2019

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The Thirty-Year Foundation of the United States Healthcare System: Fee-For-Service in Perspective

Ethan Hunter

The debate over how the United States healthcare system should function has been raging for over a century. Two decisions lie at the core of this debate and have shaped American healthcare policy for decades; giving physicians substantial sovereignty in organizing, financing, and practicing medical care, and treating medical care as a market commodity as opposed to a right. Gradually, over a period of thirty years, the combined effects of these two choices produced what Michael E. Porter and Robert S. Kaplan consider the single biggest obstacle to improving [healthcare] in our country; the fee-for-service payment and delivery system.1

At the start of the 20th century, when veneration for science and technology was rapidly increasing, Americans had what Donald A. Barr describes as an “idealized view of physicians.”2 This admiration largely contributed to the political ascendancy of the medical profession because Americans believed doctors “could be trusted to make decisions on behalf of the patient in a paternalistic manner, acting always as a disinterested agent on the patient’s behalf.” This authority allowed physicians to act in their own self-interest by establishing and preserving the notion that healthcare is a service provided by doctors to people willing to buy it. Furthermore, in 1938 the president of the American Medical Association (AMA) Dr. Irvin Abell stated the organization’s position that it is entirely the individual physician’s right to determine the conditions of his or her service and how it should be paid for. This allowed the AMA to set the precedent “that once the fee for the medical service was set, “the immediate cost should be borne by the patient if able to pay at the time of service”. Except for the poor, patients were purchasing medical care from their physician as a market commodity, and as is typical of market exchanges, were expected to pay for it at the time the service was rendered.”3 Physicians gave themselves the ability to set fees according to what markets would allow and require patients pay separate fees for each service provided. Hence the name of the payment and delivery system that would dominate American healthcare for decades to come: fee-for-service (FFS).

Fee-for-service has been a central component of American health insurance since its inception and has remained relatively unchanged over time. The problems associated with fee-for-service today are the same issues critics highlighted almost fifty years ago. In a 1970 article published by Fortune magazine and the Medical College of Virginia Quarterly, Edmund Faltermayer writes that:

“Our present system of medical care is not a system at all…Most patients pay by the cumbersome "fee-for-service" or piecework method, which involves separate billing for visits to doctors, shots, x-rays, laboratory tests, surgery, anesthesia, hospital room and board, etc., etc. The American hospital system..."is largely a figure of speech," the result of a haphazard growth of isolated, uncoordinated institutions.”4

Faltermayer goes on to describe problems with fee-for-service such as inadequate coverage and high barriers to access for citizens in poor and rural areas. These too remain problems we face today. More than 40 years later the fee-for-service system remains complex, inefficient, and fragmented.

Understanding why fee-for-service is the dominant payment and delivery model in the United States

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3 Barr, 18.
healthcare system requires analyzing the political evolution of the system itself. The roots of modern-day American healthcare are in the Social Security Act (SSA) of 1935, implemented under Franklin Delano Roosevelt (FDR).

**Section I – From the Great Depression to the Great Society**

Because of the unnatural relationship between medical care and insurance, prior to the 1930’s there were not many options for insuring against medical costs. However, during the Great Depression patients struggled to pay their bills, financially straining hospitals and making it difficult for them to operate. In response to this, hospitals came together “to offer, for the first time, insurance to cover the cost of hospital care. The hope was that people who could not afford to pay a large hospital bill once they got sick could afford monthly insurance premiums to protect themselves if they ever did get sick. These hospital plans, operated on a non-profit basis, were the origin of the nationwide Blue Cross program. Every state had its own program of Blue Cross hospital insurance. Some states added an option for insuring against the cost of physicians’ services. These were the Blue Shield plans.”

The American Medical Association (AMA) and the American Hospital Association (AHA) both lent their support to these insurance programs provided medical decisions remained under the jurisdiction of medical professionals.

Before World War II not many people enrolled in these plans. However, three actions taken by the Roosevelt administration would change that, setting the foundation for the American healthcare system in the process. The passage of the Social Security Act in 1935 and Emergency Stabilization Act in 1942, along with the decision to not pursue compulsory national public health insurance all had outsized effects on the evolution of American healthcare.

Taking the oath of office during the Great Depression, Roosevelt not only hauled the nation out of poverty but also redefined the relationship between government and the people. Almost immediately after taking office Roosevelt moved swiftly to stabilize the economy and provide financial relief to millions of suffering Americans. Roosevelt is remembered for the bold and decisive actions he took as President, notably his efforts to implement the various social programs that constitute the New Deal such as those in the Social Security Act.

