Public, Private, or Neither? Strategic Choices by the American Medical Association Toward Health Insurance from the 1910s to 1940s

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1. Introduction

The American Medical Association (AMA) is often described as a defender of private provision of health insurance and an enemy to public health insurance. In fact, while the AMA has always opposed the governments’ total control over health insurance, it has not constantly opposed the governments’ interventions in health insurance. Furthermore, it has not supported all private provisions, either. The AMA has historically changed its stance on public and private health insurance.

This paper shows how the AMA changed its strategy for health insurance from the 1910s to 1940s. I focus on this period both because health insurance coverage drastically increased from virtually none to more than the majority of the population and because the AMA drastically swung strategy. While the main purpose of this paper is to show how the AMA changed its strategy, this project is a step to answer why the AMA did so.

From the 1910s to 1940s, there were roughly three phases in the AMA’s strategic transformation. The first phase was in the 1910s when the idea of health insurance became known and the AMA supported the creation of public health insurance programs for workers while it opposed private health insurance. Second, in the 1920s and 1930s, the AMA decided to fight against any health insurance provisions, including public and private ones. Finally, the third stage was in the 1940s when the AMA gradually softened its opposition to private health insurance and finally began to aggressively promote it while it kept opposing public health insurance.

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insurance.

Health insurance is one of the tools for people to have easier access to medical care by spreading the cost of risk to both healthy and sick people. What would likely happen to people if the devastating illness occurs to them and they have to pay for medical care only from their pocket? They (or their spouses) may not continue to earn wages, may spend all saving for medical treatment, and may not be able to pay for sufficient medical treatment. They cannot be healthy enough again to go back to work. Health insurance can stop this vicious circle.

Individual doctors have complex stakes in health insurance. On the one hand, health insurance may help doctors by providing financially stable patients. On the other hand, it may financially harm doctors because it could force doctors to accept lower doctor’s fees than ones under the traditional fee-for-service practice. To make the situation for doctors more complicated, even when doctors accept health insurance, they have to make a decision on whether they live with public health insurance or private health insurance. While the common brief sees private health insurance as an ally of doctors, as described later it is not certain which private or public health insurance results in maximizing doctors’ fees.

This uncertainty was what the AMA faced when they decided their attitude toward health insurance from the 1910s to 1940s. Theoretically, the AMA had the following four options:

Option 1: Supporting public health insurance
Option 2: Supporting private health insurance
Option 3: Supporting neither public nor private health insurance
Option 4: Supporting both public and private health insurance

In the 1910s, the AMA took the first option. In the 1920s, it chose the third option. Then in the 1940s, it made a decision for the second option.1

There has been accumulating scholarship about the development of health insurance in the United States. One of the most frequently asked questions is why the United States is the only advanced country that does not guarantee universal coverage of health insurance. Among various factors, scholars have paid special attention to the strong power of the AMA against the federal government’s intervention in health insurance. The simplest explanation for this interest group

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1 The AMA took the fourth option after Medicare and Medicaid were established in 1965.
Public, Private, or Neither? Strategic Choices by the American Medical Association Toward Health Insurance from the 1910s to 1940s

approach is that the AMA’s political power has been so firm that reformers’ proposals leading to universal public health insurance have all failed. Although it is true that universal public health insurance would have been established in the United States if the AMA had supported it, this approach has an important setback. It prevented one from examining how the AMA modified its strategies toward public and private health insurance to maximize its members’ financial power. Some studies show what kind of position the AMA took toward proposals for public health insurance from the 1910s to 1940s by focusing on each critical period, such as the eras of the Progressives, New Deal, and Fair Deal. In contrast to focusing on one reform period, this paper covers the period from 1910s to 1940s and examines how and why the AMA changed its policy preferences. Finally, I pay special attention to the impact of World War II, which has been neglected by scholars, as one of the most critical influences on the AMA’s policy preferences. I argue that WWII and the following postwar period drastically changed the health insurance economy and the AMA’s strategy.

