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THE POLITICIZATION OF PERSONAL HEALTH SERVICES

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ABSTRACT

The politicization of personal health services is the process by which concerns about medical care and health services are transformed into political issues, policies, and programs. The study of that subject thus deals with the scope, scale, and effects of the government activities in the health industry.

Since World War II there have been vast changes in the demand, supply, and price of health services. In discussing how "industry" changes become politicized, we have emphasized three arenas of political conflict: (1) substantive conflict over the proper role of the government in the redistribution of personal health services; (2) the administration and financing of government health programs; and (3) questions dealing with the supply of health care services and the social costs and benefits of current health care practice.

Two arguments are advanced about these politicized issue areas. One is that their health component does not make for a common "health politics." That is, features other than the substantive problem area determine the character of political conflict in each type: the likely parties in conflict, the style of the contest, the governmental organizations likely to be concerned. Using Lowi's typology, we distinguished typical patterns of distributive, redistributive, and regulative conflict in health matters. Those distinctions supported the more general argument that no single set of political factors affect what economists call the health industry, no single process of politicization takes place, and there exists no simple formula for linking substantive "health problems" with health political processes. The second argument is that different types of health care political issues are most easily understood through distinguishable analytic schemes. The argument that there are various kinds of health care politics is extended to the view that regulatory, distributive, and redistributive issues are analyzable (with different assets and liabilities) from at least three distinguishable perspectives. Three frameworks of analysis are introduced (the problem-solving, the organizational process, and the bureaucratic bargaining) and illustrations of their impact on the analysis of health care politics presented.

THE POLITICIZATION OF PERSONAL HEALTH SERVICES

Introduction

The topic of this paper is not as obvious as may be assumed by defining both personal health services and politicization. Most of us have a satisfactory working definition for personal health services: we use them. In current parlance "politicization" is identified with public arousal, intensification of group conflict, and increased governmental activity in a policy area.

The combined topic--the politicization of personal health services--requires further definition. In this paper, personal health services refer to those aspects of medical care which are provided directly to patients--hospital services, physician services, drugs, nursing care, and the means required to produce those services. The politicization of personal health services deals with three aspects of the political process affecting medical care services. First is the arousal of concern by various publics over the distribution, financing, and organization of those medical care services. Second is the change in the government's role in the medical care industry. Third is the conflict generated by the government's exercising of its role.

It might be useful here to distinguish between concerns about health care and demands for political change in the health care industry. Concern is the awareness by population groups that something is wrong with the current state of medical affairs. It becomes a political issue with the articulation of claims on the state to change some of the objects of concern. It should be

obvious to students of medical politics that the process of moving from concerns to medical-politics issues is not straight forward, nor is it predictable on the basis of any simple model of political responsiveness to changes in the environment.

The first section of this paper characterizes the changes in the medical care industry since the Second World War and the governmental responses to those changes--adjustments in demand, supply, and price as they affect the distribution, financing, and organization of medical care. The second part deals more specifically with the politics of government involvement in medical care. Attention will b paid to the conditions under which the arousal of demand generates new public commitments such as the Kerr-Mills Act of 1960 or the Medicare Act of 1965. In addition, we we will investigate some topics in the politics of health administration, and the conflict over features of the medical care system which government programs deal with in the course of their implementation, for example, the rising costs of hospital and physician care after 1965.

Changes in the Medical Care Industry and Governmental Responses

Changes that have taken place in the American medical care industry since the Second World War cannot be used as simple indicators of political response. Governmental recognition of a social problem does not insure its successful solution, as is evident in the experience of the War on Poverty during the past four to five years. On the other hand, it is clear that since the war, questions concerning the performance of the medical care industry and the relationship of the government to that industry have become

topics of public discussion and have spurred interest group activity and a substantial growth in governmental health expenditures. At the same time significant changes have been taking place within the medical care industry itself. It is to the latter topic that we will now turn.

A. demand

One useful way of representing the industry's changes is by discussing the shifts in demand, supply, and cost of personal medical care services. Several indicators clearly show that the effective demand for medical care services has increased dramatically since World War II. Indices of family expenditures for health care, overall national health expenditures, national health expenditures as a proportion of the GNP and changes in expenditures in real terms all point in this direction.

Family expenditures for health care (measured in constant prices) have more than doubled since 1945. Moreover, the rate of increase is accelerating. From 1950-1960 the rate of increase was 8.2 percent and between 1960 and 1965, it was an increase of 9.4 percent. In the one year, 1965-1966 the rate of increase was a startling 11.1 percent.[1]

Since World War II, there has been an extraordinary rise in overall medical care expenditures, with a twelve fold increase of 4 billion dollars in 1940 to 50 billion in 1968 (Table I). Not all of these increases in expenditures, however, can be attributed to increased utilization. Price increases, as best determined, accounted for 46 percent, population increases accounted for 18 percent, and increased utilization for 35 percent.[2]

As is evident from Table I, the proportion of GNP spent on health care has also risen, from 4 percent in 1940 to 6.3 percent in 1968. Taking into account that the GNP has also been increasing during this period, the growth in medical care expenditures represents a four-fold increase in real terms.

TABLE I

Amount and Percent of GNP for Health Expenditures, Selected Years, 1940-1968

Year	*Amount*	*Percent of GNP*
1940	4 billion	4
1950	13 billion	4.5
1960	27 billion	5.4
1968	50 billion	6.3

Source: Anne Sommers, *Total Financing of Health Care: Past, Present, and Future*, Unpublished Paper, 1968.

Within the health care industry, there have been changes in the amounts and proportions of GNP spent for various types of medical care services, as can be seen from Table II. In the period from 1950-1966, the area of personal health services experienced the most striking increases. Expenditures for hospital care rose from 4 million to 15.5 million. Amounts spent for physicians' services rose from 2.7 million to 9.3 million.[3] Thus the larger the expenditures for medical care represent an increased demand for services more than an across the board inflation in the price of all goods and services.

Since the Second World War period there have not only been striking increases in the amounts and percentages spent on health services, but alterations in the means of financing medical care. By 1968, approximately 70 percent of all Americans had some form of

Table II

Amount and Percentage Distribution of National Health Expenditures by Type of Expenditure, Selected Years, 1950-66

