Book Review

Welfare Medicine: How Success Can Be a Failure*

Welfare Medicine in America: A Case Study of Medicaid. By Robert Stevens & Rosemary Stevens. New York: The Free Press, 1974. Pp. xxii, 386. \$13.95.

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Medical care is a growth industry, in rates of inflation as well as scholarship, in utilization as well as public concern. The inflation rates, public concern, and scholarly attention are all related: rising costs have been chiefly responsible for the shrill claims of a "medical care crisis."

Over the past quarter century, the share of the nation's resources spent on medical care has increased 80%, from 4.6% to 8.3% of GNP in 1975.¹ The increases in the past half decade have been explosive: a 70% rise in total health expenditures and a near doubling of the program costs of Medicare and Medicaid (the two largest governmental health efforts).² The trend shows no signs of abating: last year combined public and private health expenditures rose an estimated \$14 billion to a total of \$118 billion.³

The consequent debate on the causes of the cost spiral has posed questions about the impact of such outlays on present and future governmental efforts to finance medical care services. In addition, the economic considerations have prompted reappraisals of the quality, organization, and distribution of America's medical care facilities. Even though most Americans regard their own medical care as satisfactory, there is widespread concern that American medicine is not healthy.⁴

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1. Skolnik & Dales, *Social Welfare Expenditures, 1950-75*, 39 SOC. SECURITY BULL. 3, 15 (1976).

2. *Id.*

3. *Id.*

4. See, e.g., A DECLARATION OF INTERDEPENDENCE: DEVELOPING AMERICA'S HEALTH POLICY 34-35 (E. Shields ed. 1975); Anderson, Kravits, & Anderson, *The Public's View of the Crisis in Medical Care: An Impetus for Changing Delivery Systems?*, 24 ECON. & BUS. BULL. 44, 45-46, 51 (1971).

Reflecting that concern, a number of commentators have addressed controversial features of American medicine. Some have critically examined the unequal distribution of access to medical care.⁵ Others have reviewed the recent cycles of social concern and governmental response, concentrating on subjects as diverse as the politics of health in New York City and governmental programs for migrant workers.⁶ But few have cast their subject against such a broad historical background as Rosemary and Robert Stevens in their recent work, *Welfare Medicine in America*.⁷

Welfare Medicine is primarily a detailed political history of Medicaid since its creation in 1965⁸—a narrative of its origins, enactment, and programmatic instability. In the course of that history, however, the Stevenses touch on a number of the more widely debated aspects of American social policy: the consequences of federal-state matching fund programs for the poor, the relative merits of cash as opposed to in-kind methods of wealth redistribution, the differences between broadly based social insurance programs and selective schemes of public assistance, and the implications of programs such as Medicaid for the current national health insurance debate in the United States. A review of this work is perforce a partial review of America's welfare state and its critics during the past decade. Because the Stevenses chose the historical method, there are significant gaps in *Welfare Medicine's* discussion. For example, their historical account does not sort out the reasons for Medicaid's unanticipated growth. But the book's most critical omission is the lack of a systematic appraisal of Medicaid's performance. Nor is there much discussion of Medicaid's implications for the future of American medicine. Moreover, even as a history, the work's relatively narrow focus leaves to others the task of portraying fully the recent history of the American welfare state.

I. Medicaid's Unanticipated Development

From the outset, Medicaid was a paradoxical program. It was enacted as a practically thoughtless addition to the Medicare Act of 1965⁹

5. E.g., Aday, *The Impact of Health Policy on Access to Medical Care*, 54 HEALTH & SOC'Y 215 (1976).

6. R. ALFORD, *HEALTH CARE POLITICS* (1975); B. SHENKIN, *HEALTH CARE FOR MIGRANT WORKERS: POLICIES & POLITICS* (1974).

7. R. STEVENS & R. STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* (1974) [hereinafter cited by page number only].