The Social Security Act was designed to respond to the symptoms of the Great Depression by creating a social welfare architecture that could protect people against financial dependency and personal economic ruin. The initial provisions of the legislation included state and federally funded benefits for the elderly, dependent children, the unemployed, and those with various disabilities. Originally, the Social Security Act only supported two, essentially embryonic, health initiatives: Maternal and Child Health under Title V and Assistance to States for Public Health Work under Title VI. Even though nearly all healthcare benefits that fall under the umbrella of social security today were not included in the 1935 legislation, Dobelstein (2009) highlights the fact that “the authority for almost all of the Federal Government’s support of health care comes under the Social Security Act.”

In October 1942, ten months after the attack on Pearl Harbor, Roosevelt signed the Emergency Stabilization Act into law. Aimed at preventing inflation, the Act allowed the federal government to place price controls on the majority consumer goods, as well as a freeze on all wages. However, the government decided that:

“any fringe benefits from work were exempt from price controls. Thus, employees and their labor unions could not bargain for increased wages, but they could bargain for better health services.”

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5 Barr, 88.
7 *Understanding the Social Security Act*, 240.
8 *Understanding the Social Security Act*, 240.
9 Barr, 99.
health insurance as a fringe benefit. These policies carried over into the period after World War II, leading to a greater and greater emphasis on increasing fringe benefits from work as well as wages. The main fringe benefit workers sought was health insurance.”

Classifying health insurance as a fringe benefit for workers is one of two decisions that actively cemented employment-based insurance as the core of the United States healthcare system. The second, which came in 1954 under the Eisenhower administration, ruled that fringe benefits did not qualify as taxable income. As a result of these two policies it is often advantageous for workers to take a raise as an increase in fringe benefits instead of cash wages. Barr highlights the fact that while both laws were passed to address issues distinct from healthcare, their combined effect over time has created what he calls “a de facto national policy of employment-based health insurance.”

While the actions Franklin Roosevelt took in office no doubt served as a foundation for the development of the American healthcare system, perhaps Roosevelt’s inaction has had just as lasting a legacy. From a twenty-first-century perspective, it is important to remember that the Social Security Act “never proposed to address the full range of American social issues during the late 1930’s, nor in its development has a social welfare structure been created sufficient to address the full range of America’s social welfare problems today.” The third decisive action taken by the Roosevelt administration, passive in nature, was the decision to not pursue compulsory national public health insurance.

Before leaving office, Franklin Roosevelt would enact a wide-ranging legislative package that shaped the mold for the modern-day conception of the federal government. Yet one policy area where Roosevelt was uncharacteristically absent was healthcare. The healthcare-related components of the Social Security Act were marginal and only made small direct policy contributions to the development of the American healthcare system. Roosevelt undoubtedly possessed the legislative skills required to overhaul the system, and his four electoral victories attest to the fact that he was particularly talented at garnering public support. When it came to healthcare, however, what Roosevelt lacked was desire; he was simply uninterested in the issue and did not consider it worthy of his finite political capital.

It seems odd that such a remarkable and consequential president, a man who had experienced his fair share of bouts with illness, would fail to produce any significant healthcare legislation during three full terms in office. Yet the fact of the matter was that:

“President Roosevelt not only failed to win health insurance but also barely tried. And therein lies one of the great mysteries in the history of American health care policy. At its center sits a man of extraordinary power and political skill, deeply familiar with illness. He was a president of extraordinary times, with extraordinary opportunities. But when it came to health care, Roosevelt always disappointed his liberal advisors and chose not to fight.”

Blumenthal compares Roosevelt’s style of politics to an angler operating his fishing lines. He would “skillfully let out many lines, pulling in some, lengthening others, constantly changing lures, sometimes sitting patiently, and always knowing instinctively when to set the hook and when to cut bait. Naturally, all the lines led right back to Roosevelt.” Healthcare was the fish Roosevelt never reeled in. The issue was left out of the Social Security Act in 1935, failed to pick up enough steam during the 1938 election, and just as Roosevelt appeared ready to tackle the matter in 1944, he passed away.

