The Route to a National Health Policy Lies Through the States

GEORGE A. SILVER, M.D.

Emeritus Professor of Public Health, Yale University School of Medicine, New Haven, Connecticut

Received July 1, 1991

National health program legislation has been becalmed in the Congress for almost 80 years. Despite periodic cries of "crisis," legislation never emerges from committee. Periodically, campaigns have been mounted without success. Tactical efforts to circumvent direct action by legislating bits and pieces of related programs, Medicare and Medicaid, health maintenance organization support, and pre-budgeting, have complicated operation of the medical care system and stimulated intractable cost inflation.

For the first 150 years of American history, responsibility for public health and welfare legislation rested with the states. Most public health policies originated in a state or a few states and then later became national legislation. The state efforts were, in effect, natural experiments. After the Depression and the flood of funding from the federal government in subsequent years, the states faded as innovators.

It is proposed that funding a few state models to restimulate state initiative in this regard will provide a more effective route to a national health program.

INTRODUCTION

In the long debate over the past 80 years on the need for a national health program, three issues have emerged as crucial elements for consideration. One is how to achieve equity for the population; that is, reasonably equal access to modern medical care. The second, much more prominent today, is how to achieve this goal at a cost to individuals and society that is acceptable and fair. Finally, the matter of the quality of the medical services provided has, in recent years, acquired importance, especially in regard to the issue of medical malpractice, its costs, and its effect on medical practice.

These problems did not just come to public attention, nor are they restricted to the United States. Most industrialized countries have had to deal with the issues and attempted to control cost and improve access to medical care with a national health insurance scheme. Great Britain alone of the Western European nations began with a tax-supported system of guaranteed services rather than insurance. In this century, the United States alone has failed to resolve the controversy as to whether or not the federal government should undertake a national health program. Not only that, but, during these years, the public has been exposed to contradictory arguments over how such a system is to be funded and administered, if it were to come into being.

Within the past few decades, however, public argument over the topic has become more sharply focused, with the financial aspects at the forefront of the discussion. Uncontrollable inflation of costs, a widening gap between services available to those insured and those uninsured against the costs of medical care, along with an increase

Abbreviation: AMA: American Medical Association

Copyright © 1991 by The Yale Journal of Biology and Medicine, Inc. All rights of reproduction in any form reserved.
in the number of individuals and families without health insurance have served to center the debate on insurance coverage and cost-control measures. There is a growing consensus that the fiscal situation demands that the United States legislate a national health care plan. While opinions differ as to how this aim is to be accomplished, all the participants agree that the appropriate venue for resolution is in the United States Congress.

It is certainly true that if the nation is to be served, it must be with national legislation. But it is not so clear that the only, or appropriate approach is through the Congress directly. For the first 150 years of American history, the traditional American response to community welfare and health needs was for the states to establish the pattern and the federal government to follow. Poverty and the lack of access to medical care were not considered national issues. The Constitution supported this view. In the federalist system of shared responsibilities, the guiding principle is the Tenth Amendment, that "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." Health matters are not delegated to the federal government in the Constitution. During this period, local and state governments, close to the site of established needs and difficulties, designed the programs and assumed legislative priority.

In the nineteenth century, after the Civil War clarified the idea of national citizenship, and advances in transportation and communication united the states more firmly into a nation, state initiatives began to influence national legislation. States provided the models for the pertinent sections of the 1935 Social Security Act, the 1965 Medicaid program, the 1972 Supplemental Security Income Program, and scores of early public health measures [1]. It was in Wisconsin and Michigan, in Illinois and Massachusetts that measures were first adopted for support of poor women and children, for the elderly and the blind, decades before the Social Security Act. Pensions and unemployment compensation were state initiatives long before they became federal laws. Hard rock miners compelled western states to pass occupational health and safety ordinances 50 years before the federal government passed such laws [2]. The Sheppard-Towner child health legislation in 1921 was built on the model of earlier Connecticut law. The American Public Health Association lists dozens of "firsts," in which states legislated public health matters long before the federal government was involved, laws which became the pattern for federal laws or regulations [3].