8. As enacted in 1965, Medicaid was but an expansion of existing programs. P. 51. See pp. 1150-51 *infra*.

9. Pub. L. No. 89-97, tit. I, pt. 2, 79 Stat. 286.

and was codified as Title XIX of the Social Security Act.¹⁰ A welfare companion to Medicare's social insurance approach, Medicaid was a carryover of the Kerr-Mills program.¹¹ It continued the latter program's federal-state funding mechanism, and was therefore neither programmatically nor philosophically innovative. As a scheme for financing the medical care of some poor Americans, Medicaid retained the Kerr-Mills tradition of payments to vendors, but expanded the eligible population to include all medically needy beneficiaries of other federal-state public assistance programs.¹² While each state sets maximum income levels for eligibility, the Act required the states to comply with federal administrative guidelines. Once the state program was approved, federal funds became available to match state payments to vendors of medical care. Under the expanded program, vendor payments were available for a variety of services: hospital care for both inpatients and outpatients, certain diagnostic services, nursing home care, and physicians' services.¹³

Medicaid incorporated not only Kerr-Mills's technique of vendor payments but also its supporters' expectation that the states would restrain both the benefits and the number of eligible persons. That expectation of slow growth was reflected in estimates that Medicaid would add only \$250 million to the \$1.3 billion projected for Kerr-Mills in 1965.¹⁴ Programs for the poor were clearly presumed to be poor programs. This presumption meant that in 1965 federal legislators could confidently write sweeping language about making medical care available to all the poor by 1975; likewise, writers of HEW regulations could assume that federal rules reflecting that language would not be political dynamite. The same presumption enabled policymakers to speak boldly about the comprehensive medical benefits which Medicaid initially would offer to the categorically poor and, within a reasonable period, to all the poor.¹⁵

10. 42 U.S.C. §§ 1396-1396d (Supp. V 1965-1969) (current version at 42 U.S.C.A. §§ 1396-1396i (West 1974, 1975 Supp. & March 1976 Pamphlet)).

11. The Kerr-Mills program increased federal matching grants to states which made payments to welfare recipients under old-age assistance. In addition, it provided new federal funds for the "medically indigent" who were not receiving cash payments and "whose income might be above state eligibility levels for cash assistance." P. 29.

12. Pp. 57-69. See J. HOLAHAN, *FINANCING HEALTH CARE FOR THE POOR* 2-3 (1975). Those programs included Aid to Families with Dependent Children (AFDC), Old Age Assistance (OAA), Aid to the Blind (AB), and Aid to the Permanently and Totally Disabled (APTD). P. 61.

13. Pp. 65-68.

14. J. HOLAHAN, *supra* note 12, at 3. Far outstripping those estimates, by 1967 Medicaid costs exceeded Kerr-Mills expenditures by almost \$2 billion. P. 364.

15. This interpretation is drawn from T. MARMOR, *THE POLITICS OF MEDICARE* 37, 68 (1973), and from the reviewer's experience in the office of the Undersecretary of HEW during the summer of 1966.

Thus, few anticipated the financial, medical, or political consequences when Medicaid began in 1966. The limitations of its predecessor—Kerr-Mills—had not been carefully examined; the inflation in medical care prices which helped justify financial intervention by the government was largely ignored by congressional and HEW program comments; and, most importantly, no one anticipated the dramatic enlargement of the welfare rolls.¹⁶

When it became apparent that Medicaid was being used far beyond expectation, the adverse reaction was dramatic. Yet, while critics have decried the rise both in the number of eligibles and in the program's expenditures, few have recognized that Medicaid's real outlays have not increased since 1968. In fact, average per capita expenditures, adjusted for inflation, have slightly declined from \$167 in 1968 to \$162 in 1974.¹⁷

Welfare Medicine relates the history of political backlash beginning with the drain on state budgets, followed by public outcry, cut-backs on eligibility, recipient frustration, provider resistance, widespread charges of fraud and abuse, and ending with the emergence in the early 1970s of broader governmental efforts to regulate the medical care industry. The primary virtue of the Stevenses' book is that it relates much of this complex history with detail, clarity, and a wealth of rarely accessible sources. The Stevenses provide extensive documentation of Medicaid's political history in New York and California, the evolution of its federal bureaucracy, and the role of the courts in Medicaid's fate. Telling that tale is a difficult historical task; keeping the reader interested, as Stevens and Stevens do, is a substantial scholarly achievement.

II. Appraising Medicaid's Performance: The Difficulties

While absorbing as administrative and political history, *Welfare Medicine* is less satisfactory as an evaluation of Medicaid. In fairness, the Stevenses do not present their work as essentially an appraisal so much as a history; and they recognize that much remains to be done, including "quantitative studies of selected aspects of the program, and especially its cost and utilization"¹⁸ Nevertheless, the Stevenses trust that "the historical method" can both relate how the program

16. *Id.* at 88, 90.