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10 Barr, 99.
11 Barr, 99.
12 Barr, 100.
14 Understanding the Social Security Act.
15 Blumenthal, 23.
16 Blumenthal, 24.
17 Blumenthal, 55.
Roosevelt’s puzzling inaction on healthcare appears to trace back to several factors. First off, he did not seem to have a firm grasp on how a national health insurance program would work, “a problem that would bedevil health care advisors seeking to engage future presidents.” It is an extremely complex issue that naturally tends to get bogged down in several places. Secondly, at the height of the Great Depression other issues such as unemployment insurance and social security mattered more. Roosevelt was simply not as willing to spend political capital on healthcare as he was on other issues. Lastly, and perhaps most significantly, Roosevelt avoided confrontation with organized medicine and “showed timidity in the face of the American Medical Association (AMA).” Roosevelt and his advisors always got an earful from medical interest groups expressing their opposition to national health insurance, and the mere mention of such a program “prompted a vigorous response from the ever-vigilant American Medical Association.” The AMA was ready to fight Roosevelt tooth-and-nail if he signaled a potential push for national health insurance—which he did at various times throughout his presidency—resulting in public and private attacks on the president.

By the end of his time in office, Roosevelt had laid the foundation for future presidents to build upon in developing the United States healthcare system. While largely devoid of any major healthcare-specific policies, the Social Security Act would provide the legislative framework for subsequent administrations to expand upon in crafting healthcare reform. Furthermore, by classifying health insurance as a fringe benefit, the Emergency Stabilization Act, coupled with policies implemented under president Eisenhower, cemented employment-based health insurance as the primary means for providing Americans with medical care. Lastly, by choosing not to pursue compulsory national public health insurance Roosevelt further strengthened physician’s authority in organizing, financing, and practicing medical care, chiefly their right to require patients pay for healthcare on a fee-for-service basis.

The primary lesson of the Roosevelt Presidency, according to Dobelstein, is that “[t]he first question of health reform is how badly the president wants it.” While there was considerable pressure on Roosevelt to include a national health insurance program in the Social Security Act, intense lobbying from the American Medical Association and his general uncertainty persuaded him to leave it out. At the onset of his presidency, Roosevelt had the opportunity and political wherewithal to establish a national health insurance program. However, the great irony of it all is that he was simply not passionate enough about the issue, and Democrats would come to see healthcare as FDR’s “liberal dream deferred.”

While Roosevelt was seemingly uninterested in the healthcare issue, his successor Harry Truman had a self-described “special interest” in health that stemmed from his fiercely ideological instincts. Truman’s desire for a national health insurance program “drew on his deep commitment to New Deal principles and his conviction that national health care—and the emerging American social welfare state—was a fundamental feature of both fairness and modernity itself.”

In the fall of 1945 president Truman sent a healthcare message to congress calling for five specific reforms; “hospital construction, expanded maternal and child health services, a broad program of medical education research, national health insurance, and disability insurance to protect workers from sickness or injury.” Truman idealistically proclaimed that “[t]he American people…will not be frightened off from [national] health insurance because some people have misnamed it ‘socialized medicine’. I repeat—what I am recommending is not socialized medicine.” Nevertheless, the day following Truman’s address the New York Times reported that “cries of socialized medicine…were heard from the Republican side of the Senate.” This was not the first-time healthcare reform was labeled as “socialized medicine” nor would it be the last.

18 Blumenthal, 53.
19 Blumenthal, 54.
20 Blumenthal, 54.
21 Blumenthal, 56.
22 Understanding the Social Security Act.
23 Blumenthal, 56.
24 Blumenthal, 70.
One of the primary strategies of organized medicine and their allies in congress is to brand any reform they consider to be an intrusion on physician’s near-complete authority over organizing the payment and delivery of medical services as “socialized medicine”. Under president Roosevelt, the Committee to Coordinate Health and Welfare Activities merely suggested the possibility of “[a] comprehensive program designed to increase and improve medical services for the entire population.” At the time Roosevelt had no intention of seriously pursuing such a policy, yet the National Medical Association declared that “[i]f we have socialized medicine in America…[s]tandards of medical practice with degenerate…and patients will suffer.” Thirty years later when president Lyndon Johnson proposed a program that would provide “hospital insurance for the aged under social security”, the American Medical Association decried his plan as “the first step toward[the] establishment of socialized medicine in the United States.” Most recently, after President Barrack Obama signed the Affordable Care Act (ACA) into law, he declared the legislation as having “enshrined the core principle that everybody should have some basic security when it comes to their health care.” Congressional Republicans denounced the law as “a major step toward socialism and an aggressive government takeover of the health care system.” The aforementioned policies have very distinct objectives yet the same argument for opposing them appears time and time again. There are many people on both sides of this debate, however, the point relevant to this thesis is that labeling healthcare reform as “socialized medicine”, irrespective of the validity of such a claim, has been a popular and successful strategy for the American Medical Association and other medical interest groups. Perhaps a successful strategy for those who aim to improve the United States healthcare system would be to put forth policies which are immune to this label.