Today, as resentment grows over the sluggish responsiveness and impersonality of a distant bureaucracy, it is increasingly argued that social concerns should be responded to where the needs are felt first and most strongly. And, of course, it may be more prudent to try out new approaches to health care delivery in a few states in advance of attempting a national program. It is more reasonable to introduce an experimental program for a few million people, and find out the flaws, than to try it immediately on 250 million. "Common sense suggests trying the program on a small scale to gain advance knowledge about effects on incentives" [4]. In some instances, it may even be easier and more manageable for states to respond to their more circumscribed issues.

Justice Brandeis, in a famous dissent, noted that "[i]t is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve
as a laboratory and try novel social and economic experiments without risk to the rest of the country" [5].

It may not be amiss, therefore, to propose, instead of concentrating all our efforts on Congress as the sole vehicle for establishing a national health program, that some attention be paid to the possibility of a state initiative in that regard. The recommendation for a state rather than a federal initiative, as the desirable and feasible preliminary to a comprehensive, universal national health program, requires appreciation of the background of state initiative in earlier health legislation in this country. To a generation accustomed to look to Washington for such action, and to whom the traditional view of state legislatures is that they are corrupt, incompetent, and discriminatory, such historic review is essential.

Federalism, in its delineation of separate roles and functions for the states and the national government, was much admired by early observers of the American scene, such as Alexis de Tocqueville and Lord Bryce in the nineteenth century. Many distinguished political scientists more recently have pointed out, as Kaufman does, that "The evolution of the American system has been profoundly influenced by the doctrine that the states are the source of authority from which all other governments are derived" [6]. Once governor of New York, and then Vice President of the United States, Nelson Rockefeller, commented on the fact that state initiatives preceded New Deal legislation. He remarked that "It is also important to note . . . that those elements of the New Deal which failed, were largely in areas not tested by prior experience at the state level" [7].

We naturally turn to Washington for help, these days, because for over 50 years national legislation has controlled the financing and the scope of health and welfare, overshadowing the states' role. The major intrusion of the national government into health services—largely financial initiatives toward structural reform—resulted from necessary national involvement at the time of the Depression. The needs were great; the capabilities of the states clearly inadequate; national action was the only solution. But the increasingly massive financial investment by the federal government over the past 50 years has undermined and weakened state initiatives.

The notion of federalism as a philosophy of shared powers, of cooperative efforts by the state and the federal government, and that the absence of either partner is a fatal blow to the national purpose has been erased, in the overwhelming federal role since the 1930s. Even so, we continue to see some health legislation arising in the states. Before Medicare became law, and years before the inflation that followed its passage stimulated regulatory health legislation, the Folsom Law regulated capital expenditures of hospitals and nursing homes in New York in 1964 [8]. Perhaps we should pursue the concept of state initiative more vigorously.

HISTORICAL BACKGROUND

Because the problems of obtaining medical care are not new nor suddenly perceived developments, there is a history of social efforts to deal with them. Concern with the economic consequences of medical care costs on American families, for example, antedates World War I. The first stirrings of social activism, an effort to nationalize the medical care system by introducing an insurance system for ameliorating the economic impact of illness, began in 1907, under the auspices of the American Association for Labor Legislation. The tide of Progressivism, unionism,
and drive toward social welfare prescriptions was cut short by America’s involvement in the first World War [9].

After the war, the American roller coaster ride of enormous wealth in the 1920s dampened enthusiasm for welfare legislation. Social reform and social welfare goals did not altogether disappear, however, and the Depression in the 1930s aroused renewed interest and fervor. In the background, the liberal agenda had continued in health-related studies and women’s interest-group agitation. In 1922, a powerful coalition of women social reformers had succeeded in obtaining a federal law to stimulate state programs for social and medical assistance to pregnant women and infants [10].

