

Dead on Arrival: The Politics of Health Care in Twentieth Century America. By Colin Gordon. Princeton: Princeton University Press, 2003. xii + 316 pp. Index, notes. Cloth, \$29.95. ISBN 0-691-05806-7.

By David Rosner

Among the great, unanswered questions that have dominated health policy circles for the past twenty years, none is more urgent than the issue of how to extend health insurance to most Americans. Presently it is estimated that about forty-three million Americans are without coverage for even the most basic of medical procedures, and millions of others are covered for only minimal services. In contrast to most advanced industrial societies, which have developed some form of universal health care coverage, in the United States significant numbers of citizens are at risk of becoming ill, going uncared for, and falling into financial ruin.

Because of the disjuncture between the piecemeal quality of our health care system and the more integrated arrangements in other advanced industrial states, the question of why America lacks a national health system has become a central topic of historical scrutiny. Since the publication of Daniel Hirshfield's *The Lost Reform* in 1970, historians and sociologists alike have presented differing paradigms. Some have viewed the distinctly American culture of individualism and distrust of the state as a critical factor in the patchwork of services; others have focused on the American faith in private markets and the historical weakness of the central state; still others blame the rapacity of private interests, which have gained power in tandem with the declining strength of organized labor.

This excellent book by Colin Gordon, *Dead on Arrival*, is by far the most sophisticated attempt to address the critical question of why America lacks a national health care system. Gordon argues that certain private interests have undermined reform efforts over the course of the twentieth century. Organizing his book thematically rather than chronologically, he presents multiple factors, including labor politics, gender and race relationships, and social and class manipulations, showing how each has contributed to the unsatisfactory condition of health care in the United States. The same cast of

historians, policy analysts, and sociologists identified earlier by Hirshfield—Ronald Numbers, Rosemary Stevens, and Paul Starr, among others—as well as the American Medical Association (AMA), the insurance industry, and conservative politicians, are named in this book. In addition, Gordon depicts the changing political economy of health care, particularly labor, as central elements in an unfolding drama.

One theme that emerges repeatedly throughout Gordon's descriptions of the battles waged by the reformers against the forces of reaction is the overwhelming disparity in the resources held by the two sides. The sheer wealth of the AMA and the insurance lobby, whose political connections extend to the highest levels of power in Washington and state capitals, has dwarfed the resources of reform organizations, such as the American Association for Labor Legislation or the smaller advocacy groups that sprang up after 1910 and in the 1920s and have continued to struggle up to the present. Incrementalism, rather than bold challenges to the dominance of private insurance, managed care, HMOs, and the Blue Cross and Blue Shield systems, undermined the unity among classes, sexes, and races that was necessary to challenge these powerful interests. As unionized workers gained the ability to bargain for their own protections, they were less inclined to find commonality with their less fortunate brethren. As others bargained for what they could get from the private sector, the country soon faced what Gordon calls a "three-pronged health crisis—high costs, uneven coverage, and inadequate care" (p. 299).

Gordon begins by tracing the failure of health reform over the course of the past century, culminating with the debacle of the Clinton health reform efforts in the early 1990s. Between 1910 and 1933, Gordon argues, the goals of reformers were to provide income guarantees for breadwinners put out of work because of accident or illness. In some ways, this early emphasis on the workman became an ongoing problem for reformers as they confronted the needs of women and children, the shifting demographics of employment and unemployment, and the diminishing power of labor during the century. At virtually every turn, private interests within the medical profession and the insurance industry were able to divide working people. Private insurance companies, the Republican Party, and organized medicine could exploit deep regional fissures in the Democratic Party and divisions in the labor movement. Unions capable of bargaining for

or, as in the case of the United Mine Workers, providing strong benefit packages for their members did not need to combine forces with the unemployed, the nonunionized workforce, and members of weaker unions to gain a state-administered program.

Gordon treats with skepticism the one supposedly glorious moment in the history of federal health advocacy: the passage of Medicare and Medicaid during the Great Society era. Far from being a harbinger of a more universal system, he argues, this legislation represented the outer bounds of what would be acceptable to a variety of entrenched interests. These powerful groups worked to fashion Titles XVIII and XIX as mechanisms for funneling money to private hospitals and physicians, assigning the care of high-cost patients to Blue Cross “intermediaries.” By dividing the independent elderly from the dependent elderly (who were relegated to a contributory social insurance system) and the poor (who were segregated into public assistance), the programs solidified the class, race, and social distinctions that divided Americans among themselves. Public moneys flowed into a class-riven insurance system that supported private institutions and services, serving to undermine the energies required to wage the broader struggle for a national system. The analysis reverberates with contemporary relevancy in the light of recent Medicare and prescription-drug legislation that allows public moneys to be shoveled into the coffers of the pharmaceutical industry with no public oversight.

The most original and provocative chapter of this extraordinary book takes on race and the politics of health care. Gordon argues that “the American welfare state has always been, at root, a Jim Crow welfare state—disdainful of the claims of racial minorities, deferential to a southern-controlled Congress, and leery of the racial implications of universal social programs” (p. 172). The segregation of general hospitals in the South and of the Veterans Administration system nationwide well into the 1950s symbolized the country’s disdain for African Americans. Virtually no arena of health policy was left untouched by the ugly racism of American culture. As medicine and hospital care remained essentially “private commodities” and as medical insurance became a privileged benefit of primarily white union members, blacks, Latinos, and others found themselves disproportionately without resources or insurance. By the end of the twentieth century, the deep fissures of race and racism were barely papered over as an

arrangement characterized by vastly different rates of insurance coverage among blacks, whites, and Latinos continued to divide the population.

This is a sophisticated, impassioned, and well-documented analysis of the failures of twentieth-century American health reform efforts. I believe it will eventually be classified as essential reading, not only in history departments but also among health policymakers and the public health community at large.

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