Truman’s major legislative attempt at national health insurance was the Murray-Wagner-Dingell bill of 1945. The bill, which would have established compulsory national public health insurance, was killed by opposition from medical interest groups and failed to even receive a floor vote in either chamber of congress. While hearings on the bill were taking place Truman hardly lobbied the public for support, and his equivocation would cost him the backing of numerous social groups including even the League of Women Voters. President Truman embraced national health insurance with an ideological passion that Roosevelt never offered the issue. However, despite pleas from supporters of healthcare reform, Truman “never used his bully pulpit to try to rally the public. Scholars focused on national health insurance often wonder why the president did not spend more time pushing his proposal.” There are numerous possible explanations for this. Truman’s administration was overwhelmed by crises including nationwide strikes, communist witch hunts, and the Korean War. Furthermore, the Missourian was admittedly “something of a dub” at public speaking could not hold a candle to his predecessor’s magisterial oratory.

In 1948, following repeated setbacks, Truman commissioned Oscar Ewing, former chair of the Democratic National Committee, to publish a report on the status of the nation’s health. Truman used Ewing’s report, The Nation’s Health—A Ten Year Program, as an explicit outline for his healthcare program. The report was meticulous in its portrayal of the American health care system. In only two states did more than half the people have health insurance; less than 10 percent were insured in twenty states. The poorer the state, the lower the insurance rates. Private health insurance, concluded the [report], covered a fraction of the population, offered them

25 Barr, 11.
26 Barr, 11.
27 Barr, 11.
28 Barr, 11.
29 Barr, 11.
30 Blumenthal, 72.
31 Blumenthal, 81.
inadequate coverage, and was hardest to get where the need was greatest. Private health insurance had failed.”  

However, it is important to note that private health insurance had failed only through the lens of the liberal vision of a healthcare system centered around fairness. The privatized system that would begin to flourish over the next decade actually met many of the stipulations of the Ewing report. Unfortunately, the problems with private health insurance derided by the Ewing Report—high uninsured rates and inadequate coverage—are the same challenges American healthcare faces today.

Toward the end of his administration, Truman reluctantly retreated from national health insurance and “submitted a new healthcare bill, [the King-Anderson bill], extending [public] hospital insurance for people over sixty-five years old.” 33 The King-Anderson bill “attracted little notice and the president did not even write a message—he did not want to hear the AMA crow over his having backed down.” 34 Truman’s failure to enact compulsory national public health insurance further strengthened physician’s authority over the organization and provision of healthcare, thereby preserving the policy that medical services be paid for on a fee-for-service basis. Barr makes note of the fact that “In making medical decisions in a fee-for-service system, physicians were simultaneously looking out for the needs of the patient and for their own financial interests. As medical science and medical technology evolved and expanded, more care came to be perceived as better care. More care also generated higher fees. Both the perceived quality of care and the physician’s income went up as the physician did more for the patient. This system of dual loyalties, while seemingly good for the patient, can also place the physician in the role of an imperfect agent when making or recommending treatment decisions on the patient’s behalf.” 35 The consequences of such a system would become strikingly apparent over the next half-century.

Throughout his presidency Dwight Eisenhower proved himself to be a staunch ally of the American Medical Association and organized medicine. In a speech to congress, Eisenhower bluntly stated that he is “flatly opposed to the socialization of medicine”, adding that private health insurance, “soundly based on the experience of the people in their various communities”, could and should cover most Americans.” 36 Eisenhower would back up his speech with “the single most important health care act of his presidency.” 37

In 1954, Eisenhower sponsored the Revenue Act which ruled that fringe benefits such as health insurance did not classify as taxable income and were therefore not subject to income tax. Classifying health insurance as a non-taxable fringe benefit resulted in workers coming “to expect to receive their health insurance as a [benefit] of their employment.” 38 Furthermore, Barr describes this ruling as providing “a federal tax subsidy for the purchase of health insurance as a fringe benefit. It is not a direct subsidy, but rather and indirect subsidy, in that that less money comes into the federal treasury. This federal subsidy costs the treasury tens of billions of dollars in lost tax revenues each year and constitutes the third largest federal health care program after Medicare and Medicaid.” 39 In addition to the law’s considerable financial ramifications the Revenue Act would significantly bolster employment-based private health insurance, dashing the hopes of those who dreamed of compulsory national public health insurance during the Roosevelt and Truman years.