The Report of the Committee on the Costs of Medical Care, in 1932, focused attention on the fact that, in addition to economic barriers, there were inadequacies, deficiencies, and inequities in the medical care system that required attention and repair [11].

By this time, a variety of other efforts had been undertaken in the hope of bringing the loosely organized, private and entrepreneurial American medical care system into the public domain. A number of states had made unsuccessful efforts to legislate universal (statewide) comprehensive health insurance programs [12]. State legislators were cautious of the tax implications and were wary of writing blank checks for the medical profession. It should be kept in mind that, before 1935, there was no strong tradition of federal grant programs to support state initiatives.

Some physicians, cooperatives, and community groups did begin to organize group practices for improvement of access to modern medical care and to spread the risks of unanticipated expenditures for that care. As the Depression’s effect lengthened, the federal government was drawn into provision of payment for medical care for the indigent [13]. The rural population, less well supplied with medical services to start with, sought and obtained even more public support, in the form of model demonstrations of publicly supported, organized, medical care schemes [14].

Trade unions, which in the early days had opposed national health legislation as preemptive of union responsibilities and interference into the labor/employer negotiating process, began to champion national health insurance. The legislative drive for the Social Security Act both supported and undermined the efforts to obtain a national health program. President Roosevelt was persuaded by his congressional advisors and by medical professionals close to him that antagonizing American doctors by placing a national health program within the orbit of the Social Security Bill would doom the possibility of passage. So it was left out, with the promise that separate legislation would follow [15]. The looming involvement in World War II in the late 1930s deferred such consideration, however, as it had in the wake of World War I. Successive Wagner-Murray-Dingell Bills, from 1943 on, encouraged debate, but not legislation.

There was a brief period, during World War II, when the federal government supported large-scale medical care services in the Emergency Maternity and Infancy Care Act, but it was abandoned immediately after the war. The persistent women’s lobby, which had succeeded in obtaining federal underpinning for children’s health programs in the Title V section of the Social Security Act, was not able to maintain the momentum after World War II.

After World War II, America was again awash in affluence and a dream of abundance for all, so that social and welfare legislation was slighted. The stubborn
reformers had to content themselves with pushing bits and pieces of legislation that would appeal to interest groups. President Truman's national health insurance proposals, embodied in the Wagner-Murray-Dingell Bill modifications, never got beyond committee hearings. The focus shifted to efforts to obtain constituent elements, fragments that could be united eventually into a national program.

So we struggled from the Forand Bill in 1949 to Medicare in 1965. In 1950, the disabled were added to social security beneficiaries. Kerr-Mills in 1960 gave rise to Medicaid in 1965. Federal employees were given support for health insurance in 1959; relatives of those in the armed forces were given the same support in 1966. Organizational efforts were promoted through the comprehensive health planning and regional medical programs in 1965. Health personnel development received federal support, from 1943 in the Nurse Training Act, through medical student support, beginning in 1963.

Medicare and Medicaid, along with the lavish federal support for medical schools, produced not unexpected side effects. The inflation of medical care costs had profound influence on the Congress because of the tax implications. Between 1960 and 1970, not only did the total expenditure for medical care skyrocket, but federal contributions to those expenditures exploded [16]. Congress now had to explore control measures. Since 1970, the preoccupation has been cost control, not access or equity.

The efforts at cost control: planning, regulatory measures, payment ceilings, promotion of prepaid group practice, professional reviews, diagnostic-related groups, have not had any success. Inflation has far outstripped federal capability to control expenditures. The combination of lack of access to medical care for millions of Americans, with an unmanageable inflation of costs, fuels a drive toward a national health program.

Blendon and Taylor conclude that “In the public's mind, it is clear that America has now exhausted all the other possibilities” [17]. Industry, the major purchaser of health insurance, finds itself at a marketing disadvantage because of the high, rising, and uncontrollable costs of health insurance premiums. Physicians, through their national organization and in ad hoc clusters as well, seem to have agreed that it is time for a national program [18].