Type of expenditure	1950	1955	1960	1961	1962	1963	1964	1965	1966
	Amount (in millions)								
Total	$12,867	$18,036	$26,973	$28,887	$31,404	$33,629	$37,549	$40,893	$45,421
Health services and supplies	11,910	17,099	25,263	26,869	28,966	30,989	34,463	37,511	41,834
Hospital care	3,845	5,929	9,044	9,869	10,598	11,642	12,621	13,807	15,429
Federal facilities	728	902	1,221	1,358	1,432	1,480	1,535	1,600	1,673
State and local facilities	1,175	1,911	2,827	3,066	3,252	3,541	3,827	4,099	4,453
Nongovernmental facilities	1,942	3,116	4,996	5,445	5,913	6,621	7,259	8,107	9,303
Physicians' services	2,755	3,680	5,684	5,895	6,498	6,891	8,065	8,745	9,392
Dentists' services	975	1,525	1,977	2,067	2,234	2,277	2,648	2,808	3,015
Other professional services	395	559	862	882	902	921	940	960	986
Drugs and drug sundries	1,730	2,385	3,657	3,824	4,095	4,235	4,446	4,813	5,235
Eyeglasses and appliances	490	597	776	804	908	952	1,072	1,223	1,394
Nursing-home care	142	222	526	606	695	891	1,214	1,324	1,502
Expenses for prepayment and administration	300	614	863	997	1,088	1,097	1,176	1,298	1,629
Government public health activities	361	377	412	451	503	538	608	696	810
Other health services	917	1,211	1,462	1,474	1,445	1,545	1,673	1,837	2,242
Research and medical-facilities construction	957	937	1,710	2,018	2,438	2,640	3,086	3,382	3,587
Research	117	216	662	844	1,032	1,184	1,324	1,470	1,632
Construction	840	721	1,048	1,174	1,406	1,456	1,762	1,912	1,955
Publicly owned	496	370	443	403	421	426	471	521	508
Privately owned	344	351	605	771	985	1,030	1,291	1,391	1,447
	Percentage distribution								
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Health services and supplies	92.6	94.8	93.7	93.0	92.2	92.1	91.8	91.7	92.1
Hospital care	29.9	32.9	33.5	34.2	33.7	34.6	33.6	33.8	34.0
Federal facilities	5.7	5.0	4.5	4.7	4.6	4.4	4.1	3.9	3.7
State and local facilities	9.1	10.6	10.5	10.6	10.4	10.5	10.2	10.0	9.8
Nongovernmental facilities	15.1	17.3	18.5	18.8	18.8	19.7	19.3	19.8	20.5
Physicians' services	21.4	20.4	21.1	20.4	20.7	20.5	21.5	21.4	20.7
Dentists' services	7.6	8.4	7.3	7.2	7.1	6.8	7.1	6.9	6.6
Other professional services	3.1	3.1	3.2	3.1	2.9	2.7	2.5	2.3	2.2
Drugs and drug sundries	13.4	13.2	13.6	13.2	13.0	12.6	11.8	11.8	11.5
Eyeglasses and appliances	3.8	3.3	2.9	2.8	2.9	2.8	2.9	3.0	3.5
Nursing-home care	1.1	1.2	2.0	2.1	2.2	2.6	3.2	3.2	3.3
Expenses for prepayment and administration	2.3	3.4	3.2	3.5	3.5	3.3	3.1	3.2	3.6
Government public health activities	2.8	2.1	1.5	1.6	1.6	1.6	1.6	1.7	1.8
Other health services	7.1	6.7	5.4	5.1	4.6	4.6	4.5	4.5	4.9
Research and medical-facilities construction	7.4	5.2	6.3	7.0	7.8	7.9	8.2	8.3	7.9
Research	.9	1.2	2.5	2.9	3.3	3.5	3.5	3.6	3.6
Construction	6.5	4.0	3.9	4.1	4.5	4.3	4.7	4.7	4.3
Publicly owned	3.9	2.1	1.6	1.4	1.3	1.3	1.3	1.3	1.1
Privately owned	2.7	1.9	2.2	2.7	3.1	3.1	3.4	3.4	3.2
Total expenditures as a percent of gross national product	4.5	4.5	5.4	5.6	5.6	5.7	6.0	6.0	6.1

Source: Dorothy P. Rice and Barbara S. Cooper, "National Health Expenditures, 1950-66," *Social Security Bulletin*, U.S. Department of Health, Education, and Welfare, April, 1968, p. 14.

health insurance; only 10 percent had health insurance in 1940.[4] In assessing the alterations in the means of financing health care, caution should be exercised on two points. The first has to do with the role of private insurance and the second with the changes in private and public expenditures for health care.

Despite the fact that private consumers still account for two-thirds of all health care expenditures, the proportion of total expenditures paid for by insurance remains relatively low. About 25 percent of personal health care expenditures in 1965 were financed by insurance; this proportion has declined since then to about 23 percent. Furthermore, the distribution of that insurance coverage is strikingly uneven. In 1966 about four-fifths of the population under 65 had some insurance: 85 percent for hospital care, 78 percent for surgery, 63 percent for in-hospital medical visits, and 2 percent for dental care. Forty percent had insurance covering physician care in offices, and 36 percent for out of hospital drugs. As Lewis Reed has clearly stated, "In any one year, only a small proportion of covered persons would have any part of their expenses for these items covered."[5]

Second, although the ratio of private to public health expenditures has remained relatively stable, the ratio of federal to local government expenditures has altered. From Table III we see that between 1960 and 1966 private consumer expenditures decreased from 75.4 percent to 71.6 percent of total expenditures. Throughout this period, philanthropy accounted for only about 3 percent of total expenditures. Public authorities at all levels increased their relative expenditures from 24.6 to 28.4 percent. Within the public

Table III

Percentage Distribution of National Health Expenditures by Source of Funds and Type of Expenditures 1960-66

Source of funds	Total	Health services	Research	Construction
1966, total	100.0	100.0	100.0	100.0
Private	71.6	74.4	10.5	63.3
Consumers	66.2	71.9		
Philanthropy	3.2	1.6	10.5	31.7
Other	2.1	.8		31.7
Public	28.4	25.6	89.5	36.7
Federal	16.0	13.2	85.6	18.5
State and local	12.4	12.4	3.9	18.2
1965, total	100.0	100.0	100.0	100.0
Private	75.1	77.9	11.3	67.7
Consumers	69.1	75.3		
Philanthropy	3.5	1.7	11.3	33.8
Other	2.4	.9		33.8
Public	24.9	22.1	88.7	32.3
Federal	12.4	9.4	84.8	16.0
State and local	12.5	12.7	3.9	16.3
1964, total	100.0	100.0	100.0	100.0
Private	75.3	78.1	11.9	68.0
Consumers	69.2	75.4		
Philanthropy	3.7	1.8	11.9	34.0
Other	2.5	.9		34.0
Public	24.7	21.9	88.1	32.0
Federal	12.2	9.1	84.1	16.9
State and local	12.7	12.7	3.9	15.1
1963, total	100.0	100.0	100.0	100.0
Private	74.6	77.5	12.8	62.6
Consumers	68.7	74.5		
Philanthropy	3.6	1.9	12.8	31.3
Other	2.3	1.0		31.3
Public	25.4	22.5	87.2	37.4
Federal	12.5	9.5	83.3	19.1
State and local	12.9	13.0	4.1	18.3
1962, total	100.0	100.0	100.0	100.0
Private	74.8	77.6	13.7	61.5
Consumers	68.9	74.6		
Philanthropy	3.6	1.9	13.7	30.7
Other	2.3	1.0		30.8
Public	25.2	22.4	86.4	38.5
Federal	12.3	9.5	82.4	18.1
State and local	13.0	12.9	4.0	20.4
1961, total	100.0	100.0	100.0	100.0
Private	74.8	77.5	15.6	55.9
Consumers	69.3	74.5		
Philanthropy	3.4	2.0	15.6	27.9
Other	2.1	1.1		27.9
Public	25.2	22.5	84.4	44.1
Federal	11.8	9.3	80.3	21.1
State and local	13.4	13.2	4.0	23.0
1960, total	100.0	100.0	100.0	100.0
Private	75.4	77.9	18.9	51.1
Consumers	70.1	74.9		
Philanthropy	3.3	2.0	18.9	25.6
Other	2.0	1.1		25.6
Public	24.6	22.1	81.3	48.9
Federal	11.2	8.9	77.2	23.3
State and local	13.4	13.2	3.9	25.6

Source: Dorothy P. Rice and Barbara S. Cooper, "National Health Expenditures, 1950-66," *Social Security Bulletin*, U.S. Department of Health, Education, and Welfare, April, 1968, p. 7.

sector, however, the state and local share declined from 13.4 to 12.4 percent and the federal share increased from 11.2 to 16.0 percent.