By examining how the AMA changed its position toward health insurance from the 1910s to the 1940s, this paper demonstrates that the AMA’s strategy toward health insurance is more complex than a simple image that the AMA supports private provisions and opposes a public one. The AMA’s strategy is not

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predetermined but depends on historical contingency. This perspective opens a door for us to understand how the AMA has responded to health insurance reform plans after the 1940s. It also allows one to rethink the political behavior of other interest groups.

2. Period One: Supporting Public Health Insurance

The AMA was born in 1847 in order to nationally standardize medical education, to promote a shared medical ethics, and to advance medical science. To promote more scientific medicine and secure its members from too much competition, the AMA made efforts to diminish practitioners such as botanic practitioners, midwives, bonesetters, and abortionists, and to eliminate other sects such as Thomsonianism, Eclecticism, and homeopathy. While this objective was achieved by the early twentieth century, the AMA now had to decide how to deal with a new mechanism, health insurance, which directly influenced doctors’ income.

At the turn of the century, the United States saw the emergence of private health insurance. Commercial private health insurance firms, such as Metropolitan and Prudential which still exists as mega-insurance firms, initiated health insurance business in the late nineteenth century. They provided workers with a flat daily compensation for missed days due to illness or injury—typically two-thirds of the wage. Meanwhile, some large companies adopted a model of contract practice, employing doctors to furnish medical care to their workers in order to build

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7 By 1915, the AMA’s membership increased to about 50 percent of doctors (Numbers, *Almost Persuaded*, 27; Starr, *The Social Transformation of American Medicine*, 273).
up their employee’s loyalty. Although the size of private health insurance was very limited at that time, the AMA opposed these private health insurance plans because most of them restricted the freedom of patients’ choice of their doctors and aimed at lowering doctors’ fees.

While opposing private health insurance, the AMA saw that many doctors were financially unstable. A large percentage of the population was scattered in rural areas with low or moderate incomes, and family members usually cared for the sick. As result, doctors were not a profitable profession at that time. As described, the AMA had sought to provide more financial reward for its members by eliminating alternative medicine, but it did not cause a drastic effect. When the AMA looked for other ways to stabilize and boost its members’ finance, not private but public health insurance appeared a good option.

While private health insurance sprouted, reformers began to seek the introduction of state-level public health insurance for workers. In 1906, the American Association for Labor Legislation (AALL) was founded and prepared proposals for social security measures, including compulsory health insurance. In 1912, the platform of the Progressive Party led by Theodore Roosevelt also advocated for governmental responsibility to protect people from the hazards of sickness. In 1915, the AALL drafted a compulsory health insurance modeled after German legislation. The AALL plan held that employers and employees would administer the program under public supervision. Some important officers in the United States Public Health Service backed the AALL proposal, including important figures such as Rupert Blue, Surgeon General of the Public Health

11 Fishbein, A History of the American Medical Association, 60.
12 The AALL was established in 1906. Its members were mainly academics and they sought to reform capitalism rather than destroy it by creating social economic policies.
15 Starr, The Social Transformation of American Medicine, 246; Anderson, Health Services in the United
The AMA initially supported the AALL plan after considering an “estimation of whether or not the proposal conformed to the ethical standards they (the leaders of the AMA) were fighting to establish and was the best professional, economic, and political interests of the profession.” In 1915, the *Journal of the American Medical Association* debated the AALL proposal and claimed that it hoped physicians would take advantage of this opportunity. In the annual meeting of 1915, the Judicial Council of the AMA, led by Alexander Lambert, personal physician to Theodore Roosevelt and later the President of the AMA (1919), also submitted a report to support the public insurance schemes. Moreover, Frederick R. Green, the secretary of the Council on Health and Public Insurance of the AMA, also cooperated with the AALL and proposed setting up a three-person committee in order to revise details of the AALL proposal. This committee was held in the same building as the AALL in New York. With the AMA’s approval, Lambert was appointed the committee’s chairman in 1916.

The AMA supported public health insurance because it appeared to the AMA that public health insurance would be better to improve its members’ finance than private insurance. Private plans aimed to reduce the autonomy of solo-practitioners by controlling doctors’ fees and restricting patients’ freedom to choose their doctors. On the other hand, the AALL proposal for public health insurance seemed to guarantee these conditions. The AMA sought to maintain the existing fee setting system and of doctor-patient relationship by supporting public health insurance. However, AMA’s position soon changed.