THE ISSUES

The pressures on Congress, professional groups such as the American Medical Association (AMA) and the American Hospital Association, and the health care insurance companies are directed toward developing a legislative package that will ameliorate the suffering of the underserved, provide coverage for the uninsured, control costs, and satisfy doctors and hospitals without huge tax increases or intolerable additional wage assessments.

Physicians are sullen and discontented under the burden of regulations and constraints that seriously impede their flexibility and ability to utilize professional judgment freely. Patients are angry with inflated costs, rising insurance premiums, and various impediments and obstacles to maintaining a comfortable, friendly relationship with doctors. Other patients are unable to obtain needed medical services to the extent required, or at all. Critics and reformers attack the medical profession as greedy, uncaring, and even incompetent. Malpractice accusations proliferate, and costs and judgments soar.
The political pot keeps boiling as bill after bill is introduced in the Congress to correct the defects and resolve the issues. Solutions flow from a variety of sources—political, professional, academic, and social reform—each with little or no input from the other. As in ethnic conflicts in some geographic areas of the world, patients and doctors have been antagonists rather than allies in an effort to correct and redeem the values both seek.

In the past, physicians have displayed little leadership in positive proposals, although recently they have been more forthcoming. Medical schools do not do much to prepare their graduates for the social concerns associated with medical practice. A distinguished British physician once compared this circumstance to the Church preparing missionaries for their role in the field, by instructing them on every aspect of the behavior of their prospective constituencies except their occasional urge to eat missionaries.

Lee Goldman, Harvard cardiologist, notes that efforts to stimulate physicians into more appropriate and economical use of laboratory tests had no lasting effect. He commented that “. . . we as a profession should complain less about the difficulty of altering patients' behavior and learn more about how to change our own . . .” [19].

Patients too are reluctant to change old ways in seeking or paying for medical care. Although prepaid group practice offers significant advantages in access, cost, and quality, after 50 years of experience, fewer than 25 percent of Americans buy into group practices. There is abundant evidence of this kind of conservatism, a cautious resistance to change, in historic failures to adopt or to reject healing procedures. Ackernknecht noted that, in the Franco-Prussian War of 1870, amputations in the field without anesthesia were still the rule, though ether had been effectively utilized for that purpose by Long in 1842 and Morton in 1846. On the other hand, the negative effect of bleeding as a therapeutic measure was described in 1830, but the practice itself continued well into the twentieth century [20].

The use of citrus as a preventive against scurvy on long sea voyages was established experimentally by Captain James Lancaster of the British Navy in 1601; by Captain James Lind, also of the British Navy, in 1747, but was not adopted into general practice in the British Navy until 1795, or into the merchant navy until 1865 [21].

On the other side, in amusing counterpoint, it should be noted that “QWERTY,” the arrangement of the letters on the standard typewriter (and computer) keyboard was developed in 1873, to slow typists down and so keep the keys from tangling! As the machines improved and typists began to use two hands, this antiquated “QWERTY” keyboard became an obstacle: harder to learn and harder to use. In 1932, August Dvorak developed a keyboard adjusted to the new situation, yet it is almost impossible to find a typewriter or computer with such an efficient keyboard in the shops today [22].

Perhaps we cannot expect ideas for human betterment to be translated into acceptance at the same speed with which dress fashions and popular music race around the world. The development of a national medical care program must take into account the cautious conservatism of physicians and public resistance to change. The proposals for national health programs are closely allied to economic concerns, but often with little regard for patient care considerations.

CURRENT PROPOSALS

The current proposals for national health program planning emphasize one or another of the salient issues: cost; payment for services, including mechanisms for
insuring the uninsured; or *enlarging access*, generally through additional funding. No proposal under serious consideration begins with the policy concern of guaranteed services to all citizens [23].