Having pointed out the marked increases in government expenditures for health care and the fact that private consumers still account for two-thirds of all health care expenditures, it is worth noting the changing composition of the government investment in health care. In the late 1940's almost all government expenditures were for hospital construction, research expenses, and government employee and veteran's health care programs.[6] In the intervening quarter century two major shifts have occurred: the advent of medical assistance in 1960, and of Medicare in 1965. These two types of programs alone largely account for the increase of federal health expenditures in the period 1960-1965, from 11.2 percent to 16.0 percent. In the first year of Medicare (July, 1966-July, 1967), health insurance benefits of 2.5 billion dollars (largely hospital care) and physician benefits of 669 million dollars were dispersed. These expenditures are only one part of the portrait of the federal government's increased involvement in the medical care industry. Nearly 7,000 participating hospitals, almost 2,500 independent laboratories and slightly more than 2,000 home health agencies are included in the Medicare program. Involvement of the health insurance industry includes, for example, thirty-three Blue Shield plants and fifteen insurance companies which take on the major burden of distributing payments under Medicare's part B program alone.[7]

B. supply

There have been increases in both medical care facilities and medical care personnel, with the former greatly outpacing the latter, especially when viewed in terms of effective supply.

The largest portion of national health expenditures is for hospital care. The non-federal short-term hospitals account for the largest proportion of all hospital admissions, employees, and total hospital expenditures. From 1950 to 1965, the number of short-term hospitals, the number of hospital beds, and the number of admissions were all rising. The number of hospital beds alone increased from 505,000 to 741,000. Expressed in terms of beds per thousand population, this represents an increase of approximately 15 percent. The significant factor here is the relationship of supply expansion to total population growth. With a population increase of 27 percent as contrasted to a 47 percent increase in the number of hospital beds, it is clear that the number of short-term hospital beds has been increasing at a far greater pace than the nation's population.[8]

The per capita use of hospitals has also increased substantially. In-patient admissions per thousand rose 25 percent to a 1965 high of 137.9 as compared to 110.5 in 1950. Patient days per thousand population increased 19 percent, from 900 to 1071. Using the occupancy rate of hospital beds as an indicator of the adequacy of the supply, the fact that well under 80 percent of hospital beds are actually in use indicates that the overall supply has kept up with the demand.[9]

The supply of doctors and nurses has lagged behind the significant

increases in hospital facilities. In determining the adequacy of manpower supply, two factors, in addition to the physician-population ratio, must be taken into account: nonclinical activities and technological advances.

Although the number of physicians relative to the population has not changed significantly in the last few decades, an increasing part of the total medical work force is involved in nonclinical activities such as research and administration. In addition, since 1959 there has been an increased per capita demand for medical services, resulting from larger than anticipated rises in incomes and education, and the establishment of Medicare, Medicaid, and other public health programs. The combined effect of these two factors has resulted in a lower effective supply of physicians than otherwise would be expected.

In assessing the changes in the supply of physicians, the increases in physician productivity must be taken into consideration. While 30 years ago the average doctor saw 50 patients a week, in 1965 the average doctor 124 patients a week. This trend, associated with managerial and technological improvements, now appears to have reached a peak. Greater productivity does not seem to be offsetting the increasing effective demand for physicians' services.[10]

One indicator of shortage in the supply of physicians' services has been set forth by Elton Rayack. A shortage is said to exist when the quantity of physicians' services supplied increases less rapidly than the quantity demanded at incomes received by physicians in the recent past. Not only will the relative income of physicians rise, but there will be attempts to substitute less costly services for the

services of physicians. There has been a striking increase in the incomes of physicians since 1939, both in absolute terms and when compared to the increase in incomes of other occupational groups. Between 1947 and 1964, physicians' incomes rose 225 percent. The percentage rise in doctors' incomes was 72 percent greater than that for full-time employees in all industries. These marked relative increases in income hold for general practitioners as well as for specialists.[11]

The substitution for physicians' services with the services of cheaper personnel having less training and experience also indicates a shortage in the supply of doctors. The increasing numbers of internships and residencies offered, the increasing financial remuneration for such services, and the increasing number of foreign medical personal employed in the U.S. hospitals all document the search for substitutes for physicians' services.

Another change affecting the supply of doctors is the increasing emphasis placed on specialization of physicians. From 1940 to 1963, the ratio of full-time specialists to general practitioners has reversed itself. As a percent of total physicians in private practice, full-time specialists in 1940 accounted for 23.5 percent and general practitioners for 76.5 percent. By 1963, specialists constituted 61.8 percent and general practitioners 39.2 percent.[12]

In the nursing profession, a pattern emerges similar to that found in the supply of physicians, i.e., an increase in the overall number of practitioners with a much lower rise in the effective supply. There has been a striking increase in the number of nurses--from 82,000 in 1941 to 382,000 in 1964. But in assessing this increase

we should bear in mind, 1) the substitution of other personnel to do some of the work of RN's and 2) the decreased productivity of the nursing service when measured in terms of beds or number of patients served.