By the end of the Eisenhower presidency the foundation for the development of the United States healthcare system was set. With the Social Security Act of 1935, Roosevelt established the policy framework for future presidents to build upon in crafting healthcare legislation. The failure of the Truman administration to implement national public health insurance allowed organized medicine to hone their

32 Blumenthal, 82.
33 Blumenthal, 95.
34 Blumenthal, 95.
35 Barr, 18.
36 Blumenthal, 111.
37 Blumenthal, 113.
38 Barr, 99.
39 Barr, 99.
strategy for opposing such a system, and also presented Eisenhower with the opportunity to cement private employment-based insurance as the core of the healthcare system. Eisenhower rose to the occasion and, by employing effective coalitions of relevant stakeholders, ensured that the future of American healthcare would be centered around private markets and private insurance. Furthermore, capitalizing on the authority entrusted to them in the 1930’s, organized medicine established the precedent that providers shall have near-complete control over the organization, financing, and provision of medical care. By effectively branding any policy that deviates from this precedent as “socialized medicine”, medical interest groups preserved and protected their right to set their own fees, establish their own conditions of service, and require patients pay a separate fee for each individual service.

The experiences of the three administrations discussed thus far each illustrate a fundamental lesson surrounding healthcare reform. Roosevelt’s time in office is a testament to the basic fact that the success of healthcare reform is primarily dependent on how passionate the president is about the issue. Roosevelt was neither willing nor able to spend political capital on healthcare, and the direct effects of the health-related policies implemented by his administration were marginal. While Roosevelt had the political skills and opportunity to implement compulsory national health insurance, he lacked the desire to do so. Conversely, Harry Truman strongly aspired to make healthcare reform the core of his domestic agenda but lacked the political acumen. The lesson of the Truman presidency is that no matter how strongly a president covets healthcare reform, if they are not acutely capable politically the desired outcome will almost certainly be unattainable. Roosevelt and Truman were both opposed by the American Medical Association and its allies, along with lawmakers on both sides of the aisle. Dwight Eisenhower not only demonstrated an appetite for healthcare reform and possessed sufficiently keen political instincts, but also developed wide-ranging bipartisan coalitions of industry stakeholders and members of congress.40

Section II – Medicare, Medicaid, and the Advent of the Modern-Day Healthcare System

If healthcare reform requires a president who is fervently devoted to the issue, remarkably skilled politically, and enjoys a vast nation-wide support base, Lyndon Johnson perfectly fit the mold. At the onset of his presidency Johnson envisioned a domestic agenda the likes of which could only be rivaled by Roosevelt’s New Deal, and “health care sat right at the heart of it.”41 Throughout the twenty-six years preceding his time as president Johnson had been a member of both houses of the United States Congress, serving as Senate Majority Whip, Senate Minority Leader, Senate Majority Leader, and Vice President of the United States. Johnson spent his time in congress cultivating a sprawling network of relationships with Republicans and Democrats in every corner of the country. Johnson’s extensive career as a Southern Democrat combined with his formidable interpersonal skills made him uniquely suited to tackle an issue as demanding as healthcare reform.

Johnson’s passion for healthcare, something he felt deep inside his “capacious Texas Gut”, had never been seen before in American presidential history.42 To put his ambition in perspective, in 1964 Johnson told journalist Joseph Kraft “[t]here are three big things we are running [towards]…One is peace, one is prosperity, and one is Medicare.”43 Joseph Califano, the president’s top aide for domestic affairs, said “the whole area of health care was very near Johnson’s core.” Observers attribute Johnson’s passion for healthcare to his childhood in Southern Texas when he experienced the devastating effects of the Great Depression.44 When asked why he thought healthcare was as pressing an issue as peace and prosperity, Johnson replied, “we are really trying to do something for the people. We think the average

41 Blumenthal, Lyndon B. Johnson: The Secret History of Medicare, pg. 163.
mother wants peace, she wants her husband to have a job, and they’re looking for somethin’ to take care of ‘em in their old age, and that’s what we’re trying to do, is to give them a government that appeals to ‘em.”\(^{45}\) Initially Johnson’s healthcare package was limited to expanding public hospital insurance for the elderly, however his intense ambition and unrivaled political expertise would enable him to obtain much more comprehensive legislation.