17. K. DAVIS, NATIONAL HEALTH INSURANCE: BENEFITS, COSTS, AND CONSEQUENCES 42 (1975); L. RUSSELL, B. BOURQUE, & C. BURKE, FEDERAL HEALTH SPENDING 1969-74, at 64 (1974).

18. P. xx.

developed *and* provide an understanding of Medicaid's "strengths" and "weaknesses."¹⁹ Throughout, they do evaluate Medicaid, but because of the historical organization the bases for assessing the program's "strengths" and "weaknesses" are not systematically presented. This problem is in some ways typical of what one may regard as the Fabian school of social policy historians.²⁰ With a clear notion of what social programs should be like, Fabian historians can treat the gap between standard and fact as evaluation. Telling the tale of a program is, by reference to the ideal program, simultaneously evaluative. But the energy is directed at narrative, not explicit appraisal.

For example, at the time of its enactment Medicaid had two announced purposes: increasing the poor's access to medical care and providing that care in the mainstream of American medicine. In other words, the poor were to receive more medical care and receive it from the same providers utilized by the rest of the population. How well the program satisfied those purposes is only ambivalently treated in *Welfare Medicine*. On the one hand, the Stevenses argue that Medicaid was "phenomenally successful"²¹ in the magnitude of its coverage; on the other hand, they seem to believe that Medicaid's root problems, though evidenced by rising costs, inhered in the program's "goals, authority, and administration."²²

Recent research has demonstrated that Medicaid did substantially expand the poor's access to medical care but failed to bring the poor into the mainstream of providers. The increased use of physician services by the poor since 1965 is impressive. In 1964, families whose incomes were below the federal poverty line averaged 4.3 visits per member to a physician. By 1973, visits for the same group had risen to 5.6, compared to 4.6 and 4.9 for middle and upper-income family members respectively.²³ Furthermore, the poor are now hospitalized more frequently than before Medicaid's implementation.²⁴ Both these

19. *Id.*

20. What I have loosely termed Fabianism refers to the mode of social policy analysis often found in the publications of the British Fabian Society but is particularly evident among the Stevenses' former colleagues at the London School of Economics. Examples of such historical writing include B. ABEL-SMITH, *A HISTORY OF THE NURSING PROFESSION* (1960); B. ABEL-SMITH, *THE HOSPITALS, 1800-1948: A STUDY IN SOCIAL ADMINISTRATION IN ENGLAND AND WALES* (1964); B. ABEL-SMITH & R. STEVENS, *LAWYERS AND THE COURTS: A SOCIOLOGICAL STUDY OF THE ENGLISH LEGAL SYSTEM, 1750-1965* (1967). But the extensive use of historical materials by such authors is not restricted to books of history: their analyses of current issues in social welfare—such as R. TITMUSS, *COMMITMENT TO WELFARE* (1968)—stress the necessity of understanding where we are by how we got there.

21. P. xvi.

22. P. 132.

23. UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, *PUBLIC HEALTH SERVICE, HEALTH UNITED STATES 1975*, at 289 (1976).

24. *Id.* at 309.

trends make a mockery of any claim that Medicaid has been a complete failure.

Increased access alone does not establish that the poor have attained meaningful parity in utilization or quality of care. The poor suffer from illness more frequently than other segments of the population; thus, equal access to care would mean even higher rates of utilization than now exist. Moreover, the poor (and rural) are markedly less likely to have a regular source of care than the non-poor (and urban).²⁵ Children from central cities and rural areas are least likely, according to 1970 data, to see a physician at least once during the year. Perhaps most importantly, the poor continue to have fewer physician visits in response to days of disability than the rest of the population.²⁶ Yet the increased access to *some* medical care associated with the expansion of Medicaid is undeniable.

Whether the quality of care the poor receive equals that of the rest of the population is far more problematic. It is clear, however, that the poor receive their care from different sorts of physicians in different types of settings than do the non-poor. Medicaid has not markedly improved the access of poor children to mainstream private sources of care and has had a minimal impact on the current pattern of locating and providing care to the poor.²⁷ Poor children, particularly racial minorities in the central cities, are still the most frequent users of hospital outpatient services. In 1974, approximately 4.5% of the regular physician visits by the general child population were to hospital-based facilities; among children in central cities the percentage was twice that.²⁸ While the poor use more outpatient departments and general practitioners for their care, the more affluent disproportionately receive specialist care in physicians' offices.