The lack of consideration for the interrelated effects of apparently independent legislative action is notable in the recent effort at cost control. This isolated legislative approach mandated hospital pre-budgeting and has had the effect of worsening patient care, by stimulating hasty discharge of very sick patients [24].

The American Medical Association proposed, first, simply extending Medicaid but has moved on to adding legislation for broader work-related health insurance, for improving access. Still, the AMA is cautiously more voluntary than compulsory insurance-related and does not deal with cost or quality control in their recommendations [25].

The Pepper Commission, a congressionally organized group, addresses itself entirely to improving the insurance aspect and to assuring that most Americans will be covered by work-related, or expanded Medicare and Medicaid insurance. While its proposal contains references to quality and cost control, the specifics are lacking, and the language is not encouraging: “recommends private and public initiative” [26].

Alan Enthoven hopes to improve access, quality, and cost control by augmenting work-related insurance and investing in wide-scale group practice. This approach minimizes the possibility of cost control and does nothing to guarantee access for the marginally poor and uninsured [27].

It is becoming fashionable to propose an American version of the Canadian health care system. The best known of such proposals is that of the Physicians for a National Health Program, who propose a “single, comprehensive public insurance program,” in which the present sources of payment would flow into a single public fund; put the doctors and hospitals on an annual budget for operations; and allow physicians to select payment either on fee-for-service, based on a mandatory national fee schedule, or by capitation and salaries [28].

It ought to be pointed out that the Canadian system didn’t spring fully armed from the brain of the Canadian Parliament. There was a ten-year lag between the establishment of the first universal health program in the province of Saskatchewan, and the legislation of a country-wide health program by the Canadian Parliament.

There is a legitimate question as to the applicability of an unmodified Canadian plan. United States citizens do not behave like Canadians in a number of ways, most notably in their political acceptance of government’s role in social action and its intervention in family matters. Will Americans accept the queuing and delays in elective surgery characteristic of the Canadian medical services? True, for the poor and uninsured in the U.S.A., that is routine now. But what of the other 85 percent of the population? The Canadian city of Windsor, Ontario, across the river from Detroit, Michigan, had a comprehensive health insurance plan in operation from the early 1930s. The two cities are similar in many ways—auto manufacturing, the auto workers’ unions negotiating health benefits—but the Detroit auto workers never adopted the comprehensive health insurance program of the Windsor auto workers.

What we might do, if we are so inclined, after examining the bugs and glitches in the Canadian system, is to use their model as a basis for an American model, improve on it, and avoid their mistakes!

Others look abroad for a pattern of improvement, to Britain, the Netherlands, or
Germany [29]. While adoption of a modified Canadian model is possible, it is far less likely that the conservative streak in American politics, usually coupled with a kind of nativism, would allow easy and swift adoption of a foreign medical care program.

PLANNING FOR A NATIONAL PROGRAM BY WAY OF THE STATES

Despite the vigorous recommendations and demands for change, it is doubtful that federal legislation is imminent. We've spent nearly a century in a fruitless effort to legislate a national health program for the United States. We've tried a frontal assault in Washington almost annually since 1939. We've tried flanking attacks, resulting in dozens of bits and pieces of legislation and regulation, in the hope that the pieces would eventually be joined in an edifice. Instead, the effect seems to have been to confound the issues and set us back in costs, increase inflation, and diminish access. Since the subject of national health insurance has been broached, it has been subjected to limitless discussion, debate, and defiance, but not to legislative action. I am reminded of the acid comments of a British professor of social medicine, that "both parties practice a form of political contraception, in which no matter how suggestive the preliminary movements, there are no embarrassing legislative consequences."