C. cost

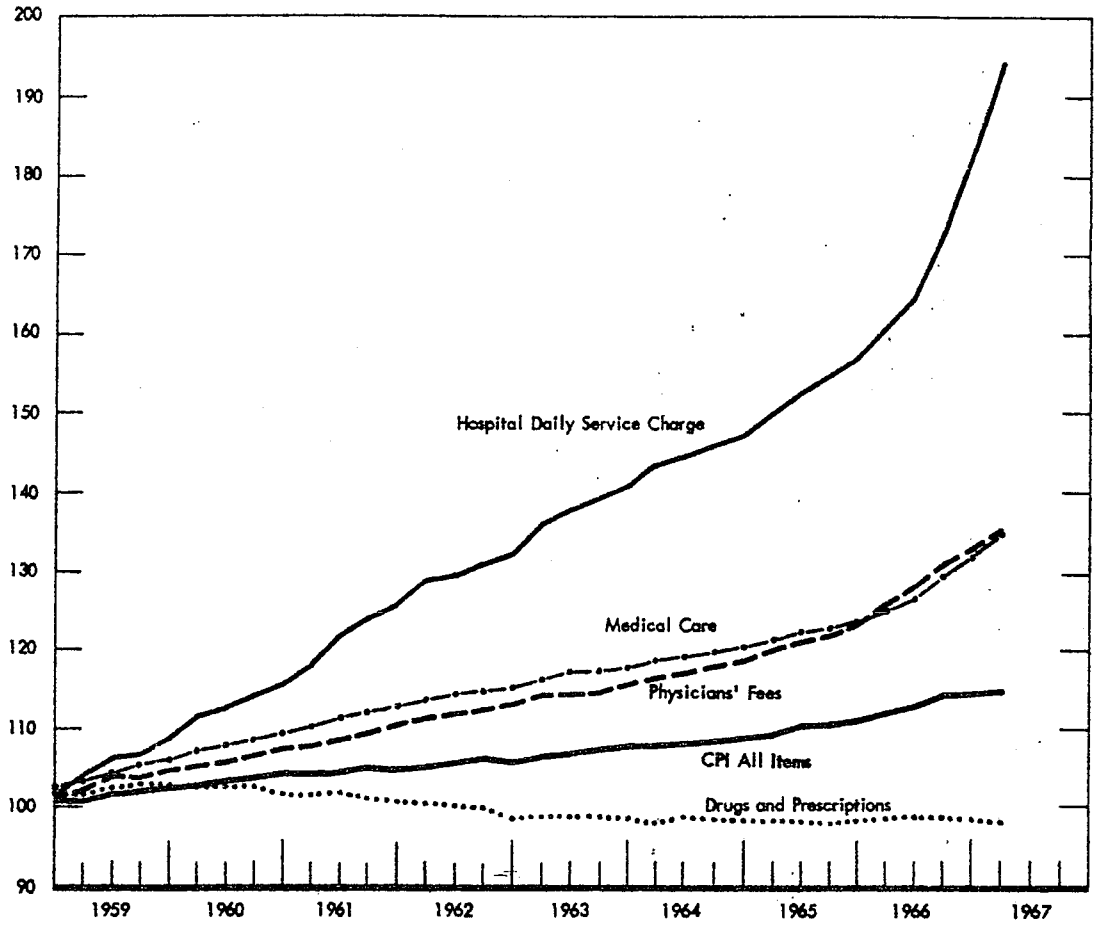
Though the cost of medical care services might be described as spiralling, any evaluation of these increases must necessarily take into account price increases of other goods and services. We will use the Consumer Price Index and its medical care components as indicators of relative change in health care prices. More specifically, we will discuss the following three topics: overall increases in medical care prices, increases in the cost of medical care services, and the differential increases within the medical care industry.

Both the Consumer Price Index and its medical care component have been continuously rising. That the latter has outpaced the former is clearly evident from Chart I, which illustrates the trends of the various components from 1959 to 1967. Since World War II, medical care prices increased 110 percent, while the CPI increased 66 percent. It should be noted that in general, the price of all services has risen faster than that of commodities. A comparison of medical care services and services in general shows the former rising at a faster rate. While the price for all services increased by 95 percent from 1946 to 1966, the price of medical care services increased by 129 percent.[13]

Within the medical care industry, hospital daily service charges have experienced the most dramatic increases. Table IV presents the percentage increases for all consumer prices, all medical

CHART I

Quarterly Index of Consumer and Medical Care Prices, 1959-67



Source: Dorothy P. Rice and Loucele A. Horowitz, "Trends in Medical Care Prices," *Social Security Bulletin*, U.S. Department of Health, Education, and Welfare, July, 1967, p. 16.

care prices, hospital daily service charges, and physicians' fees since World War II. Hospital daily service charges increased by an

TABLE IV

Percentage Increases in Consumer Price Index and Medical Care Components, 1946-66

Item	*Percentage Increase from 1946-66*
Hospital daily service charges	354%
All consumer prices	66%
All medical care prices	110%
Physicians' fees	94%

Source: Dorothy P. Rice and Loucele A. Horowitz "Trends in Medical Care Prices," U.S. Department of Health, Education, and Welfare, *Social Security Bulletin*, July, 1967, p. 20.

extraordinary 354 percent, more than five times the rate of increase in the CPI, more than three times the rate of increase in all medical care prices, and nearly four times the increase in the rate of physicians' fees.

The annual rates of increase further demonstrate the changes in hospital daily service charges. From 1946 to 1960, the annual rate of increase was 8.3 percent. From 1960 to 1965, the annual rate of increase was 6.3 percent, signifying a general deacceleration in the upward price trend. In 1966, however, this trend was sharply reversed, both in terms of the hospital daily service charges and other hospital service charges included in the CPI. Hospital daily service charges increased by 16.5 percent from December, 1965 to December, 1966; operating room charges increased by 9.3 percent as compared to a 5.9 percent increase in the previous year, and the rise in prices for X-ray diagnostic series was nearly five times the 1.5 rate of increase in 1965.[14]

Physicians' fees followed the same general trends as those for hospital daily service charges. While these fees have more than doubled in the past two decades, in 1966 the rate of increase rapidly accelerated. In that year almost one-third of physicians in all regions of the nation increased their fees for office visits, with the increase averaging approximately 23 percent. The index of physician's fees for December, 1966 was 7.8 percent higher than the December, 1965 figure--more than twice the rate of increase during the previous year and more than twice the rate of increase for all items in the CPI. It should be noted, however, that there have been variations in the level of price increases among the different types of physicians and for different types of procedures. From December, 1965 to December, 1966, family doctor office and house visits increased by 24.0 and 25.0 percent respectively; fees for in-hospital surgical procedures increased by 12.7 percent and in-hospital medical care procedures by 19.8 percent.[15]

In summary, since World War II there have been vast increases in the demand, supply, and price of medical care. The increases in national expenditures for health care services indicate the rise of effective demand. The rapid growth of non-federal short-term hospitals and, though less drastic, the increase in medical manpower personnel show a substantial growth of supply. And with hospital daily service charges and physicians fees experiencing the greatest acceleration, the price of medical care has risen dramatically.

The Politics of Government Involvement in Medical care

The politicization of personal health services is the process of transforming concerns about medical care and health services into

political issues, policies, programs and new demands. It involves an aroused concern over two aspects of the health industry: 1) the organization, distribution, and financing of medical care services and 2) the effects of federal health care programs on the medical care industry. The politics of health services thus deals with the scope, scale, and effects of the government's role in the health industry.[16]

Viewing the politicization of personal health services in this way makes explicit the contention that there is no single pattern for substantive health concerns becoming political issues. One may reasonably ask which areas of health concern become politicized. Is it the most important or least important concerns which typically reach the political arena? Are there some that never become politicized, and if so, which ones?

Three broad concerns about health care services can be distinguished. The first involves substantive conflict over the proper role of the government in the redistribution and financing of personal health services. The second deals with the administration and financing of government health programs. The third involves questions dealing with the supply of health care services and the social costs and benefits of health care.

Since the Second World War, most of these concerns have become politicized. Should the government enact national health insurance, who should receive the benefits of governmental health programs, how should those programs be administered and financed, and what will be the effects of those programs on the costs of hospital and physician services have all been questions that have been widely publicized by the mass media, aroused activity in interest groups, and provoked

congressional debate and action. The one area that has received the least attention in the political arena is the social (as opposed to program) costs[17] of particular forms of government involvement in health.