Throughout the meticulous process of drafting the legislation that would constitute his reform package, Johnson negotiated tirelessly with Republican and Democratic congressmen as well as the medical interest groups whose support he knew was paramount. The starting point for the administration was a modified version of the King-Anderson bill which had been submitted by President Truman and supported to no avail by President Kennedy.\(^{46}\) King-Anderson “provided for sixty days of hospital care for the aged” and formed the basis of the legislation put forth by the Johnson White House. A different faction in congress was more focused on assisting the poor and supported the Kerr-Mills bill which was centered around a social security cash benefit. Johnson had no intention of prioritizing the elderly over the poor or vice versa, and immediately set out to find a middle-ground. Although the sociopolitical atmosphere of the time undoubtedly played to the advantage of those seeking healthcare reform, Johnson fully comprehended the power wielded by the American Medical Association and sought to irritate organized medicine as little as possible.

While Johnson’s negotiations with congress kept him more than preoccupied, the American Medical Association began to voice their concerns surrounding the legislation. The organization feared that if King-Anderson was passed, those with hospital insurance would demand doctors’ fees be covered as well and suggested a voluntary plan— “Eldercare…a hybrid of insurance and public assistance: [b]eneficiaries would pay part of the cost, and the federal government would pay the rest of the cost of hospital care and doctors’ fees through general revenues.” Johnson was a deal-maker through and through, and when he was told how much it would cost to give the doctors and hospitals what they wanted and get the bill out of the House Ways and Means Committee, Johnson said, “‘Only $500 million a year? Give it to them. Let’s get the bill.’”\(^{47}\) Johnson’s compromise with organized medicine would ultimately prove to be a large fee-for-service nail in the coffin of the United States healthcare system.

Attempting to appease hospital groups, the administration “agreed to pay hospitals not what a [medical] service might be worth, but whatever it cost them to provide the service—which meant that the least efficient hospitals would be paid the most.” Organized doctors’ groups received similar concessions and would be reimbursed by Medicare and Medicaid on a fee-for-service basis just as they were by private insurance. The only stipulation was that the fees could not exceed what was “usual and customary” in their community; an extremely nonspecific and largely unenforceable rule.\(^{48}\) As a result of Johnson’s concessions, not only would the new legislation supply doctors and hospitals with more patients to treat every year, it also afforded providers just as much latitude in setting fees for new publicly insured patients as they previously had in setting fees for privately insured patients.

Throughout his time in office Johnson fought off attacks from Democrats, Republicans, and the private sector, ultimately crafting the most consequential healthcare reform package the United States had ever seen. In the end, Johnson, the political wizard, brought all three factions together in support of a “three-pronged bill.”\(^{49}\) The administration’s modified version of King-Anderson covers sixty days of hospital fees for the elderly and would become Medicare Part A. The American Medical Association’s “Eldercare” is a voluntary program that partly subsidizes doctors and physician’s fees for the elderly and would become Medicare Part B. Lastly, the Kerr-Mills Bill provides grants to states for subsidizing the cost of medical services for the poor and would be ratified as Title XIX, Medicaid.\(^{50}\)

\(^{45}\) Blumenthal, 166.

\(^{46}\) Blumenthal, 179.

\(^{47}\) Blumenthal, 179.

\(^{48}\) Blumenthal, 179.

\(^{49}\) Blumenthal, 180.

\(^{50}\) Blumenthal, 180.
By the end of Johnson’s presidency, the United States healthcare system offered public health insurance to people either above the age of sixty-five or below the poverty line, and private health insurance to people below the age of sixty-five and above the poverty line. Not only did Johnson’s healthcare package all but ensure that insurance, whether public or private, would be the mechanism through which essentially all Americans would receive healthcare, it further engrained fee-for-service into the system as the way in which the overwhelming majority of providers were reimbursed. 51, 52 If Franklin Roosevelt’s New Deal social programs are the soil from which the modern-day American healthcare system has grown, Lyndon Johnson’s Medicare and Medicaid are almost certainly the seeds. However, by compromising with the American Medical Association and allowing fee-for-service to be the system’s primary way to receive nutrients, Johnson made a critical error, the consequences of which continue to plague American society today.

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