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*States*, 89.


17 Anderson, *Health Services in the United States*, 74. JAMA is published by the AMA for introducing new medical technology and editorial opinion on topics related to medical practice.


20 In contrast to many reformers at that time, Rubinow believed that the United States could skip the phase of private insurance development and immediately establish a public insurance system (Anderson, *Health Services in the United States*, 69).
3. Period Two: A Switch to Oppose Any Health Insurance

Although a united front for public health insurance for workers seemed to have been consolidated by 1916, the coalition fell apart soon afterward largely because of World War I. Immediately after the United States entered the war, the AMA closed down its committee on social insurance, which had submitted the final report to the House of Delegates for supporting health insurance. The AMA House of Delegates mentioned in 1918 that proposed public health insurance was a “dangerous device...announced by the German emperor from the throne the same year he started plotting to conquer the world.” Moreover, as the wartime economy during WWI boosted the income of physicians, health insurance lost its appeal for the AMA to secure doctors’ income. Then the AMA began to oppose any type of health insurance, whether public or private. In 1920, the AMA officially announced their opposition to “the institution of any plan embodying the system of compulsory contribution.” WWI gave doctors ideological and financial reasons to stick with the traditional fee-for-service system.

After the war, as part of campaign against public health insurance, the AMA fought against existing national programs for mothers. In 1921, the Infancy and Maternity Protection Act of 1921, called the Sheppard-Towner Act, allowed the federal government to provide matching funds to states for prenatal hygiene and infant care, helping to reduce rates of maternal and infant mortality. After the AMA began to oppose public health insurance, the AMA launched a campaign against this act labeling it an “imported socialistic scheme” of “state medicine.” The program was discontinued in 1929.

21 The House of Delegate is the AMA’s policy-making body.
23 Fishbein, A History of the American Medical Association, 321. See also Anderson, Health Services in the United States, 79; Hacker, “The Historical Logic of National Health Insurance,” 111–2; Starr, The Social Transformation of American Medicine, 260. To avoid confusion, both not only public but also private health insurance can be compulsory. Private health insurance plans often forced all employees in a company to join.
24 Anderson, Health Services in the United States, 47.
25 As quoted in Skocpol, Protecting Soldiers and Mothers, 513.
The AMA also fought against the expansion of governmental care for veterans. In 1922, Congress passed a law to expand veterans’ hospital facilities from WWI veterans to include the veterans of the Spanish-American War, the Philippine Insurrection, and the Boxer Rebellion, and to provide medical and hospital services for non-service-connected incidents, such as neuropsychiatric disabilities or tuberculosis. Other non-service-connected disabilities were soon added to veterans’ care. Between 1925 and 1941, as a result, 73.6 percent of all hospital cases were non-service-connected. In response to the expansion of the VA health service, the AMA warned in 1928 that veterans’ health service would lead to the total nationalization of medicine. In their annual meeting, the AMA’s Bureau of Legal Medicine and Legislation called the attention of the House of Delegates to the federal government’s attempt for the “socialization of medicine through the expansion of the care given to veterans.”

The AMA’s struggle with the movement to introduce public health insurance for workers continued during the New Deal reform. In 1934, President Franklin D. Roosevelt set up the Committee on Economic Security, which Secretary of Labor Francis Perkins led as chairperson, in order to study social security. Its subcommittee on medical care included health insurance specialists who had fought for public health insurance in the previous few decades. In particular, Edgar Sydenstricker, one of leaders for the AALL plan, directed a technical study about health insurance. The reformers made efforts to introduce public health insurance in the Social Security Act of 1935; however, the AMA’s opposition led Roosevelt to give up his idea because if he had included health insurance in the bill, the “political dynamite” would have destroyed the prospects of the entire bill.