The form taken by a health concern and the political process by which the issue is handled constitutes another dimension of the politicization process. Lowi has classified issues as to whether they are principally distributive, regulative, or redistributive. While in the long run all governmental policies may be considered redistributive, in the short run certain kinds of government decisions can be made without regard to redistribution of limited resources. Similarly, while all government policies involve some type of regulation, not all policies are primarily regulative. Distributive policies are those "characterized by the ease with which they can be disaggregated and dispensed unit by small unit, each unit more or less in isolation from other units and from any general rule."[18] They involve individualized decisions and do not polarize individuals or groups into a class of winners and a class of losers. Regulatory policies are also specific and individual, but their impact cannot be isolated to the same degree as distributive policies. On the whole, the "impact of regulatory decisions is clearly one of directly raising costs and/or reducing or expanding the alternatives of private individuals."[19] They involve a determination of the indulged and the deprived and are usually "disaggregable only down to the sector level."[20] Redistributive policies involve much broader categories in their impact, categories approaching "social classes." "The aim is not use of property but property itself, not

equal treatment but equal possession....The nature of a redistributive issue is not determined by the outcomes of a battle over how redistributive a policy is going to be. Expectations about what it can be, what it threatens to be, are determinative."[21]

These classifications aid in demonstrating how the three "health policy" areas mentioned previously assume quite different forms of politicization. While government's involvement in financing medical care services may be a redistributive issue, the supply of medical care facilities and services directly affects subgroups of the population and most typically appears as a distributive issue. Financing and administrative questions usually arise as regulatory issues since they most directly concern specified producer and consumer groups and directly influence their costs and available alternatives.[22]

A. the proper role of government in health care

The distribution of health care services first became a political issue in the U.S. in the early twentieth century. The dispute was centered around the proper role of the federal and state governments in redistribution and financing of personal health care services.[23] The case of Medicare illustrates the origins of this type of issue, the nature of such a dispute, and the political process by which redistributive issues are typically resolved.

Concern over personal health care services was aroused in the early 1900's. During the period 1910 to 1920, the American Association for Labor Legislation made a concerted effort to get model health insurance bills through several state legislatures. Once concrete proposals had been formulated, critics began voicing their objections; the American Medical Association, by 1920, was opposed to any compulsory

medical insurance plan.

Health insurance had now reached its first stage of politicization--the arousal of social concern. Reacting to the introduction of health insurance bills in state legislatures, the American Medical Association organized labor, and insurance companies created special committees to investigate the issues and make proposals for resolving them. In the mid-twenties the Committee on the Costs of Medical Care emerged to study the structure of American medicine, and while the research was being conducted, there ensued a period of watchful waiting.

In the early 1930's, groups within the federal government renewed interest in government health insurance, claiming access to medical care as a basic human right. Although it was agreed that problems in the accessibility of care existed, controversy arose over the nature of the solution. Would there be reliance on private or public insurance? Who were to be the beneficiaries? What type of financing mechanisms should be employed? What should be the actual benefits?[24] After the National Health Conference in 1938, compulsory health insurance was no longer an issue confined to a state, but became nationwide in scope. Various groups throughout the country grew interested in the problem, issued position statements and thus heightened the already intense ideological debate.

The whole issue of government involvement in personal health care was to take a form typical of American social welfare policy in general. The broad-based, comprehensive health care plan that was first introduced by President Truman in the late 1940's and early 1950's was transformed by a set of government elites who defined the terms of the debate and responded to presumed political objections.

Health insurance policy largely followed Lowi's redistributive type, involving broad categories of persons who would be materially affected. The political issue was posed by government elites selecting among potential courses of action and then seeking a broad consensus to get past legislative obstacles.

A comparison of different approaches to government health care in social insurance and public welfare may help to illustrate both the background of the Medicare debate and the persistent, divergent approaches to the problems of social welfare in American politics.

Social security programs seek partial solutions to commonly recognized problems through a regressive financing mechanism. Equal tax rates are paid by all contributors irrespective of level of income, with the result that lower income workers pay a larger proportion of their income in social security taxes than do higher paid workers. Beneficiaries are selected not through tests of destitution, but by tests of presumptive need: the orphaned, the widowed, disabled, and aged are presumed to be in need of assistance. Contribution to the social security system thus entails automatic payments of benefits to all those who fall into recognized circumstances of risk, regardless of current income.

The welfare approach is aimed at the needs of the impoverished and disadvantaged whose inadequate savings and insurance cannot protect them against unfortunate contingencies. Private, local, state, and federal "charity" programs are to provide the appropriate remedies. Levels of payment under these programs are determined individually by measuring the gap between the financial resources and the needs of the potential beneficiary. Government welfare

programs rely on general revenue funding, providing a more progressive tax base than that of social security. Under the welfare approach, federal action is viewed as the least desirable, last gasp means to solve social welfare and health care problems.

The nature of the disputes over beneficiaries, benefit scope, financing, and administration has been clarified by Lawrence Friedman in his distinction between "middle class social welfare programs" and "charity programs."[25] Figure I sets forth these distinctions around which the Medicare debate focused.

FIGURE I

Middle Class Social Welfare Programs

Beneficiaries	Broad demographic unit; not selected by means test
Benefits	Earned as of right
Financing	Regressive, ear-marked taxes such as Social Security
Administrative arrangements	Centralized, non-discretionary, clerk-like with highly developed and explicit rules of entitlement

Charity Programs

Beneficiaries	"Needy" persons selected by means test
Benefits	Not earned, but granted
Financing	General revenues (not ear-marked)
Administrative arrangements	Discretionary, decentralized

The scope of the public debate that followed illustrated Lowi's view of redistributive policy issues as "ideological conflict" in a "class war." The pressure group alignment was strikingly similar to

that on other controversial social welfare policies like federal aid to education and disability insurance. The extreme ideological polarization promoted by these groups remained remarkably stable despite significant changes in the actual subjects of the dispute, with debates rarely progressing beyond discussions of first principles, and denunciations of collectivism and socialism. Yet the politization of medical care also follows the pattern of public power political processes, and illustrates the wider scope of the generalizations made by Wildavsky about that pattern.[26] The polarization of the AMA and AFL-CIO dominated factions divided the active participants into two well-defined camps with opposing views. The disinclination to listen to the other side, the over-simplifications and suspicions, the expenditure of large parts of their resources in order to secure a favorable outcome all marked the sharp ideological cleavage. The development of professional bureaucracies with full-time staffs who make a career out of fighting a particular issue--a defining feature of ideological politics--took place with the symbolic prominence of Wilbur Cohen,[27] joined by Social Security experts, the staff of the AFL-CIO and Senior Citizen Clubs on one side, and the AMA, Chamber of Commerce, the American Hospital Association and the American Farm Bureau staff on the other side. One can turn to the committee hearings, newspaper accounts, and records of interest group activity to see that 1) a small group of people dominated the discussion, 2) prepared responses were ready for the next round of attacks on both sides, and 3) friends and foes were clearly and stably defined.