While Medicaid has thus moved toward its goals with mixed success, little political attention has been devoted to evaluating those achievements and shortcomings. Instead, as the Stevenses make clear, criticism has focused on Medicaid's costs. Some of that attention is understandable, as total expenditures have far exceeded initial estimates. Yet, while similar dramatic increases have marked the Medicare program for the elderly, the political controversy over it has not matched Medicaid's. Part of the reason is that the federal-state financing of welfare programs decentralizes, and therefore multiplies,

25. National Center for Health Statistics, Division of Analysis, Report, at table C.7 (1974) (on file with *Yale Law Journal*) [hereinafter cited as Report].

26. L. ADAY & R. ANDERSON, DEVELOPMENT OF INDICES OF ACCESS TO MEDICAL CARE 42-43 (1975); Aday, *supra* note 5, at 215-16.

27. Report, *supra* note 25, at table C.7.

28. *Id.*

fiscal conflict, while financing Medicare through Social Security centralizes political oversight at great geographic remove from state and local tax disputes.

Critics who attribute the increased Medicaid costs to mismanagement fail to perceive the true causes. The predominant reason for the growth in Medicaid's expenditures is the increase in the number of eligibles.²⁹ The national economic conditions that affect the numerical size of America's welfare population are beyond the control of Medicaid's managers, however competent. A second important factor in Medicaid's expenditure growth over the past decade has been the unmatched inflation in medical care prices.³⁰ In dealing with increased prices, Medicaid's performance has been mixed, not disastrous as reports of budget overruns would have one believe. But not all cost reduction efforts have been without adverse effect. Many states have reduced costs by restricting eligibility and benefits. The poor in those states have thus borne part of the impact of a medical cost inflation to which Medicaid did not significantly contribute. Some states, most notably California and New York, have paid physicians on a fixed fee schedule lower than Medicaid's "usual and customary" reimbursement schedule. Here again, the impact has been to restrain the growth in Medicaid's program costs at the expense of making poor patients less attractive to mainstream providers of care. The dilemma is clear. Cost control in Medicaid has often conflicted with the goal of expanding access of the poor to mainstream American medicine.

Another misconception underlies the tendency to equate Medicaid's difficulties with the political controversies over Aid to Families with Dependent Children (AFDC). It is politically fashionable to link AFDC growth to the proposition that Medicaid is beyond fiscal control. But Medicaid is significantly affected by the aged's increased use of social welfare programs generally. Nearly 40% of Medicaid expenditures in 1970 were for the elderly. AFDC health outlays for adults and children that year comprised \$1.7 billion of the \$4.8 billion total, nearly \$50 million less than expenditures for the elderly.³¹ A realistic appraisal of Medicaid's growth, therefore, must emphasize the actual distribution of expenditures among recipient groups.

The growth of Medicaid, one must conclude, is paradoxical. Most of the rising costs are explained by the growth of welfare and the general medical cost inflation, not by Medicaid's generosity. To the

29. J. HOLAHAN, *supra* note 12, at 27-28, 32.

30. *Id.* at 27-31.

31. *Id.* at 10.

extent that Medicaid reached more of the poor in the late 1960s, it successfully expanded access. With substantial utilization among both the aged and non-aged, costs had to rise. When costs rose, those who had expected slow expenditure growth were outraged. Substantive program success, ironically, has meant instability in political support and an intense search for scapegoats among the poor and the providers. Unfortunately, in relating the history of the growth of Medicaid expenditures, *Welfare Medicine* fails to sort out and appraise the diverse contributing factors.

III. Medicaid and American Medicine

Welfare Medicine is most unabashedly evaluative in examining the interaction of Medicaid with the structure of American medicine. Medicaid's enrichment of providers, the authors assert, occurs because of an "unreconstructed, predominantly private system of medical care delivery."³² Because they blame the private system for Medicaid's cost difficulties, they conclude that "further extensions of health benefits will have to tackle the structure and function of the health care system."³³

It is safe to presume that American medical arrangements shaped the fate of Medicaid far more than the program transformed American medicine. As John Holahan has written, "Medicaid has been as much a victim of rising prices as a contributor, and perhaps more so" in view of its financing of care for less than 10% of the population.³⁴ So there is good reason for regarding Medicaid as the expression, not the cause, of American medicine's problems. But are those problems best understood as those of an "unreconstructed, predominantly private system"—problems which would be solved by a reconstructed public system?