After the Social Security Act passed without public health insurance for workers, Roosevelt appointed an Interdepartmental Committee to Coordinate

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Health and Welfare Activities, consisting of assistant Cabinet secretaries for future action in social security. The Technical Committee on Medical Care was established in the Interdepartmental Committee with the expressive purpose of reviewing the health service provisions and making recommendations in health insurance. The Public Health Service, Children’s Bureau, and the Social Security Board were in charge of the Technical Committee. The Social Security Board, which was created to administer most of the programs in the Social Security Act of 1935, became the leader in planning public health insurance. Arthur Altmeyer, along with his prominent adviser on health insurance, Isidore Falk, took a leadership role in pushing for the introduction of public health insurance.

The Technical Committee called a conference, the National Health Conference, in order to make a tentative recommendation for public health insurance. For the first time, this officially brought labor into the discussion. The recommendations by the National Health Conference led directly to a public health insurance bill introduced by Senator Robert Wagner (Democrat-New York) in 1939. The Wagner bill proposed federal grants to states for their health care programs, including health insurance. State governments were to have a large discretion to administer the program.

The AMA reacted to the federal government’s efforts for health insurance legislation with furious opposition. After discovering the Social Security Act provided that the SSB would seek future legislation in the areas of health

31 Anderson, Health Services in the United States, 113; Starr, The Social Transformation of American Medicine, 275.
33 Starr, The Social Transformation of American Medicine, 266; Derickson, “Health Insurance for All?” 1338. The labor organizations realized that they could not provide workers’ benefits by themselves. They sent 15 delegations, the second largest group. The health care providers sent the largest delegation.
34 Derickson, “Health Insurance for All?” 1339.
insurance, the AMA called a special meeting of the House of Delegates in February 1935, something which had occurred only once before. In the meeting the AMA reaffirmed its position that it opposed any government intervention in health insurance. The AMA played a major role in blocking the Wagner Bill of 1939.35

In sum, WWI was a turning point for the AMA. The war lowered the priority of domestic policy. More importantly, doctors improved their finance in the strong wartime economy. In the 1920s the AMA transformed its strategy into opposing any type of health insurance, and in the 1930s it consolidated this position. The AMA concluded that doctors would be better-off with the traditional fee-for-service system: they needed neither public nor private health insurance. However, the coming of World War II changed the politics of health insurance.

4. Period Three: Private Plans as an Alternative to Public Health Insurance

In the third phase, the 1940s, the AMA encountered the rapid increase of private health insurance plans and the reactivation of the movement toward the creation of public health insurance. The AMA could no longer hold two battle lines, fighting against both public and private health insurance, and chose, reluctantly at first and more aggressively later, to promote private health insurance as an alternative to public health insurance. In the 1940s, the AMA for the first time clearly established itself as the defender of private provision of health insurance. To understand why the AMA did so, an innovation in private health insurance and the impact of World War II have to be taken into account. Therefore, this section is divided into three parts. The first part demonstrates what innovation in private health insurance took place and how the sprout developed during the war. The second part shows how WWII impacted the movement for public health insurance. The final part discusses why the AMA changed its strategy in the postwar era.

35 Starr, The Social Transformation of American Medicine, 269.
4.1 Private Health Insurance in the Late 1930s and the Wartime

The emergence of a new type of private health insurance in the 1930s led the AMA to realize that private health insurance might not always be an enemy to doctors. In 1929, the Baylor University Hospital in Texas started an insurance plan to provide schoolteachers with financial compensation for their hospital care. This hospital insurance was soon called Blue Cross. Blue Cross grew because it avoided an adverse selection problem—sicker people more likely participate in insurance—by targeting not individuals but employee groups. Moreover, the Blue Cross plans were given favorable tax-status by the state governments. The leaders in Blue Cross plans pushed for state governments to pass legislation that gave them nonprofit status and extended to them favorable tax treatment for hospitals.

The American Hospital Association, the largest hospital organization, soon endorsed Blue Cross plans. By the end of 1936, 21 Blue Cross plans had been established. Thirty-nine Blue Cross plans had 6 million in enrollment by 1940. Blue Cross plans demonstrate that private health insurance was not necessarily a foe to medical providers by showing them that medical providers could be in charge of administering private health insurance.