Redistributive policies[28] also centralize and stabilize conflict

in American politics.[29] The stability of the contestants in the Medicare debate and the debate itself have already been outlined. Throughout the battle, the Department of Health, Education, and Welfare was the central agency of bill-drafting and planning. Extensive debate took place in Congress, but the bill Congress enacted was in large measure the Administration's proposal. As Lowi says generally of redistributive issues, "the effort to anticipate conflicting demands and build into legislative proposals mollifying features, [is] in the hands of the central government's bureaucracy."[30]

In order to understand the politicization of health care issues which, like Medicare, focus on the government's redistributive role, one ought to ask what conceptual framework is most appropriate for analyzing relationships between social problems and the political system. Is the policy outcome best characterized in terms of the model of demands flowing upward from aroused groups in the public to the legislative arena? Are policy results better understood as the outcome of a rational decision-making process? Or is there some other model that more aptly describes the process by which such a redistributive issue is resolved?[31]

Allison has distinguished three different models of analysis commonly applied to public policies: the rational problem solving, the organizational process, and the bureaucratic bargaining model.[32] In the rational problem solving model, the basic unit of analysis is national choice; the "choices and actions of the nation are viewed as means calculated to achieve national goals and purposes." In other words, "the explanation of a rational action consists of showing what goal the nation was pursuing in committing the action

and how in the light of that goal the action was the most reasonable choice." According to the organizational process model, organizations are the basic unit of analysis, with policies viewed as "outputs of organizations functioning according to standard patterns of behavior." The bureaucratic-bargaining model explains outcomes in terms of "a series of overlapping bargaining games," focusing on "the position and power of the principal players, and the understandings and misunderstandings which determine the outcome of the game." The basic unit of analysis is a bargaining game with decentralized actors.

The orgins of an issue like Medicare may conveniently be described in terms of the rational problem solving model. Health insurance problems were selectively defined, demands selectively created, and issues selectively put on the political agenda. The pattern of responses to Medicare from 1952-64 is easily assimilated to the organizational process model, as is clear from the description of the contestants in the institutionalized debate over Medicare. The outcome, Public Law (89-97), is best understood from a bargaining framework with its focus on the executive as managing conflicting claims, with some room for innovation left to Congress. The final legislative package is more fully comprehensible as "the result of compromises, coalitions, and competition among different players with quite different problems and objectives."[33]

B. the politics of administration of government health programs

How the government finances its health programs and how these programs affect the private medical sector are two important questions concerning the administration of personal health services. The issues most frequently open to these questions are medical price increases,

increases in the demand for health services, and payment methods to doctors, hospitals, and other health "firms."

Government policies on the financing and administration of public health care programs become what Lowi has termed regulatory policies. They are specific in their impact--affecting clearly differentiated producer and consumer groups: doctors, hospitals, nursing homes, and insurance companies on the one hand, and those who use medical services and facilities on the other. That the "impact of regulatory decisions is clearly one of directly raising costs and/or reducing or expanding the alternatives of private individuals," is particularly the case in the medical care industry, with substantially higher rates of increase in hospital daily service charges and physician fees since the advent of Medicare and Medicaid. The effects of government health care programs on medical consumer and producer groups demonstrate how regulatory decisions are "cumulative largely along sectoral lines."

Both the price and cost of medical care have clearly become politicized issue in the 1960's. Medical price changes are published monthly by the Department of Labor (The BLS Index). Since the advent of Medicare, the BLS index has taken on symbolic political importance, announcing each-month the price increases that, before Medicare, were less newsworthy. Price increases are associated with government program costs, and the government is criticized as the potential or real generator of increased medical prices. The result is much anxious public discussion of payment methods and their effect on the cost of medical care facilities and services in the private sector.[34]

The governmental method of paying physicians, for instance,

assumes political significance for obvious reasons. First, there has long been substantial conflict over the appropriate way of paying physicians--conflict both between the state and medical organizations and within the medical industry. Secondly, the preference for particular payment methods are intensely held, especially by physicians. Finally, decisions about payment methods have significant financial implications for both the governments and physicians involved.

To understand more fully the relationship between the financing of public medical care programs and concerns about the price inflation of medical care services, it is useful to investigate the striking price increases since 1965, the year Medicare and Medicaid were instituted. The Medicare law called for the following physician payment plan: the Social Security Administration would pay--through intermediaries--80 percent of the "reasonable" fees charged by physicians. The patient would pay the first $50 (deductible) and 20 percent of the balance (co-insurance). The three criteria of "reasonable" charges included: 1) the charge had to be the "customary" one for the service, 2) it could not be more than the prevailing rate for the service in the doctor's locality, and 3) it could not be higher than what the insurance companies would pay for similar treatment in their own medical plans. The Social Security Administration and insurance companies, however, had no effective way of determining customary fee profiles of American physicians in the fifty states. Doctors set their own prices within supposed limits and were reimbursed if fees were regarded as "reasonable" by an insurance company. The result was,

> under Medicare doctors got higher average payments--by raising their usual fees, and by charging many low-income patients higher rates than previously; they also retained a way of charging wealthy patients more than the government would reimburse--by having patients suffer the insurance company's decision that a fee was unreasonable; and doctors, for a while, got a higher percentage of paid bills--because some patients could not get reimbursed if they had not already paid their bills.[35]

By June, 1966, when the Social Security Administration outlined how reasonable charges should be determined, the operative standard for customary fees could not easily be changed. Thus the price increases brought about in 1966 affect the fees that Medicare (and private consumers) will pay American doctors in the future.

While the price of medical care services has become politicized, an intense, but narrow conflict has developed over methods of payment. Physicians and their professional organizations, the AMA most notably, are the most active extra-governmental actors in the discussions of payment methods. Furthermore, it is significant that there is more concern about the *method* of pay than the *amount* of income doctors should receive from the state. By contrast, in England the issue of the appropriate payment method and policy is closely associated with the level of physicians' incomes. In the U.S., decisions were made about the methods of payment without explicit recognition given to the likely effect of such methods on the total income American physicians will enjoy.[36] The level of doctors' incomes became important after payment methods generated unexpectedly high program costs, as occurred after the start of Medicare.

The administration of government health programs raise issues more characteristic of Lowi's regulatory policy than of either redistributive or distributive policy. While doctors are predominantly

concerned with the method of payment, the rising price of medical care (as indicated in the BLS index) is felt directly by consumers of medical services and wide-spread concern is aroused. The concern is no longer whether the government should become involved in the health care industry, but rather the nature of its involvement. That concern focuses both on increases in overall program costs and increases in the price levels of medical care services and facilities. The nature of the political conflict is changed once the issue turns to who receives tangible benefits, and sharply distinguishes administrative politics and legislative politics.

C. supply of medical care services and social costs

Distinct from the two previously mentioned types of health-political issues are conflicts over the supply of doctors, hospitals, and other health care facilities. Rather than debate on the nature of government involvement in the health care industry or on program costs and price costs in general, the politicization of supply issues turns to the impact of government programs on specific sub-groups in the population and to localistic considerations.

The supply of doctors and hospitals does not typically involve the broad ideological issues characteristic of redistributive policies. Nor are supply issues viewed as regulatory--clearly raising costs and/or expanding or reducing the alternatives of private individuals. Rather they are distributive because of "the ease with which they can be disaggregated and dispensed unit by small unit, each unit more or less in isolation from other units and from any general rule." They involve disputes in local communities about the availability of doctors and/or hospitals in that community. Individual committees

and health planning commissions are the typical central actors, rather than nation-wide interest groups such as the AMA, labor unions, and Blue Cross-Blue Shield Associations, or an entire profession, producer, or consumer group. Supply decisions become national policies through an accumulation of highly individualized decisions.