It is here that *Welfare Medicine* most strikingly reveals the loyalties of the Stevenses to the British National Health Service model. To decry an "unreconstructed" private American system is to oversimplify the problems which do exist. Our medical care arrangements constitute a mix of public, not-for-profit, and proprietary institutions, of small entrepreneurs and cooperative ventures, all operating amidst a bewildering variety of financing mechanisms. All levels of government combined now finance 40% of all medical care costs;³⁵ thus, calling

32. P. 202.

33. P. 358.

34. J. HOLAHAN, *supra* note 12, at 31.

35. OFFICE OF MANAGEMENT AND BUDGET, SPECIAL ANALYSIS BUDGET OF THE UNITED STATES GOVERNMENT FISCAL YEAR 1974, at 170 (1975); STAFF OF SUBCOMM. ON HEALTH OF THE HOUSE COMM. ON WAYS AND MEANS, 94th Cong., 2d Sess., BASIC CHARTS ON HEALTH CARE 44-45 (1975).

the system "private" indicates little more than⁷ that facilities are not publicly owned and physicians are not salaried. There are, of course, serious difficulties with the cost, quality, distribution, and organization of American medical care, but they will not yield to public financing alone. The common concern about these topics in the western industrial countries testifies that many of our medical care problems are intractable and not simply the results of an ideological resistance to a larger governmental role in medicine.³⁶

The preference for public ownership of facilities and direct control of personnel permeates *Welfare Medicine*. Yet, within the United States, our experience with public schools and public transportation hardly supports the argument that public ownership promotes equity and generosity. Nor is it persuasive to characterize our current cost problems as peculiarly those of a "private" system. It can be argued that fee-for-service remuneration—combined with state failure to monitor the quality of care—leaves the public vulnerable to quackery. It might be that nationalization of medicine within the market economy would address such problems successfully. But it cannot be shown from cross-national research that the cost problems of modern medicine are so closely linked to the nature of the financing and legal control of its facilities and personnel.³⁷

Welfare Medicine is also disappointing in its discussion of changes in government regulatory efforts towards medicine. It concentrates on how the states reacted to Medicaid's cost increases but skirts the development of health planning and regulatory bodies. The charges of program overlap, duplication of equipment, and unnecessary surgery are part of the litany of the current public debate over American medical care.³⁸ The concern for controlling costs, increasing regulation, and expanding financial access through national health insurance partly resulted from the experiences of Medicare and Medicaid, but it was less the impact of these programs on the American poor that

36. See R. MAXWELL, *HEALTH CARE—THE GROWING DILEMMA* (1975).

37. The degree of public financing of health does not appear to be the significant factor in lower health expenditures. In Canada, Sweden, and the United States comparable shares of national income are spent on health while the proportion of government spending varies from 40% in the United States to nearly 100% in Canada and Sweden. A stronger case can be made that concentrating financial responsibility and administrative authority at one level of government—and thus diverting political competitors for public health expenditure from other public ministries—produces lower levels of medical care outlays. For a discussion of Great Britain's comparatively ascetic record on this count, see Marmor, Heagy & Wittman, *The Politics of Medical Inflation*, in *HEALTH: A VICTIM OR CAUSE OF INFLATION* 299 (M. Zubkoff ed. 1976).

38. P. 357. For a report on one of these complaints, see SUBCOMM. ON OVERSIGHT AND INVESTIGATIONS OF THE HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94TH CONG., 2D SESS., *COST AND QUALITY OF HEALTH CARE: UNNECESSARY SURGERY* (Comm. Print 1976).

prompted reform attention than the threats to private and public budgets from rising medical care expenditures.³⁹

IV. Medicaid's Place in America's Welfare State: The Politics of Change without Choice and Choice without Change

The overriding concern about costs which has dominated discussion of Medicaid has, in turn, obscured other issues. Of those, possibly the most significant has been the role of Medicaid in the future of America's poverty policy. A programmatic history of Medicaid such as *Welfare Medicine* could not have been expected to address that issue systematically. Nevertheless, the issue is important and merits greater attention.