The spread of Blue Cross inspired some “maverick physicians” to create health insurance plans for medical-surgical expenses, later called Blue Shield. Paul Starr describes that Blue Shield was “the junior partner” of Blue Cross. State or county-level medical associations began to study and operate this doctor-friendly private health insurance. As early as 1932, for example, the Michigan State Medical Society began its study of health insurance. In 1939, the California, Michigan, and Pennsylvania medical societies established programs that targeted statewide residents.

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The AMA was initially puzzled about the Blue Shield plans because it had seen private health insurance merely as a third-party intervention between doctors and patients. However, they first accepted certain types of private plans which did not have an effect on doctors’ fees. The AMA House of Delegates stated in 1938 that “in any plan or arrangement for provision of medical services the benefits shall be paid in cash directly to the individual member. Thus, the direct control of medical services may be avoided.” Despite this concession, however, the AMA did not go further to engage in promotion of private plans at that time.

Nonetheless, soon the AMA had to revise its strategy when WWII increased private health insurance coverage. The war caused unprecedented mobilization and resulted in the expansion of private health insurance. As the war mobilization rose and the labor market tightened, the war industries faced difficulties attracting workers, and war industries began to offer private health insurance as a fringe benefit. The federal government also played a role, both consciously and unconsciously, in further promoting private health insurance. In fear of inflation, the government adopted the “Little Steel” formula to control wage increase in July 1942. Because employers could not attract workers by increasing salary, more employers included health insurance benefits in the negotiations with labor unions. The Revenue Act of 1942, furthermore, allowed full tax deduction of employers’ health insurance costs, which made private health insurance more attractive when employers suffered from high wartime tax. Several regional War

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42 Anderson, Health Services in the United States, 125.
44 Alan Brinkley, The End of Reform: New Deal Liberalism in Recession and War (New York: Alfred A. Knopf, 1995), 210. The formula was named after the War Labor Board’s rule to let workers in four steel companies increase wages based strictly on rises in the inflation rate between January 1, 1941 and May 1, 1942.
Labor Boards also began to order the establishment of group health insurance.47

While private health insurance was growing, the AMA gradually transformed its strategy. In June 1942, the AMA’s House of Delegates approved private health insurance with the service principle which provided patients with not cash compensations but medical services.48 In 1943, Blue Shield was formally established when the AMA created a commission to coordinate the statewide physicians-led insurance plans for surgical costs on a national basis.49

Blue Cross and Blue Shield plans took advantage of this wartime situation and increased membership from 6.4 percent of the population in 1941 to 14.2 in 1945.50 This wartime expansion of private health insurance left a legacy to postwar reconstruction: private health insurance became part of fringe benefit and it became a weapon for the AMA to block universal public health insurance. Before showing the AMA’s postwar strategy, however, it is important to examine how the war impacted the movement for public health insurance.

**4.2 War and the Movement toward Universal Public Health Insurance**

As WWII expanded private health insurance, the war also encouraged reformers to introduce public health insurance as part of national defense measures. When Adolf Hitler overran neighbor countries and invaded France in mid-1940, Great Britain stood alone in Europe. In response to this situation, the United States prepared for future battle against Germany by centralizing and rationalizing political institutions and policies. Meanwhile, reformers began to see health insurance as a tool to make the people ready for the coming war.

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High rejection rate in the physical examination of draftees, increasing demand of medical care for military personnel, the influence of the Beveridge Plan in Great Britain, and public support all inspired reformers to push for public health insurance.

Beginning in 1940, news about the high rejection rate in the physical examination of draftees shocked the nation. In its *Annual Report* published in 1941, the Social Security Board for the first time clearly stated that good health of the population would be necessary to pursue a war: “In time of war, the past and present well-being of the population at home is the essential base on which is erected the structure of special defense activities in the field, in factories, and on the farms.” In October 1941, furthermore, President Franklin D. Roosevelt expressed his concern about the rejection rate in physical examinations, which had increased by 10 percent since July of that year. Right before Pearl Harbor, the President suggested that something be done to address the problem.