While the supply of doctors and hospitals in the nation may be adequate, a local community can experience several shortages. Shortages in this case, become political issues only for the community involved. The recent case of patients being turned away from Harlem Hospital due to a lack of space and funding provides an example of this localized type of politicization of personal health services.[37] For the residents of Harlem who are unable to obtain adequate medical care, for the mayor of New York, and for health planning commissions in New York, a political issue was created which involves both dispute at the city level and specified subgroups of the population.

The supply considerations point to the problems of the social costs and benefits of government involvement in health care. One social cost consideration is the impact of government payment practices on the general prices of medical care services, as illustrated by the relationship between the increase in physician fees and the initiation of Medicare. Further, there are problems concerning the relationship between particular forms of government health expenditures and the efficiency of the medical eare industry. This type of problem becomes apparent when the distinction is made between the costs of medical care and the costs of government health programs.

Considerations of efficiency and social costs are much more difficult to represent politically than considerations of program cost and financing. It is the former set of issues which receive the least attention in the politicization of health care. The misallocation of health resources encouraged by hospitalization health (as against more comprehensive) insurance is not hard to document. The difficulty is arousing the entire community's interest in more efficient allocation of health care resources when there is little reason for individual constituents to make the community's interest their own.

American Politics and the Politicization of Health Care

The politicization of personal health care services may be considered in the light of the analytic framework most appropriate to different health issues. We have discussed the variable relation between substantive health concerns and the political form taken by an issue. Thus the use of appropriate models of analysis takes on a significance not only for specific political decisions but for health care issues in general.

Central to the choosing of any one analytic framework is an understanding of what follows from the terms in which an issue is posed. That is to say, if an issue is raised in framework "A", it may take on quite different dimensions than if raised in framework "B". Using the three models of the Allison typology commonly employed by political scientists in policy analysis--the rational actor model, the organizational process model, and the bargaining-bureaucratic model--and applying these models to

the Medicare issue, it was clear that each framework raised a different set of questions. Whereas the first model leads to questions about the health problems of the aged and alternative solutions to them, the second model raises questions about the organized groups involved in the conflict. The bargaining model focuses on the trade-offs made among government elites. One model may not be superior to the others for the whole gamut of medical care issues. It is quite possible that different types of issues are best explained by different models. Thus the initial stages of formulating the Medicare issue in the public arena might be best described by the use of the rational actor model; the 1952-64 debate over benefits, beneficiaries, scope, and administration by the organizational process model; and the resolution of the conflict in 1965 by the application of the bargaining model. Questions dealing with the administration and financing of government health programs might also most appropriately be viewed in terms of the bureaucratic-bargaining model, since they involve narrower sectors of the population--most often government bureaucrats and the spokesmen of medical producer groups.

In addition to knowing the form of analysis most appropriate, the political processes typically involved in different health care areas should be noted. Lowi's classification of distributive, regulative and redistributive policies provided a useful typology of American political processes. Regulatory processes appeared most prominent in issues of health costs, distributive processes in questions of supply, and redistributive processes in determining the scope and the objects of direct government financing of personal

health services.

The Lowi typology leads to, but does not provide generalizations about the content of policies. For example, in many U.S. social welfare policies, the outcome has been what Friedman terms middle class programs, in which the distinguishing features include financing, non-comprehensive benefits, the avoidance of means tests, and non-discretionary, centralized administration. Thus, policies can also be distinguished and compared on the basis of clients served, financing mechanisms used, redistributive impact, and administrative structure.

It becomes apparent from the above analysis that what is often considered a topical area, e.g., health care issues, or what economists classify as an industry is not the same as a political arena. The discussion of the politicization of topics and problems in the health industry is suggestive of some characteristic patterns in American politics and typologies used to analyze them. It is clear that the various aspects of the health care industry create different types and styles of conflict, and that the politicization of health care issues does not assume a single, unique form. Having dealt with the processes involved in the politicization of conflicts over health policy, further investigation should serve to illuminate other aspects of government involvement in the health sector, most notably the continuing concern over the distribution of benefits.

NOTES

[1]Anne Somers, *Total Financing of Health Care: Past, Present and Future*, Unpublished Paper, 1968.

[2]*Ibid.*

[3]Dorothy P. Rice and Barbara S. Cooper, "National Health Expenditures, 1950-66," *Social Security Bulletin*, U.S. Department of Health, Education, and Welfare, April, 1968, p. 14.

[4]Elton Rayack, *Professional Power and American Medicine*, Cleveland: The World Publishing Company, 1967, p. 46.

[5]Cited in Somers, op. cit.

[6]In the year 1949-50, public expenditures for health and medical care totaled 3,065.3 million dollars. Out of this, medical research accounted for 72.9 million, medical facilities constructed for 522.3 million, veterans' hospital and medical care for 582.8 million, and Defense Department hospital and medical care for 336.2 million. These four categories alone accounted for well over one-half of all public expenditures for health and medical care. "Public and Private Expenditures for Health and Medical Care, Fiscal Years 1929-67," *Research and Statistics Note*, No. 1, U.S. Department of Health, Education, and Welfare, November 20, 1967, p. 5.

[7]"Health Insurance for the Aged: Initial Operating Data." *Research and Statistics Note*, No. 1, U.S. Department of Health, Education, and Welfare, Social Security Administration, January 6, 1967.

[8]Herman and Anne Somers, *Medicare and the Hospitals*, Washington, D.C.: The Brookings Institution, 1967, pp. 46, 57.

[9]*Ibid.*

[10]*Ibid.*, p. 106

[11]Rayack, op. cit., pp. 108-130.

[12]*Ibid.*, p. 113.

[13]Dorothy P. Rice and Loucele A. Horowitz, "Trends in Medical Care Prices," U.S. Department of Health, Education and Welfare, *Social Security Bulletin*, July, 1967, p. 16.

[14]*Ibid.*, p. 20.

[15]*Ibid.*, p. 22.

[16]This is not a subject which political scientists have studied extensively. Herman Somers has, of course, written extensively about medical care subjects, but this emphasis has been as much on public sector economics as on political science. The analysis of the problems of Medicare and the hospitals, for example, focuses on patterns of hospital practice and the identification of areas for reform, describing the political process as a prelude to the "problems" of Medicare's administration. See Somers and Somers, *Medicare and the Hospitals*, Washington, D.C.: The Brookings Institution, 1968. Herbert Kaufman has enumerated political science studies of health topics and suggested topics of future research in "The Political Ingredient of Public Health Services: A Neglected Area of Research," *Milbank Memorial Fund Quarterly*, October, 1966, Vol. XLIV, No. 4, Part 2.

Two areas of health politics have been widely investigated: the internal politics of the AMA and local health care disputes. For the AMA, see the now somewhat dated work by Oliver Garceau, *The Political Life of the American Medical Association*, Cambridge, Mass.: Harvard University Press, 1941; Corrine Gilb, *Hidden Hierarchies*, New York: Harper & Row, 1967; and the superb, but not widely known study by Hyde, et al., "The AMA: Power, Purpose and Politics," *The Yale Law Journal*, Vol. 63, No. 7, 1954. Typical of the urban politics case studies (but a fascinating one) is E. C. Banfield's analysis of the problems of locating a hospital in Chicago, in *Political Influence*, Chicago: The Free Press, 1964.