The focus on costs is understandable: Medicaid's fiscal impact on governmental outlays to the poor has been enormous. It has come to be the largest single program for the poor by the measuring rod of public costs (\$9.2 billion in 1973).⁴⁰ By contrast, the most controversial welfare program, AFDC, represents a smaller fiscal outlay (\$7.8 billion in 1973).⁴¹ Yet the politics of these two types of redistribution—in-kind and in-cash—have been strikingly different. Throughout the late 1960s and early 1970s, the proposal for a guaranteed income to America's poor was continually on the national political agenda. A presidential commission deliberated between 1968 and 1969 on what income maintenance scheme the nation should adopt to replace the allegedly inadequate, inequitable, and fiscally burdensome patchwork of public assistance.⁴² During President Nixon's first term, the centerpiece of his domestic strategy was a guaranteed income for families with children—the widely publicized Family Assistance Plan (FAP).⁴³ Yet, though public choice focused on cash transfers for the poor, policy change did not involve any cash transfer program. Instead, changes were marked by new programs which had not been included in the reform debate.

Within public assistance, the aged, disabled, and blind poor were shifted to a new federal program that emerged in the wake of FAP's

39. For an elaboration of this argument and the polling data on which it is based, see Marmor, *The Politics of National Health Insurance*, 3 POL'Y ANALYSIS (Winter, 1977; forthcoming).

40. Skolnik & Dales, *supra* note 1, at 15.

41. M. BARTH, G. CARCAGNO & J. PALMER, TOWARD AN EFFECTIVE INCOME SUPPORT SYSTEM: PROBLEMS, PROSPECTS, AND CHOICES 15 (1974).

42. For the findings and recommendations of that commission, see THE REPORT OF THE PRESIDENT'S COMMISSION ON INCOME MAINTENANCE PROGRAMS, POVERTY AMID PLENTY (1969).

43. For the history of FAP, see Marmor & Rein, *Reforming "The Welfare Mess": The Fate of the Family Assistance Plan, 1969-72*, in POLICY AND POLITICS IN AMERICA: SIX CASE STUDIES 3 (A. Sindler ed. 1973).

flop, the 1974 Supplementary Security Income program.⁴⁴ But, even more clearly, the balance of American antipoverty efforts turned without national debate to the categorical noncash schemes of food stamps and Medicaid. Why this happened is a topic *Welfare Medicine* does not address systematically. Where it discusses the struggle over FAP, *Welfare Medicine* regards the debate as having delayed Medicaid reforms.⁴⁵ This is no doubt true if only because the debate absorbed the energies of the nation's top federal welfare officials.

Yet there is a more profound relationship between Medicaid's growth and the demise of welfare reform dreams. Just as Medicaid's decentralized financing scheme relegated budget disputes to the state and local levels, the federal welfare reform efforts centralized the dispute over the proper treatment of the poor. The outlays for Medicaid emerged from the dispersed decisions of state political processes; no one chose to spend what Medicaid cost, though governments had to pay for what Medicaid patients used. In contrast, the fight over FAP made explicit the costs of public assistance reform. As recent research on FAP has made clear, the federal politics of redistribution gave liberals and conservatives ample opportunity to weigh the claims of the poor on the nation's resources.⁴⁶ Although failing by a close margin in 1972, FAP revealed the powerful opposition of the American public and its politicians to unconditional cash grants to the poor.⁴⁷ The Medicaid program, along with food stamps, shows by contrast how rapidly programs for the poor can grow when (a) the benefits are tied to legitimate items of expenditure (food and medical care, not booze) and (b) the costs of relatively generous treatment emerge from decentralized program operations, not national choice.

Welfare Medicine, then, is a fascinating guide to the controversies spawned by Medicaid's unexpected development. Its documentation of Medicaid's fate is inspiringly extensive, and its literary grace is a welcome change from much social policy analysis. But the Stevenses' historical account has left to others the task of fully appraising Medicaid's past. Likewise, *Welfare Medicine* has only an abbreviated discussion of Medicaid's implications for the future of American medicine. Nevertheless, scholars who seek to fill those gaps will owe a substantial debt to the Stevenses for their administrative and political history of the great program afterthought of 1965, Medicaid.

44. 42 U.S.C. § 1381 (Supp. IV 1974).

45. Pp. 221-26, 327-29.

46. E.g., M. BOWLER, *THE NIXON GUARANTEED INCOME PROPOSAL: SUBSTANCE AND PROCESS IN POLICY CHANGE* (1974); V. BURKE & V. BURKE, *NIXON'S GOOD DEED: WELFARE REFORM* (1974).

47. See Hoffman & Marmor, *The Politics of Public Assistance Reform: An Essay Review*, 50 SOC. SERV. REV. 11, 15 n.6 (1976).