In short, none of the proposals seems to be any closer to resolution in the Congress than they have been for years. If there is not to be, or at least not yet, a congressional legislative mandate, what then? Historic evidence makes stimulation of state initiative in this regard a promising approach to a national health care program. Many states are already engaged in a variety of experimental approaches to meet their own needs: extending Medicaid, compelling employers to buy insurance for their employees. A dozen or more states are discussing plans for improving and extending medical care services. California, Connecticut, Florida, Illinois, Indiana, Ohio, Michigan, Missouri, and Washington are preparing initiatives [30]. The National Governors' Conference has had this subject on the agenda in 1990 and 1991.

In Massachusetts, the legislature passed a compulsory insurance law in 1989, but has as yet been unable to fund it. Hawaii passed a compulsory insurance law in 1974, but only after long judicial delays was the state able to put the law into effect. It provides for three channels of insurance, not a single-payer system, but has been successful in reducing costs, to some extent. Oregon has been notable in the public exercise of debate on a rationing system for controlling the costs of medical care, but only for the poor at first [31].

Given the straitened circumstances of the states, and the unpredictable costs of experimenting with a new and as yet untried program, if a truly comprehensive model for a national health program is to be generated by a state, that state will need federal financial support. With such underwriting, the federal government could put out what are essentially, "Request for Proposals," as it does for other experimental programs. There would need to be conditions, "specifications," because, after all, this plan is to be the template for a national program.

Federal encouragement of other kinds will be needed as well. For example, the ability of the states to innovate is contingent upon receiving waivers to use their share of Medicare and Medicaid funds in new ways, and to allow a bargaining agent to negotiate fees for physicians. Special federal regulations may be required to handle reimbursement across state lines, for people who routinely receive care in a neighboring state.
This theoretical plan is not to suggest that the appropriate response to the need for a national health policy requires a painfully slow state-by-state progression toward that goal. "State initiative" is not intended to create a national medical care program piece by piece. Such an effort would be self-defeating, since it would only add further fragmentation, discordance, and inequities to an already unsatisfactory national picture. The federal role must be collaborative, utilizing state initiatives for initial developments of an anticipated equitable national system of medical care delivery. Not only should the projected state programs be consistent with national goals, but the federal government must be a secure partner in the approach and the eventual operations.

To encourage state initiative in developing a comprehensive, statewide, universal medical care program, the federal government should make incentive grants available to states that propose to design such programs. American pluralism suggests that more than one state initiative should be encouraged. When the Congress turns to designing a national program, it will have the benefit of the various state experiences. Schultze has written of "market analogues"—public funding of competing public programs, in order to allow selection of the one that is most efficient, economical, and satisfactory—multiple state experimentation would permit such encouragement [32].

Insofar as the state initiative is to be generated on behalf of the eventual national solution, the federal government in its "specifications" should require the demonstration projects to meet basic conditions that will reinforce the national requirements: Each subsidized state initiative ought to guarantee universal coverage, comprehensive benefits, a single public payer, global budgeting, and quality assurance.

The proposal does take into account the various necessary conditions for an improved medical care service. It offers a guarantee of access, in that the entire population is included; it has more regulatory oversight for cost savings; and it presents an opportunity for quality control via the reporting to a central payer. It attacks, but does not interfere too heavily with, the status quo and therefore does not antagonize current professional beneficiaries. From cost estimates of comprehensive services of this kind, and reduced costs of improved administration, an incentive grant from the federal government would be in the neighborhood of $200 million for each million people to be served.

The states would be encouraged to experiment with forms of organization, reimbursement, and administration. But the basic conditions would involve equal access for all citizens to comprehensive services and universal eligibility. Local communities would be expected to participate in policy planning, operational controls, and funding. States would also be encouraged to experiment with program design, particularly in administrative decision making—how patients and physicians operate as a "team," allocation of local resources (such as hospital beds), and the need to take into account small-area variations in the utilization of procedures. The conjoint leadership of health professionals with consumers should be cultivated. An excellent existing model of a well-functioning "team" relationship of this kind exists in the quality assurance department in operation at Group Health Cooperative of Puget Sound, the nation's largest consumer-governed health care organization and third largest prepaid group medical practice [33]. One of the keys to their success is that health professionals, rather than insurance billing departments, lead the efforts to improve the quality of care [34].