The opponents of public health insurance began to worry that the increasing war mobilization would provide an opportunity for the government to radically intervene in health insurance. As early as in June 1941, Olin West, Secretary and General Manager of the AMA, warned Paul McNutt, the head of the Federal Security Agency, that the AMA had been informed that “the Social Security Department [Social Security Administration] is as fully convinced as ever of the need of an extensive federal health program, and that Social Security officials believe that such a program, including compulsory health insurance, can now be introduced as a defense measure without special Congressional action.” West cautioned McNutt that if such a plan existed “the medical profession is entitled to


have definite information about it from official sources.” This complaint showed that the AMA was well aware of the ongoing movement to expand public health insurance by linking it with war planning.

The government’s attention to the health of the population became more serious after the United States entered the war in December 1941. The federal government had to deal with the increasing rejection rate among draftees, make existing manpower in war industry more efficient, and maintain the morale of the nation. Health insurance became part of these governmental efforts.

In late 1942, the Beveridge Plan released in Great Britain encouraged reformers in the United States. The Beveridge Report proposed a radical reform in social security in order to create a “cradle to grave” welfare system. The report included the establishment of a National Health Service that would offer medical care to the entire population. Richard Titmuss notes that the Beveridge Report was “in part an expression of the needs of war-time strategy to fuse and unify the conditions of life of civilians and non-civilians alike.”

Wilbur Cohen, an advocate for public health insurance in the Roosevelt Administration, took a “tremendous interest” in the Beveridge Plan, and he had it translated into American English to “help make the report intelligible to them [the newspaper men].” In January 1943, the Social Security Bulletin, the official monthly report of the Social Security Board, included a summary of the Beveridge Plan. It clearly showed that the war would be a great opportunity for changes “which will be acceptable to all but which would have been difficult to make at other times.”

54 Olin West, “Letter to Paul V. McNutt,” June 27, 1941, RG 47 Records of the Social Security Board, Central File, 1935–1947, Box 60–056.1, National Archives, College Park MD. The Federal Security Agency was the umbrella organization which coordinated the New Deal programs, including social security programs.


Altmeyer also noted in February 1943 that a unified social security program “would greatly aid in the successful prosecution of the war.” The Beveridge Plan helped the advocates of public health insurance in the United States convince American people that an “American Beveridge Plan” would be necessary.

Influenced by the Beveridge Plan, Senator Robert Wagner submitted to the Senate a bill with Senator James Murray (Democrat-Montana) in June 3, 1943, and Representative John Dingell (Democrat-Michigan) submitted the same bill to the House. It was popularly called the Wagner-Murray-Dingell bill. The WMD bill of 1943, “an American answer to the Beveridge Plan,” was an omnibus bill and called for a “cradle-to-grave” system of social security. The bill’s center of attention was a proposal for the creation of a comprehensive, national, and prepaid health insurance program for workers and their dependents. This plan would give more authority to the federal government than did the Wagner bill of 1939. By linking it with national security measures, reformers pushed for a more radical intervention in health insurance.

Public opinion widely supported the WMD bill. According to Fortune magazine, 74.3 percent of Americans were in favor of public health insurance in 1942. A Gallup poll asked in 1943, “At present the Social Security program provides benefits for old age, death and unemployment. Would you favor changing the program to include payment of benefits for sickness, disability, doctors and hospital bills?” 59 percent answered yes. The poll also asked if people would pay 6 percent of their income for programs in the WMD bill, which was proposed at that time, and 80 percent of people said that they would.

60 Poen, Harry S. Truman Versus the Medical Lobby, 32; Starr, The Social Transformation of American Medicine, 280.
61 The WMD bill planned to pay the cost by a payroll tax, 6 percent each from employees and employers.
62 Steinmo and Watts, “It’s the Institutions, Stupid!” 341.
With public support, President Harry Truman embraced health care as one of the most important issues in domestic policy after the war was over. On September 6, 1945, Truman proposed a 21-point program that updated the Economic Bill of Rights proposed by Roosevelt in January 1945. On November 19, in his special message to Congress, Truman reiterated one of the most important rights mentioned in the 21-point program: the right to adequate medical care. What his proposal was different from the WMD bill was that it would cover almost the entire population, not just those whom the Social Security Program targeted at that time, including professionals, agricultural workers, and domestic workers.64