Much more work as been done on the politics of European health programs. Harry Eckstein's, *The English Health Service*, Cambridge, Mass.: Harward University Press, 1958 is a full account of the politicization of hospital reform and medical care distribution in England. His *Pressure Group Politics*, Stanford, Calif.: Stanford University Press, 1960, is a detailed description of policy-making in the British National Health Service and the British Medical Association's role in those policies. For a critique of Eckstein, see my "Doctors and Politics in England," unpublished paper for the U.S. Public Health Service, November, 1967. William Glaser's "The Compensation of Physicians," unpublished report to the U.S. Public Health Service, 1966, is the most detailed comparative study of physician politics, but, unhappily, is not easily available. Copies are on file both with the Public Health Service and the Bureau of Applied Social Research, Columbia University. Social administration scholars in England have done much of interest to political scientists. See especially the work by Professors Abel-Smith and Titmuss: Abel-Smith, "The Payment of the General Practitioner," *Medical Care*, (1963), and Titmuss, *Essays on the Welfare State*, London: George Allen and Unwin, Ltd., 1958 and *Commitment to Welfare*, New York: Pantheon Press, 1968.

[17]This distinction is familiar to economists, and proceeds from the distinction between real costs (measured by the use or factors of production) and pecuniary costs (measured by dollar program expenditures). To clarify the social cost program distinction, consider the following simple, but, alas true, situation. The U.S. government pays for the first 60 days of hospital care under Medicare, subject to a deductible of approximately $40.00. A patient who could be shifted to a nursing home for convalescence faces a $20.00 deductible and a $5/day co-insurance for the first 20 days of nursing home care. Were the patient to convalesce for the same period (60 days), his out-of-pocket expenses in the hospital (A) would be $40.00. If he were transferred to a nursing home after 3 days (B) in the hospital, his outlay would be $40.00, plus $20.00, plus $100.00, or $160.00. In (A), the program cost to Medicare would equal the average price per hospital day ($40)X 60 - $40, or $2360. In (B), the Medicare program cost would be 3 x 40 - 40 + 57 + 1/3 (40) - $160, or $672.40. The 1/3 (40) represents the fact that nursing homes have an average price, approximately 1/3 the price of hospital stay; the $160 represents the out-of-pocket expenses of the Medicare patient.

(A) clearly is financially better for the patient, and conversely, inferior to (B), ceteris naribus, for the Medicare program. But (A) is also better from a societal standpoint if the patient medically requires the level of care available at a nursing home (or extended care unit, in the jargon). Yet the financial incentives to the patient (and his doctor insofar as he worries for one patient) are for hospital care, with the result of inefficiency (the use of higher levels of care than needed) and higher program costs ($2360 v. $672.40). One could also give illustrations of the social costs increasing as the program costs for the government decrease, but the distinction should now be evident.

[18]Theodore Lowi, "American Business, Public Policy, Case Studies, and Political Theory," *World Politics*, XVI, (1963-64), p. 690.

[19]*Ibid.*

[20]*Ibid.*, p. 691.

[21]*Ibid.*

[22]This need not be the case. Programs which pay physicians (e.g. Medicare) affect factor income, and, hence, the distribution of income. Administrative disputes over physician payment could (and in England frequently does) become a broad public issue, redistributive in character and involving the ideological and class appeals associated with incomes policy questions. The variability in the politicization of the same issue is a subsidiary point to which we will return, a point of special interest for policy-makers concerned with substantive health policy questions, but affected by the type of politicization policy issues assume.

[23]The regulation and education of physicians has been politicized much earlier. See Donald Fleming, *William Welch and the Rise of American Medicine*, Boston: Little-Brown & Company, 1957 for the story of the fights over professional standards and the effort to expose quacks and expel them from the legally certified profession in the last half of the nineteenth century. This theme, and the analysis of educational reform, medical specialization, and the role of the medical school can be found in Gilb, *op. cit.*

[24]The history of these developments is succinctly told in Odin Anderson's chapter in Feingold's *Medicare: Policy and Politics*, San Francisco: Chandler Publishing Company, 1967.

[25]Lawrence M. Friedman, "Social Welfare Legislation: An Introduction," *Stanford Law Review*, XXI, January, 1969.

[26]For a complete enumeration of these generalizations, see Aaron Wildavsky, *Dixon-Yates*, New Haven, Conn.: Yale University Press, 1962, pp. 304-5.

[27]Cohen was commonly referred to as the potential "czar" of American medicine, a spectre that turned into fact for many in the months following the enactment of Medicare. At an August 1966 meeting of the American Nursing Home Association in Washington, Cohen was invited to speak about Medicare's nursing home reimbursement policy, and, in an ugly outburst, was booed. That a group within the nursing home operators, none of whom had dealt with Cohen, could respond in such a way was made possible by the emergence of symbols of good and evil in the protracted and public debate over the desirability of the Medicare policy.

[28]Whether or not Medicare did involve substantial redistribution between higher and lower income Americans is not the concern here. The point in question is the fight over whether redistribution should take place and, if so, how much.

[29]Lowi, *op. cit.*, p. 715.

[30]*Ibid.*

[31]Similar questions have been asked about the Cuban Missile Crisis by Graham T. Allison, Jr., in his "Conceptual Models and the Cuban Missile Crisis: Rational Policy, Organization Process, and Bureaucratic Politics," unpublished paper presented at the 1968 annual Meeting of the American Political Science Association, Washington, D.C. The differences which the framework of analysis makes can be seen by contrasting three formulations of the puzzle about the missile crisis. 1) Why did the U.S. government *decide* to blockade Cuba (rational action framework); 2) Why did the U.S. government *blockade* Cuba *as it did* (organizational process model); 3) Why did the United States blockade Cuba (bureaucratic politics)? For a fuller discussion of analytical models and Medicare policy, see "Medicare and the Analysis of Social Welfare Politics," in *The Politics of Medicare*, London and Boston: Routledge and Kegan Paul and Little-Brown, forthcoming. Part of this analysis, but much abbreviated, can be found in my "Congress: The Politics of Medicare," Allan Sindler, ed., *American Political Institutions and Public Policy*. Boston: Little-Brown Co., 1969.

[32] *Ibid.*

[33] Theodore R. Marmor, *The Politics of Medicare*, London: Routledge & Kegan, Paul, forthcoming.

[34] See the *Report to the President on Medical Care Prices*, Department of Health, Education, and Welfare, 1967, for an example of the concern about increasing health prices and the search for remedies.

[35] Theodore R. Marmor, "Why Medicare Helped Raise Doctors' Fees," *Trans-action*, September, 1968, p. 17. Also in Institute reprint series.

[36] Professor Herman Sommers, a member of HIBAC, the Health Insurance Bureau's Advisory Council within the Social Security Administration, has remarked that his interest in the incomes of physicians has not been shared by other members of HIBAC and that very little has been done to investigate the impact of public programs in income distribution. Current studies (1969) by the Senate Finance Committee, however, are raising this issue. See, *New York Times* News Service article on the Senate committee studies, July 2, 1969.

[37] See "Harlem Hospital Rejects Dozen as Crisis Spreads," *New York Times*, March 24, 1969, p. 1.