Not the least of the benefits achieved by the process could be a new relationship of
the medical care system to patients, to wipe out the hard economic facade that has been medicine’s countenance for many years now. This change would mean not only provision of more sympathetic and personal care, but more evidence of concern by professional caregivers, in the doctors’ offices and in the hospitals for solicitous, prompt, and competent medical services and elimination of the carelessness associated with poor or inept diagnosis and treatment, thoughtlessness, and neglect.

In short, the growing recognition of the need for a national health plan compels us to seek the surest and most effective route to that end. Eighty years of unsuccessful maneuvering at the congressional level hardly reassures us that the congressional route is the way to go. The traditional pathway to important national social legislation is through the states. At least part of the delay in legislating a national health program in the United States may be attributed to the lack of good state models for the nation to emulate. The route to a national health program may well wind through the states.

The states themselves are beginning to look about for a resolution in those terms. A shared program of federal, state, and local public financing, as suggested here, in an appropriate organizational design appears promising. With federal stimulus in the form of financial underpinning, selected states should be encouraged to undertake experiments in fashioning individual plans. The correction of flaws and deficiencies discovered in the operation of these state plans would provide the structural basis for an eventual federal program.

There may be dissent from those who seek immediate federal action, and who argue that the “principle” of national purpose demands national action. Wilbur Cohen, onetime Secretary of the Department of Health, Education and Welfare, had an amusing and insightful response to arguments of procedure “on principle.” He would say, “Sometimes we have to give up our principles and do what’s right.”

REFERENCES

1. Public Assistance: The Federal Role in the Federal System. Report Number A-79. Washington, DC, ACIR, July 1980, pp 5–21; see also Dye TR: Policy, Economics and the Public. Chicago, IL, Rand McNally, 1966, pp 116–118

2. Derickson A: Health Programs of the Hard Rock Miners’ Unions 1891–1925. Ph.D. dissertation, UCSF. 1986, p 297

3. Milestones of Public Health in America. Washington, DC, American Public Health Association, 1985

4. Rivlin A: Systematic Thinking for Social Action. Washington, DC, Brookings, 1971

5. Mr. Justice Brandeis: Dissenting opinion in New State Ice Co. v. Liebmann, 285 U.S. [311] 1931

6. Kaufman H: Politics and Policies in State and Local Governments. Englewood Cliffs, NJ, Prentice-Hall, 1963, p 30

7. See also Jacob H, Vines KN: Politics in the American States. Boston, MA, Little Brown, 1971, p 389; and Altman DE, Morgan DH: The role of the state and local government in health. Health Affairs 2(4) (Winter): 7–31, 1983

8. Rockefeller NA: The Future of Federalism (The Godkin Lectures). Cambridge, MA, Harvard University Press, 1962, pp 15–16