Truman emphasized the benefits of health insurance by stating, “Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people’s needs.” A health fund, Truman continued, “should be built up nationally, in order to establish the broadest and most stable basis for spreading the costs of illness, and to assure adequate financial support for doctors and hospitals everywhere.”65 Truman’s special message to Congress was the first presidential message which exclusively targeted the subject of health.66

Legislative activities in Congress also reflected Truman’s enthusiasm. At the same day of Truman’s special message, the Wagner-Murray-Dingell bill was reintroduced. At this time, the bill specifically addressed health care. The bill emphasized that medical services under the bill should be “comprehensive and complete.”67 The proposal estimated that between 75 and 80 percent of

63 Arthur J. Altmeyer, “Financing Hospital Care Through Social Insurance: An Address Before the Second War Conference of the American Hospital Association,” September 15, 1943, 3, RG 47 Records of the Social Security Administration, 1946–1950, Box 4-speeches by Arthur J. Altmeyer, NACP. This question did not clarify whether 6 percent would cover the entire program or only the additional benefits.

64 Hacker, The Divided Welfare State, 223.


66 Poen, Harry S. Truman versus the Medical Lobby, 63.

67 “Statement of Arthur J. Altmeyer, Chairman, Social Security Board on S. 1606, Before the
the population would be covered by the proposed program. The bill proposed that administrative power belong to the Surgeon General, and that the National Advisory Medical Policy Council be established, including representations of the medical professions and the public.68

The Democrats’ loss in the 1946 mid-term election disappointed reformers, but they saw a hope in the result of the elections in 1948. The 1948 elections brought not only Truman’s victory but also Democratic majorities in both houses of Congress. Advocates for public health insurance felt that they had a “green light” from voters. “Political events in 1948 gave some reason to believe that at long last the need for a more adequate and integrated Social Security system was coming to be recognized,” Altmeyer wrote, “President Truman made the action of the Republican Congress...the major issue in his campaign, along with his continued advocacy of a National Health Insurance System. Therefore, his election, and the election of a Democratic Congress, constituted something of a mandate for Social Security Legislation.”69

In sum, wartime solidarity sentiment encouraged reformers to propose more centralized and extended version of public health insurance. Furthermore, Truman continued this effort after the war. Now the result of the elections in 1948 offered a hope for reformers to achieve their goal. By these transformations, the AMA saw a very different political circumstance in the late 1940s from in the prewar period. In response to more hostile proposals by reformers, the AMA began to aggressively promote private health insurance as an alternative to public health insurance.

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4.3 The AMA’s New Strategy to Promote Private Plans

According to the AMA’s view in the 1920s and the early 1930s, any health insurance, whether public or private, was the devil. By the mid-1940s, however, by seeing the development of Blue Cross and Blue Shield, the AMA realized that private health insurance was a better devil than public insurance. By the late 1940s, eventually, private health insurance became an angel to the AMA. After seeing the rapid expansion of private health insurance and the intensification of the movement for public health insurance, the AMA concluded that it would be wise for it to aggressively promote health insurance.

A turning point for the AMA was the election in 1948. Seeing the Democrats’ victory for both the White House and Congress in the 1948 election, the AMA warned its members that, “Armageddon had come” and collected an additional 25 dollars from each member for its campaign against public health insurance. The AMA hired the public relations firm Whitaker and Baxter to conduct a “national education campaign” against the WMD bill through the media, distribute pamphlets, and gain support from other organizations. Whitaker and Baxter was given a much larger budget, 1.5 million dollars in 1949, than the Committee for the Nation’s Health, a prominent group supporting public health insurance, which had a budget of $104,000. In fact, Whitaker and Baxter undertook what then was the most expensive lobbying efforts in American history.

Whitaker and Baxter distributed one million copies of a pamphlet entitled “Compulsory Health Insurance—Political Medicine—Is Bad Medicine for America!” which were placed in physicians waiting rooms across the country. More importantly, Whitaker and Baxter instructed the AMA to advance the promotion of private health insurance as an alternative to public health insurance.

