface, to be conceptually at odds, they have largely been taken to be effectively fused—with efficiency gains paralleling improvement in the individual experiences of citizen-patients. Such a scenario was sketched at a rather early point in the debate by Alain Enthoven, and has been elaborated across the intervening decades. Predictably, reform

efforts have often focused on increasing the market power of health care consumers, balancing that of providers in the process.

Patient empowerment vis a vis providers has, perhaps equally predictably, proven difficult to put into action. As of mid-2008, it remained the case that, within the NHS, "patients remain remarkably powerless when they walk into a doctor's surgery," and "the doctor/nurse knows best culture remains alive and kicking."[87] Such observations point up the divergence between macro-level (government) efforts to extend greater choice to patients, thus theoretically strengthening their hand, and the oft discouraging power inequities experienced on the level of the individual care episode. Thus it remains that "talk of patient-doctor partnerships" largely remains just that—talk.[88]

So long as patients, and patient groups, remain poorly informed about care options on an individual level, it will continue to be difficult to achieve significant savings through the invisible hand of the market—a hand that, after all, is only as effective as the sum of each individual transaction. Moreover, though many Americans certainly wish to experience lower out-of-pocket health care charges, and British government officials struggle to keep the NHS within budget WITHOUT compromising care, it is unclear whether citizen-patients desire the greater 'power' government proposes to grant them. Recent experiments in broadening choice on both sides of the Atlantic have resulted (at least at first) in considerable public bewilderment and, indeed, popular backlash.

The rollout of the prescription drug program under the 2003 MMA in the United States, and the introduction of hospital choice in England are particularly illustrative of

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[87] Cole (2008), 5.
[88] *ibid.*

this trend. As indicated above, the Medicare prescription drug benefit was initially lambasted by critics on account of its complexity, and the difficulty with which seniors sifted through the numerous private plans on offer. Citizen-patients and doctors expressed similar frustration when the government expanded opportunities for choice of hospital within the NHS. Many complained of the unwieldy nature of the system employed, and seemed to find it needlessly complicated.

In the British case, health care was employed as a party-building mechanism, and a means of ensuring continued loyalty and association with the State. The modern health care system began to develop shortly after the final round of (male) franchise expansion.. British political elites used social and health benefits as one way of building party loyalty; and Britons came to associate the provision of health care with the state, and its constituent political parties. Those seeking health care were, indeed, citizen-patients, with a particular emphasis on the citizen' aspect of that identity. This quality of the British patient identity, in turn, would serve as a bulwark against sustained efforts on the part of successive (post-1989) governments to transform its citizens into health care consumers. Both institutional formation (in the period between 1911 and 1948) and the culture it engendered had established the very different identity of citizen patient. Market penetration of the British health care system in recent years has therefore been incomplete at best.

In contrast, Americans established universal white male suffrage in the mid nineteenth century. There too, of course, agents of the State used the available programs to help build the parties. But in this case, the programs were those 19th century reliables: postal services, customs houses, veterans pensions. Health care was not yet relevant, as

modern principles of health care, much less its ‘proper’ system of delivery, had yet to be uncovered.

Market elaboration in the guise of managed care made little additional headway in the American system. The lack of a long-running (overt) connection between partisan government and health care, combined with the prevailing individualist mindset in the United States would seem to ensure that market innovations in health care would be embraced. Instead, market strengthening in the form of managed care faced a patient rebellion. Why should that have been the case? One reason has to do with the imperfect fit between the brand of liberal individualism found in the American polity, and the conceptual role of the individual under a market system. The traditional American emphasis on self-reliance has long come with a strong tendency to form groups, and to value individual relationships. While Americans have therefore tended to bristle at the idea of 'socialized medicine,' they have also shown little desire act purely independently in the health care arena. Instead, Americans have looked to professional leadership in health care, represented by the individual doctor-patient relationship in microcosm. Markets, on the other hand, are seen to call for the effective severing of that relationship, with doctors and patients alike instead arrayed in a state of commercial confrontation. Moreover, managed care promised to limit individual citizens' choice of physician. In the American, as in the British system, the appearance (if not the reality) of choice has recently gained greater prominence in the public sphere. In the American case, choice had long been a hallowed right of patients, and it was one of the rationales offered by those who opposed a more robust government presence in health care. While British efforts to open the NHS to market competition involved the expansion of choice,

American managed medicine represented a narrowing of options for the country's citizen-patients. It was partly against the crags of choice, therefore, that the formidable vessel of managed care ran aground.

Though it was concerns over efficiency and cost-effectiveness in health care that provided the initial rationale for the Thatcher-era reforms, successor governments would come to focus on ‘choice’ as the overarching goal of continued policy change. This value was particularly pursued through hospital policy, as patients were, at least in theory, to be offered a broader array of venue options. The government increased the number of health care options available to NHS citizen-patients by providing incentives for private-sector participation, particularly in the area of primary care. While choice informed many key decisions relating to NHS reform, it did not inspire each individual policy. Thus the hospital reorganization plan for London released in 2007 envisioned greater hospital specialization, and therefore the narrowing of care options available at individual treatment facilities.

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