9. Starr P: The Social Transformation of American Medicine. New York, Basic Books, 1982, pp 392–401

10. Numbers R: Almost Persuaded. Baltimore, MD, Johns Hopkins University Press, 1978, p 113

11. The Sheppard-Towner Act

12. Numbers R (ed): Compulsory Health Insurance. Westport, CT, The Greenwood Press, 1982

13. The Federal Emergency Relief Act of 1935 permitted payment to physicians through state authorities.
14. Roemer MI: Rural Medical Care. St Louis, Mosby, 1976, and Sinai N, Anderson O: EMIC. Ann Arbor, MI, University of Michigan School of Public Health, 1948
15. Pifer A: Foreword to the 50th Anniversary Edition of The Report of the Committee on Economic Security of 1935. Washington, DC, National Conference on Social Welfare, 1985, p x
16. See, for example, publications of Health United States, from the U.S. Department of HEW (now HHS) for successive years.
17. Blendon RJ, Taylor H: A health system that needs surgery. New York Times (May 6), 1989
18. A variety of proposals have appeared within the past two years in the New England Journal of Medicine. See, for example, Himmelstein D, Woolhandler S: A national health program for the United States. N Engl J Med 320:102–108; 1989; and Relman A: Editorial reflection on the national leadership commission's health care plan. N Engl J Med 320:314–315, 1989
   The American College of Physicians: Access to health care. Ann Int Med 112 (9) (May 1): 641–661, 1990
   An economist's animadversion is contained in Enthoven A, Kronick R: A consumer choice health plan for the 1990s. Part 1. N Engl J Med 320:29–37, 1989, and Part 2. N Engl J Med 320:94–101, 1989
19. Goldman L: Changing physicians' behavior. N Engl J Med 322:1524–1525, 1990
20. Ackerman E: A plea for a “behaviorist” approach to writing history of medicine. J Hist Med 22:211–214, 1967
21. Rogers EM: Diffusion and Innovation. New York, Free Press, 1983, pp 7–8
22. Ibid
23. With all due respect, Congressman Dellums has been submitting a bill, refined annually, that proposes a national health service model, federal tax-supported, for universal, compulsory medical care services in nationwide modules, served by salaried physicians, in publicly owned hospitals. While this bill does maintain such a stance, it has not been given an opportunity for consideration by the crucial House committee that would make it a serious contender.
24. “...Medicare’s prospective payment system resulted in the increased transfer of terminally ill patients from hospitals to nursing homes.” Sager MA, Easterling DV, Kindig DA, Anderson OW: Changes in the location of death after passage of medicare's prospective payment system. N Engl J Med 320(7):433–439, 1989
25. Todd JS, Seekins SV, Krichbaum JA, Harvey LK: Health access America—strengthening the US health care system. JAMA 265:2503–2506, 1991
   An earlier proposal aimed only at Medicaid extension is discussed by Matheson SM: The states' roles and responsibilities for providing universal and affordable health care for the American people. In Providing Universal and Affordable Health Care. The Richard and Hinda Rosenthal Lectures. Washington, DC, Institute of Medicine, 1989, pp 10–27
26. A Call for Action: Washington, DC, US GPO, 1990
   See also Rockefeller (Senator) JD IV: A call for action. JAMA 265:2507–2510, 1991
27. Enthoven A, Kronick R: A consumer choice health plan for the 1990s. Part 1. N Engl J Med 320:29–37, 1989, and Part 2. N Engl J Med 320:94–101, 1989. See also the more recent article by the same authors, Enthoven A, Kronick R: Universal health insurance through incentives reform. JAMA 265:2532–2536, 1991
28. Himmelstein DU, Woolhandler S, Writing Committee of the Working Group on Program Design, Physicians for a National Health Program: A national health program for the United States. N Engl J Med 320:102–108, 1989; see also Grumbach K, Bodenheimer T, Himmelstein DU, Woolhandler S: Liberal benefits, conservative spending. JAMA 265:2549–2554, 1991
   A supporting editorial from the editor of The New England Journal of Medicine, Relman A: Universal health insurance: Its time has come. N Engl J Med 320:117–118, 1989, implicitly approves the sentiments.
29. Kirkman-Liff BL: Health insurance values and implementation in the Netherlands and the Federal Republic of Germany. JAMA 265:2496–2503, 1991
30. Memo summarizing state universal health care proposals. Washington, DC, Citizen Action, July 1990
31. Fox DM, Leichter HM: Rationing care in Oregon: The new accountability. Health Affairs 10:7–27, 1991
32. Schultzze CL: The public use of private interest. Harpers (May): 43–62, 1977
33. Group Health Cooperative Fact Sheet. Seattle, WA, Group Health Cooperative of Puget Sound, September 1990
34. Personal Communication from Dr. Bruce Perry, Director, Office of Quality Care Assessment, Group Health Cooperative of Puget Sound. November 19, 1990