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70 Starr, The Social Transformation of American Medicine, 284.
71 Social Security Administration, “Social Security History.” The endorsements came from no fewer than 1,829 organizations, including the Chamber of Commerce, the American Bar Association, the American Farm Bureau Federation, the American Dental Association, the American Legion, the General Federation of Women’s Clubs, and others. The Catholic Church also reversed its long-term support for public health insurance to that of opposition.
72 Poen, Harry S. Truman Versus the Medical Lobby, 152; Starr, The Social Transformation of American Medicine, 286.
73 Poen, Harry S. Truman Versus the Medical Lobby, 145.
Whitaker and Baxter had worked for the California Medical Association when Governor Earl Warren proposed the introduction of a state-wide compulsory health insurance program in 1945. Whitaker and Baxter suggested to the CMA the promotion of private health insurance by claiming, “You can’t beat something with nothing.” They made the same advice to the AMA. In February 1949, they wrote to the AMA that, “We want everybody in the health insurance field selling insurance as he never sold before.” Whitaker and Baxter concluded, “If we can get ten million more people insured (privately) in the next year and ten million more in the next year, the threat of socialized medicine in this country will be over.”

Meanwhile as the AMA decided to aggressively push for private health insurance, the AMA made sure that private health insurance which was out of the Blue Shield network would not threaten private practitioners. Otherwise, as it had learned from the past, private health insurance might lower doctors’ fees. Doctors lobbied the state legislatures to grant regulatory powers to supervise private health insurance through state departments of insurance, with which medical associations often had close ties. By 1950, almost all the states had passed such legislation.

Now the AMA consolidated its strategy to promote private health insurance as an alternative to universal public health insurance.

5. Conclusion

This paper demonstrates the AMA’s strategy to health insurance is more complex than a common belief that the AMA has stubbornly opposed public health insurance. From the 1910s to 1940s, the AMA drastically swung its stance on health insurance: from favoring public insurance, to supporting neither, to promoting private. The AMA’s motive to increases its members’ finance largely influenced its strategic transformations. When the nature of private health insurance and the government’s proposals for public health insurance changed, the

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74 As quoted in Starr, The Social Transformation of American Medicine, 282.
75 Hacker, The Divided Welfare State, 228.
76 As quoted in Hacker, The Divided Welfare State, 228.
77 Anderson, Health Services in the United States, 126.
AMA amended its attitude toward health insurance.

This paper will develop into two directions. One is to further investigate why the AMA changed its policy preferences. One might ask whether the AMA’s opinion was always monolithic. The answer is, No. There were conflicts between the AMA and the regional medical societies and between progressive and conservative leaders in the AMA. Another also might ask what kind of role ideology played in the AMA’s strategic changes. In fact, many of the AMA’s claims against public health insurance were connected with the American traditional ideas, such as liberalism and individualism. I would like to study how these factors together with economic factors influenced the AMA’s strategic decisions. The other direction is to study how the AMA modified its strategies after the 1950s. This article demonstrates that one has to go beyond a dichotomous perspective — whether the AMA supports or opposes reform proposals — and to study what kind of stakes the AMA sees in reform proposals and private health insurance. Through such a study, we can see how serious the AMA has supported or opposed health insurance reform proposals and the basis for their decision-making. My next projects will be to investigate how the AMA reacted to proposals for Medicare and Medicaid in 1965, Bill Clinton’s health care reform in 1993, and a proposal of the next president who will be elected in 2008.
Public, Private, or Neither? Strategic Choices by the American Medical Association Toward Health Insurance from the 1910s to 1940s

Takakazu YAMAGISHI

Abstract

The American Medical Association (AMA) is often described as a defender of private provision of health insurance and an enemy to public health insurance. In contrast to this image, the AMA has neither always opposed public health insurance nor supported private health insurance. This paper shows how the AMA drastically changed its position toward public and private health insurance from the 1910s to 1940s: from supporting public, to supporting neither, and to supporting private. This paper also investigates why the AMA did so. I pay a special attention to the AMA’s response to private health insurance and the government’s proposals for public health insurance in order to control doctors’ fees. This study makes one rethink how interest groups make policy preferences.